AMERICAN HEALTH CONSULTANTS®

# HEALTHCARE BENCHMARKS™

The Newsletter of Best Practices

## IN THIS ISSUE



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# Good food in a hospital? Dare to dream and palates will follow

*Make food service staff your goodwill ambassadors: Bon appetit!*

No one chooses a hospital based on its food service. It's a truth that **Mary P. Malone**, MS, JD, executive director at Press, Ganey Associates in South Bend, IN, understands. But that doesn't mean those dismal scores your food service gets on its patient satisfaction surveys should be left to languish.

"If you believe in performance improvement and are interested in measuring things and getting better at them, then you have to look at ways to improve everything," she says. "If you have the opportunity to improve something, you should."

The results can be astonishing. Boston-based Massachusetts General Hospital's food service director was named restaurateur of the year last year by the Massachusetts Restaurant Association.

## *From simple changes to total overhauls*

Fixes for your food service woes can range from simple revamps to complete overhauls. Swedish Hospital in Seattle has a room-service-style food-on-demand system that required $500,000 in renovations — including a computer system upgrade, natural gas appliances in the kitchen, new china, sauté pans, and glassware, as well as setting up a deli station. The cost also included consulting fees.

A similar revamp was done at Rush-Copley Medical Center in Aurora, IL. There, patients choose from a restaurant-style menu whenever they want to eat. Structured like room service in a hotel, the program allows patients to order anything, including snacks, from a menu anytime the kitchen is open, providing their orders meet their dietary restrictions.

Food is delivered within 30 to 45 minutes of the order being placed. The hospital, says Malone, reports a 20% increase in

patient satisfaction scores. But the cost will be recouped with annual savings of more than $18,000, in part through less food waste.

Sure money is tight, Malone says, but a lot of good ideas don't involve building new kitchens or providing staff with silver service training. "Here's a simple thing you can do. Make sure that people aren't saying to patients who don't eat their meals that they wouldn't eat [the food] either."

There's also the "pizza-box test," which anyone can conduct. "Are there fast-food bags around? If your staff don't eat the [facility's] food, that sends a powerful message to the patients," Malone adds. "It tells them how to feel about it before they've even tasted it."

Another easy implementation: Tell staff not to open food in front of chemotherapy patients. They can be nauseated easily, and the sudden wafting of aromas can turn them off the idea of eating completely. **(For more uncomplicated ideas, see story, p. 87.)**

## *Good training makes a difference*

A lot of improvement comes from training, says Malone. "What's the point of putting in expanded menus if staff don't let the patient know there is a choice?" she asks.

Points that Malone likes to emphasize when talking about how to improve nutrition departments include:

• **Food isn't just about food service.**

"It's the measurement of the entire patient experience with food," Malone notes. "And a lot of your score will be dependent on how food service and nursing departments work together." One facility solved the cold food problem by putting a service bell on the nursing desk in each unit. When the food came up, the bell was rung. If a staff member wasn't working on a code, he or she came out immediately to deliver the food.

• **Food service staff are ambassadors.**

They travel around the hospital in a way that other people don't. "Go ask your cafeteria staff: What's good today? If they say nothing, or say, 'Nothing,' they aren't being good ambassadors."

• **Food is more than sustenance.**

"Food has symbolic meaning," Malone says. In times of crisis in her own family, everyone settles in around a cup of tea. "But I dare you to get a cup of tea in a hospital. You can get coffee, but not tea."

• **Delivery of food may be the best thing that happens to the patient that day.**

They are sick; they are poked, prodded, tested, and have to run around in flimsy hospital gowns. "If you act as if you are the best thing in their day, what gains could you make?" asks Malone.

It is a myth that any of the suggestions Malone has up her sleeve are simple. "They seem easy to think of, but they aren't necessarily easy to implement. You have to get everyone doing these things all of the time."

## *All aboard!*

Getting employee buy-in and including them in performance improvement from the start is as key to achieving success in food service as in any other area, says Malone. And she has a whole slew of clients who have taken that rule to heart to prove it.

