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Peer review: New program helps rehabilitate problem physicians

Hospitals can avoid messy revocation of privileges

A Colorado program that has proven successful in assessing problem physicians and helping them overcome their shortcomings now is being rolled out on a national basis, offering health care organizations an option short of revoking a physician's credentials. Advocates of the program call it a constructive way to help physicians whose credentials are in question but whose careers might be saved with an in-depth assessment and retraining.

Physicians in Colorado have had this option available for 10 years, but in the past year it was incorporated in the Philadelphia-based National Board of Medical Examiners' (NBME) Institute for Physician Evaluation (IPE). That means any physician in the country can participate, though the national rollout is still moving slowly. The NBME hopes to have the program available in several centers throughout the country, but for now physicians have to travel to the original site in Aurora, CO.

The program is intended to help physicians who need a thorough assessment of their medical education, practical skills, practice management, and overall clinical performance. For most, the program becomes an option when they are in danger of losing their privileges due to medical errors or complaints of incompetence or impropriety.

For a smaller number of physicians, the program can be useful when they are seeking to take on new responsibilities, such as a family practice physician who wants to move into pediatrics. The assessment can help the physician and privileging hospitals determine whether the physician is ready for that move.

In Colorado, the program is known as Colorado Personalized Education for Physicians (CPEP); the national program is the IPE. The IPE provides essentially the same services on a national scale that CPEP has offered for years, but under the auspices of the NBME.

The IPE program is not yet well-known among peer review professionals,

but it should be of great interest, says **Martha Illige**, MD, medical director of the program and an assistant professor at the University of Colorado Health Sciences in Denver. She says the program fulfills a need for thorough assessments.

"Medical practice is very complex, and no one single test with a pass/fail is going to tell you whether this person is competent or not," she says. "We have to look at medical knowledge, the ability to apply that knowledge, patient care documentation, communication skills, even interpersonal relationships. That's when you're going to get a real idea of what's going on with this person."

The IPE program is more comprehensive than any other assessment program that has come before it, says **Peter Scoles**, MD, vice president for assessment programs at the NBME. The group hopes to make IPE a nationally recognized standard for assessing physicians, providing a uniform yardstick previously unavailable to peer review professionals.

Program is intense, not for everyone

The IPE assessment's value comes from its thoroughness. Illige acknowledges that the two-day interview process and a review of relevant materials can be extremely uncomfortable for the physician. The two days can include role playing in which the physician interacts with simulated patients, plus a lot of questioning and discussion about current information in the specialty or field of practice.

Surgeons may be observed at work, and the referring organization can send whatever information might be relevant to the physician's assessment. That includes any evidence of previous mistakes or impropriety. **(For an example of how a physician would be assessed and educated, see article, p. 120.)**

IPE does not recommend what should be done with the problem physician, but it does provide the health care organization with a complete report.

"The findings range from 'this is a terrific physician with one bad outcome,' to 'the incident that got your attention was only the tip of the iceberg,'" Illige says. "For about 20% of physicians, we say that they have strong skills but may want to brush up in some areas. No formal education program is necessary for them, and most hospitals would stop their questioning process there. For about 15%, we report that they do not have the basic skills to practice and look dangerous. We give information that details why that's so and explain why they shouldn't practice unsupervised."

For that 15%, the physician's age often determines the ultimate outcome. Younger physicians will seek additional training, while older physicians often take that assessment as their signal to retire.

"For the lump of people in the middle, about 65%, we report that they have some issues of concern but that they could work well under supervision, in a well-structured program," she says. "We offer the education services to help them improve while they remain in practice. Some hospitals will say yes, they can work under those conditions, and others will say no and let the physician go. That often depends on how much they need physicians in their area."

About 400 physicians have been through the program, and follow-up information indicates that about 80% are now practicing without restrictions. Those good results are partly the result of working only with physicians who can be helped by the program, and the IPE program is not for everyone. **(For more on how to determine when it is a good option, see article, p. 119.)**

Program saves a doctor's career

Advocates of the IPE program stress that it is not punitive and should not be viewed as "the place where bad doctors go." Quite to the contrary, they say, the IPE program provides a fair and objective assessment for physicians in trouble and others who aren't, then offers an opportunity to improve. That can be a good opportunity, says **Bob Spencer**, JD, an attorney in Greenwood Village, CO, who represents both physicians and hospitals in peer review.

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He previously was on the board of CPEP.

Spencer says physicians should welcome IPE as another option that doesn't damage their careers. The assessment can work in the physician's favor when it shows that he or she is well-qualified and the referring organization's fears were overstated.

"When there are legitimate problems, the medical executive committee or the peer review committee may suggest to a physician that a way to resolve the issue is to enroll with IPE for an evaluation," he says.

"If the physician does that and successfully completes the process, taking whatever steps are necessary to correct the issues, then my experience is that the hospital will work with that physician and not take steps like restricting privileges or revoking them altogether," Spencer adds.

Giving hospitals an option

That is an option the hospital might not have otherwise, Spencer says, especially in a smaller community where physicians are reluctant to assess a competitor's skills for fear of anti-competitive conduct and the sheer awkwardness of the situation. IPE provides a reliable assessment for both parties, far removed from any personal relationships.

"It helps to get the monkey off the hospital's back a little bit," he says. "The medical staff are always on the horns of a dilemma when faced with what to do with a peer. They want to protect patients but not destroy the career of someone they work with every day. Sometimes, that results in staff not taking aggressive action when perhaps they should."

But Spencer emphasizes that sending a physician to the IPE is not letting him or her off easy. Spencer has seen many physicians go through the process, which he describes as grueling.

Peer review committees should position the IPE option as