For instance, in 1997, peer group comparisons put Champlain Valley Physicians Hospital's food service scores in the bottom 2%. A 356-bed hospital in Plattsburgh, NY, the facility had some 10,800 admissions in 2000, and its mean scores in food service are now in the 90th percentile compared to its peers.

**William Myers**, director of nutrition services for the facility, created several programs, including "Sizzle with Service" and "Give Them What They Want" — certainly not something that springs to mind when thinking of hospital food services.

"All of the programs that we have developed and implemented are built on the principles of good customer service and doing all that we can to exceed our customer's expectations," says Myers.

"We present the material differently each time and keep it fresh. We use stories or case studies to put examples in real-life terms. We keep our staff


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informed of our patient satisfaction scores and actively solicit ideas and suggestions from [everyone] we interact with. We actively follow up on any issue or suggestion that is brought to us, which has resulted in countless system modifications that have greatly improved our quality and service."

### Keep the problem in perspective

For those who already take food service seriously, keep it in context, warns Malone. "Food service and noise are always pretty low scores. If you have a score of 79 in food service, that is hugely better than an 80 in nursing. And if you are a hospital that is in the 25th percentile overall but in the 50th in food, your food service is outperforming the institution, and you probably have bigger problems than cold meals."

Patients and visitors complain about food service — reason enough for administrators to care about it. "We did some work a couple years ago on the trend among patients to recommend hospitals to friends and relations," says Malone.

"That trend is slipping — in line with how customers of other industries are less likely to make recommendations," she explains. "The point is that you can continue to make improvements, but you will have a hard time keeping up with the speed at which customer needs and desires are changing. We face a lot of challenges in this industry, and the role of food services in patient satisfaction is just one. But that doesn't mean you shouldn't act."

### How high to set the bar

The issue is how high the bar should be set, Malone concludes. "If you are only happy to have your food service staff show up for work, then you don't have the bar high enough," she says.

"Southwest Airlines continually has a large number of people apply for entry-level counter-help positions, even in a hot economy. Disney can get minimum wage earners to perform beautifully. Rethink your assumptions about what to expect from food service.

"Create an underlying sense of pride among your employees. Motivate them to understand the importance of taking care of patients and their families. Yes, you have to have good systems and processes. Food temperature is important, but so are staff attitudes," Malone adds.

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# 10 cheap and easy ways to improve food service

Interested in improving food service without breaking the bank? **Mary P. Malone**, MS, JD, executive director of consulting services at Press, Ganey in South Bend, IN, has a list of relatively cheap and straightforward ideas that some of her clients have implemented.

### Reaping large increase in satisfaction

Most have led to significant increases in food quality scores on patient satisfaction surveys.

The first three ideas led to an increase from 66.5 to 70.2 points on the food quality scores in patient satisfaction surveys:

1. Riverside Methodist Hospital, part of OhioHealth in Columbus, instituted taste panels before every patient tray line to engage staff in looking for improvement opportunities. Participants in the panel included managers, dietitians, supervisors, cooks, and tray-line personnel.

2. Although the Riverside food department is responsible for tray delivery, it sought to increase interaction with patients. Someone visits all new patients, describes the diet the physician has ordered, and provides additional information about available services.

3. Riverside also focuses on appetizing plate presentation and garnishes as simple touches that can make a difference to patients.

4. At Valley Children's Hospital in Madera, CA, breakfast is served on demand from a breakfast cart.

Every morning the cart is taken to the patient

floors. This has replaced the traditional tray line and trays.

5. Since it caters to children, Valley Children's Hospital offers restaurant-style food, which kids frequently request.

6. Memorial Hospital and Medical Center in Midland, TX, includes a 25% discount coupon for the cafeteria in its food and nutrition admissions packet for patients' visitors to use.

7. Patients at Presbyterian Medical Center in Philadelphia are visited following meal delivery to determine if they got everything they ordered and if they wanted something else.

8. Presentation is important, so Moses H. Cone Memorial Hospital in Greensboro, NC, tries to emulate how food is presented in a home environment. Rather than using packaged drinks and cereals, they pour their own. They have increased scratch baking and enhanced their salad mix.

9. Using better dishes, cloth napkins, and eliminating plastic bags with tiny paper napkins and cheap eating utensils further enhances the dining experience at Moses H. Cone.

10. In Lubbock, TX, Covenant Medical Center has made a concerted effort to focus on improving patient perceptions with explanations regarding special diets. A registered dietitian conducts special inservice programs for the staff of several cardiac units.

The education blitz includes an information sheet that nurses provide to patients upon admission. The sheet includes basic information on diets for cardiac care, diabetes, reduced sodium, and test diets common to cardiac care.

In 1998, the mean food service question score improved from the 57th percentile to the 93rd percentile when compared to all hospitals.

### *Many paths lead to improvement*

"As these stories show, the paths to improvement are as varied as our clients," says Malone.

But the common element is team involvement. And she has one last tip: "Stop calling them 'late trays,'" she says.

"If you call them that, no matter how fast you get them to the floor, they'll always be late. Use the term 'courtesy tray' instead." ■

# Virtual learning web site leads the VA to success

It doesn't surprise **Victor S. Wahby**, MD, PhD, director of the Veterans Health Administration's office of special projects in Washington, DC — part of the Department of Veterans Affairs (VA) — that every day brings at least one new idea for health system and facility improvement.

He predicted his idea to tap into the power among the more than 182,000 employees in 172 hospitals, 134 nursing homes, and more than 500 clinics would be a success when he launched his web site four years ago. Now he gets submissions not just from those employees, but from health care workers in other facilities as far away as Spain, Canada, and Pakistan.

Now about 30 of those lessons are being published in a compendium, the third to be printed, for VA facilities to have access to at any time. "We use a storytelling format where leaders tell a story about a situation, usually a crisis, how he or she dealt with the situation and the lesson learned," explains Wahby.

The past two editions have included sections on lessons of the month and the lesson of the year. But Wahby decided not to publish in that format this time. "It implies the others aren't as good," he says. "I don't think it should be called best practices either. Just better practices. We can always do better."

For those outside the VA system who want access to some of those valuable lessons, the Lesson's Learned web site, called the Virtual Learning Center, is still up, running, and collecting more ideas (http://www.va.gov/vlc).

### *Collecting ideas from around the country*

It started, in part to, help bring good ideas from across the vastness of the VA to one place. And the idea was a hit from the start. "We had hundreds of ideas come in during that first year or so," Wahby says.

"Now the pace has slowed, but I think the quality of the lessons is higher. People consider a little more carefully before they submit them." There are about 1,100 lessons available for the public, at large, to look at, as well as another 200 or so that are only available on the intranet.

*(Continued on page 90)*

# Lessons Learned at a Rate of More than One per Day

Of the more than 1,300 Lessons Learned available for public perusal on the Veterans Administration web site — http://www.va.gov/vlc — more than 30 came in during June. **(See story on the VA Lessons Learned project, p. 88.)**

Here's a sampling of what users can see on the site, including the topic, the date submitted, and the facility presenting the idea:

- ✔ Leasing of Water Towers for Cell Phone Antennae (6/29/2001: Health Care System Hudson Valley, NY)
- ✔ Nonprofit Community Relations to Raise Revenue (6/29/2001: Health Care System Hudson Valley, NY)
- ✔ Patient Safety is Measurable (06/29/2001: VAMC Bronx, NY)
- ✔ Task Assignment Sheet Development for Food Service Workers (6/29/2001: VAMC Northport, NY)
- ✔ Use of Pre-plating in Advanced Tray Delivery (6/29/2001: VAMC Northport, NY)
- ✔ Computerized Patient Record System Quiz in Flash (6/28/2001: Health Care System Hudson Valley, NY)
- ✔ High Performance Development Model Compilation (6/28/2001: Health Care System Hudson Valley, NY)
- ✔ Official Personnel Folder Database Creation for JCAHO Tracking (6/28/2001: Health Care System Hudson Valley, NY)
- ✔ On Line e-Safety Training (6/28/2001: Health Care System Hudson Valley, NY)
- ✔ Upload to TEMPO from Hospital-based Education System (6/28/2001: Health Care System Hudson Valley, NY)
- ✔ Use of Flash for Education Instruction (6/28/2001: Health Care System Hudson Valley, NY)
- ✔ Standardized CBOC Operations Manual-On-line (6/26/2001: VISN 02 Albany, NY)
- ✔ Patients Monitoring Patients to Prevent Elopement (6/20/2001: Health Care System New Jersey)
- ✔ Assisted Community Transitions Improves Outcomes for Work Therapy Participants (6/18/2001: Health Care System San Diego)
- ✔ Improvement Of Pharmacy Customer Waiting Time (6/18/2001: Health Care System New York Harbor)
- ✔ Furnish Medical Physicals to Increase Revenue (6/15/2001: Health Care System New Jersey)
- ✔ Bar Code Medication Administration Enhancement (6/14/2001: Health Care System New Jersey)

*(Continued)*

- ✔ Clothing For Needy Veterans (6/14/2001: Health Care System New Jersey)
- ✔ Life Video (6/14/2001: Health Care System New Jersey)
- ✔ Physical Move of Primary Care Teams (6/14/2001: Health Care System New Jersey)
- ✔ Putting a Processing Station for Sendouts in Our Phlebotomy Area. (6/14/2001: Health Care System New Jersey)
- ✔ Referral of Chronic Pain Patients to the Mental Hygiene Clinic and/or the Health Psychology Clinic (6/14/2001: Health Care System New Jersey)
- ✔ Simplify Request for New Medical Library Book Form #10-7149 (6/14/2001: Health Care System New Jersey)
- ✔ Use Of Templated Nurses Notes for Gastroenterology Procedure Instructions for Patient Preparation (6/14/2001: Health Care System New Jersey)
- ✔ Direct Delivery of Incontinent Products by Warehouse to Wards (6/13/2001: Health Care System New Jersey)
- ✔ Instituting an Intranet Web Page to Facilitate Communication Between a Centralized Food Production Facility and its Receiving Sites (6/12/2001: VISN 03 Bronx, NY)
- ✔ ICU Family Support Group — Brooklyn Campus (6/08/2001: Health Care System New York Harbor)
- ✔ VA Western New York Healthcare System's Leadership Listening Posts (6/08/2001: Health Care System Western New York)
- ✔ Integration of Tai-Chi-Chuan as a Successful Modality for Health and Well-being in the Rehabilitation Setting for Both Staff and Patients (6/07/2001: VAMC Bronx, NY)
- ✔ Care of the Veteran with Dementia in the Home-Project AHEAD (6/06/2001: Health Care System New York Harbor)
- ✔ Bed Control — VA New York Harbor Healthcare System — Brooklyn Campus (6/04/2001: Health Care System New York Harbor)
- ✔ VA Prosthetic Treatment Centers — Paradigm of the Future (6/04/2001: VAMC Minneapolis)
- ✔ 7 Day Internal Appeal Process for Patient Complaints (6/01/2001: Health Care System Hudson Valley, NY)

"There are so few large organizations that share ideas like this," Wahby says. The military is one example, but in health care, "they are pretty nonexistent. There is the Best Practices Network [www.best4health.org] and the Joint Commission [on Accreditation of Healthcare Organizations] has some [information] available based on incidents. I would love to have some sort of consortium where we could call a meeting and really get people learning lessons from others and comparing notes."

Because he has spoken about the Virtual Learning Center to other organizations, Wahby says he knows there is a great deal of interest in

mimicking what the VA has done elsewhere. "I was on a panel recently with a guy from the [American Medical Association], and he would love to take [the idea] back [to his organization]."

This year, the web site has started collecting information from visitors on whether they implemented an idea, how much time or money was saved, and how they measured the impact on quality of care. "We want this to be evidence-based," he says. "Starting next year, we hope to have some really good data on this."

The Veterans Administration in general — and VA health facilities in particular — doesn't have the best reputation, Wahby says. "But we are turning that around. We lead the nation in patient safety, and no one can touch our Lessons Learned program."

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# A sample lesson learned: All-too-frequent users

*(Editor's note: This lesson was submitted by San Francisco VAMC, Dec. 1, 2000.)*

A small number of patients were using the urgent care clinic in an excessive and inappropriate manner.

A computer review identified patients who had made three or more visits to the urgent care clinic. They were invited to participate in a monthly group clinic for high users of the medical practice urgent care clinic.

The health education curriculum emphasized resources available through the VA Medical Center as well as overall health promotion.

Of the 60 high users identified, 18 participated in the group clinic. The mean number of sessions attended by these participants was 4.4.

Before the intervention, the mean number of participants' visits to the urgent care clinic was 5.7; this decreased to 1.8 visits in the year during which the group clinic was instituted.

This decrease was statistically significant, with a p value less than .0001. All patients who completed an evaluation form at the end agreed that the group clinic was a useful way to spend their time and that the sessions helped them understand better how to access VAMC services.

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*View the full lesson on the Virtual Learning Center web site at http://www.va.gov/med/osp/cgi-bin/browse.asp?lesson=1387.]* ■

# Regional differences are part of breast cancer care

One in nine women will get breast cancer sometime in her life. For those women and their families, finding the best care is vital. But getting the best treatment may be as much a matter of where you live as anything else.

According to a new clinical research study conducted by Solucient, a health care consulting firm based in Baltimore, less than half the women in the South are likely to receive breast conserving surgeries (lumpectomies). In the West, only 50.2% of women have it, in the North Central region, 51.1%. The Northeast does best, with 60.5% of women having that surgery. The overall rate for the study was 50.8%.

The gold standard of care for those receiving lumpectomies is to have radiation therapy afterward. Overall, only 45.7% of the patients had it. The West was best in this category, with 51.8% of lumpectomy patients receiving radiation follow-up. That compares to 49.3% in the Northeast, 46.2% in the North Central, and only 39.8% in the South.

The study commentary notes that radiation therapy is "greatly underutilized," even among teaching hospitals, larger hospitals, those in the West, and among the better performing hospitals in the study.

But there may be one good reason for the lack of follow-up radiation, says **Barbara Hawkins**, RN, MS, OCN, manager of the breast care program at Southwest Washington Medical Center (SWMC) in Vancouver. Her facility was one of the top 100 hospitals named in the Solucient study.

"Certainly, early detection may make lumpectomy alone a viable treatment option," she says.

At SWMC, the focus is on getting people in early for diagnosis. "We have received support from the Susan G. Komen Foundation to provide free mammograms, and we are a prime contractor for the Breast and Cervical Health Program through the Centers for Disease Control and Prevention," Hawkins explains. "That means that we can have any woman, regardless of age, insurance, or even citizenship come in for detection, diagnosis, and treatment. We get them in the system early and follow them through."

One reason Hawkins contends there may be regional differences in the kinds of breast cancer treatments offered is that when a mastectomy is done, it is more likely to be the complete treatment. If chemotherapy is required, it's simply a monthly treatment for four to six months. If a patient chooses a lumpectomy, it usually requires radiation therapy five days a week for five to six weeks.

"Part of it is the location of the patient and the location of services. If the patient lives in a rural area or there are transportation issues, then getting her in that often can be a real challenge," she says. "Offering a lumpectomy in that circumstances isn't the right thing to do."

SWMC treats about 200 breast cancers a year from a six-county area. Out of those, about 60 result in mastectomies. And of that number, maybe a quarter opt to have immediate breast reconstruction surgery.

In the Solucient study, 13.2% of the 168,000 patients included had such surgery immediately. The rates regionally varied from a low of 9.5% in the West to 15.1% in the Northeast. Bigger hospitals were more likely to offer the surgery (21.3% of facilities with more than 500 beds, but only 6.9% of those with less than 200 beds). Patients with private insurance were more than 10 times likely to receive it than women on Medicare: 23.6% of the former, and 2.1% of the latter.

## *Too many decisions at once for patients*

Judging a facility based on its immediate reconstruction rates may be misleading, says Hawkins. "We always ask if they want it done up front," she says. "But often, we are asking [patients] to do so much all at once [that] it can be a hard decision to make. It can take up to a year to complete the reconstructive surgery process. Some women just prefer to wait."

**Helen K. Chew**, MD, director of the division of hematology / oncology, at the University of California (UC), Davis Cancer Center in Sacramento presides over another one of the 100 top hospitals listed in the study.

She says having hard data on what is common practice is important in learning what areas need improvement. "We found out from data that access to the breast clinic after a positive mammogram was something we had to work on," Chew explains. "That's a really anxiety-ridden period for patients. We have been able to cut the turnaround time in pathology and cut that time to a week or two."

## *Team approach creates top performers*

Being a large academic institution is certainly helpful in keeping the UC Davis facility at the top of the heap. "A real key to our success is being multidisciplinary," Chew says.

"We allow patients to seek multiple opinions, from surgeons to oncologists to radiologists. That helps make for well-informed patients. They know all their options. And in an academic institution, we can offer trials," she adds.

"We are doing sentinel lymph-node biopsy study, which is even less disfiguring than lumpectomies," Chew points out. "It's new and exciting, but it is still unproven. Even when something is sexy, we like to see the data to prove its worth."

There are two things that SWMC does, Hawkins says, which makes it stand out from other facilities and improves breast cancer care:

**1.** There is a twice-monthly breast cancer conference in which every positive breast pathology of the previous two weeks is discussed by a multidisciplinary team including the radiation and medical oncologists, pathologists, radiologists, surgeons, cancer researchers, and primary care physicians.

"For 14 months, this has served as a good learning venue for us and provided a way for the various disciplines to talk together about what is happening in specific cases. This isn't like a tumor board where only three or four cases are selected. This is all of them," she adds.

**2.** The facility provides a strong patient focus. There is a breast cancer library for patients, which is funded by donations and grants. It includes research journals and mainstream books, as well as two computers with Internet connections.

There is a breast peer program that links survivors with newly diagnosed patients. There are support groups for patients, caregivers, and children of patients.

"We try to link patients with their peers in all cases," Hawkins says. "That is where the most powerful connections come. We are only trained professionally and technically. The peers are the ones who are there for the whole journey."

Chew says it's important to remember the patient. "We all offer pretty good medical care in this country," she notes. "It's the rest of the stuff that becomes so important to improve upon. We can always do better on things like psychosocial support, which isn't necessarily thought of as medicine, but which can make a lot of difference to the patient."

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# Do the job properly: See cataract surgery clearly

Cataract surgery is the most common surgery done in an ambulatory setting. If you want to be a top performer, then you should hone your teamwork skills, says **Naomi Kuznets**, PhD, director of the Accreditation Association for Ambulatory Health Care's (AAAHC) Institute for Quality Improvement (IQI) in Wilmette, IL.

The institute looked at 329 cases submitted by 18 organizations in its second study on cataract extraction with lens insertion. Nothing much changed between the 1999 and 2000 study, she says. But it is even more clearly evident that the best organizations are the ones that take the teamwork message to heart.

"The best performers don't sit back on their laurels," she notes. "They are interested in continually doing better and in working together to improve."

Prima donnas need not apply to these organizations, she notes.

"In the best of the best, the anesthesiologists clean up their own mess. Why wait for a tech if that will slow down the turnover of the room? They pick up slack from each other and aren't married to specific job descriptions," Kuznets adds.

Among the findings of the study:

• **Pre-procedure time ranged from a low of less than an hour to two hours.**

The median time was 78 minutes. Tips from the better performing facilities include having only one patient at a time in each area; providing multiple patients with their blocks at the same time; and making sure the patient is ready when the surgeon walks in so he or she is not delayed at all.

• **Procedure time ranged from about seven minutes to 35 minutes, with a median time of 16 minutes.**

The best performer has learned over time that it takes five sets of instruments to support proper cleaning and sterilization and to maintain the team's pace.

• **Discharge time ranges from less than 10 minutes to about an hour.**

The median time is 23.5 minutes. The best performer states that its patients recover from Brevital before going to the OR and is ready for instructions immediately in the post-op area. Nursing staff at that organization also call patients within a few hours of surgery to check patient status, verify understanding of instructions, and answer questions. Good patient education seems a common thread among those with the lowest discharge times.

Knowing how long it takes to move a patient through the system is important to success, says Kuznets. "We are going to be looking at this in many more studies now. If you have a really long pre-procedure time, but find it isn't long enough, you have a problem."

She says another differentiation between the best organizations and their counterparts is that the better performers are able to negotiate better deals for drug and supply costs. "Even if you aren't big and you know enough — and your physicians are willing to do an exclusive deal with a company to get better prices — you can negotiate good deals."

Many representatives will say they can't get customers prices as low some of the better performers report. "But if you know your market and you ask the right questions, you could be surprised," she says.

Average cost for intraocular lenses ranged from just less than $40 to more than $150. The best performer uses Alcon Intraocular Lens, has a midrange annual volume of procedures, but is

able to negotiate this good price. It does 80% of its business exclusively with one company. The next best performer, which had the lowest annual volume, uses the Chiron Intraocular Lenz and only pays an average of $40 each. If a facility is owned by a hospital, it may be easier to get better supply costs, regardless of the size of the organization or its volume.

Sedative and narcotic costs combined ranged from less than a dollar per case for an organization that only used sedatives, to about $6.50 for a facility that uses both. The best performer uses Midazolam (1.5 mg to 3.5 mg) and Fentanyl (50 mcg) for each case.

### *For your future reading pleasure*

There is a great deal of interest among members in this study, Kuznets says. "People are interested in seeing how implementing changes one year impacts their performance the next. When we do satisfaction evaluations of our studies, we get comments that participants do use this information."

Just how well the changes organizations made last year will impact their performance this year should be evident next spring, when the 2001 Cataract Extraction with Lens Insertion study becomes available. The institute is collecting the data now and should start the number crunching this fall.

Along with that third cataract edition, the IQI is working on two other studies of interest, says Kuznets. In an upcoming diagnostic colonoscopy study, procedure time will be compared to how many polyps and other abnormalities were found. "Some organizations that look like they have a long procedure time were actually doing well compared to others which had less complicated cases."

More than 800 patients in 33 organizations will be featured in that study. "One interesting finding is that a small but significant group say they wouldn't go back for another colonoscopy even if it was recommended," says Kuznets. "A large number of those had severe discomfort: a four or five on a scale of five. And of those, most of them had no preoperative medication. That has a potentially disastrous public health consequence. It means we may not catch cancers early."

A second upcoming study is not a traditional study, but looks at the 1,300 organizations accredited by the AAAHC. Forty-five percent of them responded to questions about medical errors that result in injury or illness as well as near-miss situations. "The Institute of Medicine looked at hospitals. We want to look at ambulatory settings."

Some 30% of the accredited organizations are looking at medical errors and near misses. Some are involved in mandatory programs, while others have started voluntary efforts, Kuznets says. "We asked them if they were not involved now, what would motivate them to become involved. Only a very small number say nothing would entice them to investigate this subject."

Although the data are still being analyzed, the larger the organization, the more likely it is to be interested in understanding its medical error and near-miss rates, she says.

The exception is ambulatory surgery centers, which although they might not be associated with a network, have large clinical staff that are affiliated with professional organizations that offer them help with this subject. "We have to find ways to help the smaller organizations," she says. "Maybe national professional organizations

## Cataract Surgery: Anesthetic Block Combinations

| Anesthetic | Percentage of Respondents Using |
|---|---|
| Retrobulbar alone | 20% |
| Peribulbar, monitored anesthesia care (MAC)* | 19% |
| Retrobulbar, IV, MAC | 18% |
| Peribulbar, IV | 14% |
| Peribulbar, IV, MAC | 9% |
| Peribulbar alone | 8% |
| Retrobulbar, IV | 7% |
| Retrobulbar, Peribulbar, other | 3% |
| Retrobulbar, MAC | 2% |

* Monitored anesthesia care differs from local and regional anesthesia by the use of sedatives and other agents that are given as inhalants or by IV; the dosages are so low that the patients are responsive and breathe unassisted.

*(Editor's note: Those using block anesthetics completed their procedures in an average of 17.4 minutes compared to 16 minutes for those using topical anesthetics. About 45% of respondents use the latter.)*

*Source:* Institute for Quality Improvement, Wilmette, IL.

have to take a bigger role. For the small group, there are issues of confidentiality, of time and money."

This report will be sent on to state legislatures, state medical boards, and branches of the federal government that are interested in the topic.

*[For more information, contact:*

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NEWS BRIEFS

# New patient safety standards in effect

Medical errors will have to be reported to patients and hospitals will have to take specific steps to prevent such problems, according to new patient safety standards implemented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in July.

A 1999 Institute of Medicine report estimates that medical errors kill between 44,000 and 98,000 hospital patients annually, and the new standards were designed to "create a culture of safety in hospitals and other health care organizations" according to JCAHO president **Dennis O'Leary**, MD.

Such a culture should strongly encourage the internal reporting of medical errors, and actively engage clinicians and other staff in the design of remedial steps to prevent future occurrences of these errors, he says.

The additional emphasis on effective communication, appropriate training, and teamwork found in the standards' language draw heavily upon lessons learned in both the aviation and health care industries.

A second major focus of the new standards is on the prevention of medical errors through the prospective analysis and redesign of vulnerable patient care systems such as the ordering, preparation and dispensing of medications.

Potentially vulnerable systems can readily be identified through relevant national databases such as JCAHO's Sentinel Event Database or through the hospital's own risk-management experience.

Finally, the standards make clear the hospital's responsibility to tell a patient if he or she has been harmed by the care provided.

With the new standards implemented, more than half of all of JCAHO's hospital standards

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relate directly to patient safety.

Further information on the new standards, including a list of the standards affected and the changes involved, can be found at http://www.jcaho.org/news_frm.html. ▼

# Solucient launches a new pharmacy tool

Solucient, a health care consulting company based in Baltimore, is launching a new interactive electronic pharmacy tool to help hospitals look at drug cost and utilization.

Solucient RxView was developed to help hospitals understand and measure drug cost and utilization. It compiles and organizes a hospital's data using an Internet-based data submission process to quickly provide clients with targeted reports on drug cost, utilization, and outcomes.

These standard and custom reports identify opportunities for clients to reduce cost and improve patient care. It integrates readily available patient discharge data with inpatient drug dispensing data, allowing clients to establish comprehensive performance benchmarks.

Solucient RxView supports both macro- and micro-level analyses. Medical directors and financial administrators can use it to take a broad look at all aspects of pharmacological management, and clinical staff can drill down to review drug trends in disease management and the impact those trends have on patient care.

For more information on the product, visit the company web site at www.solucient.com. ▼

# NCQA draft of disease management standards

As readers of *Healthcare Benchmarks* read this issue, officials at the National Committee for Quality Assurance (NCQA) are reading through public comments directed at its disease management standards. The new program was released for public comment in June, with comments due by July 31. Final standards should be released in December.



Members of the Disease Management Association of America (DMAA) were among those who helped develop the program.

Many different types of organizations will be eligible to participate in NCQA's disease management programs.

Although most participants will likely be free-standing disease management (DM) organizations contracting with a managed care organization or employer, other organizations providing DM services — behavioral health care organizations, medical groups, etc. — are expected to participate as well.

Health plans and other organizations contracting with NCQA-accredited or certified DM programs will receive automatic credit on related quality improvement standards that they would otherwise be required to satisfy.

NCQA will offer disease management organizations two types of review. Accreditation is designed for comprehensive programs that address a full range of functional areas in disease management, including:

- patient self-management services;
- practitioner support;
- program content;
- clinical systems;
- coordination of care;
- measuring clinical performance.

Certification, by contrast, focuses just on one or more of the above functional areas.

The draft standards can be downloaded from NCQA's web site at www.ncqa.org. ■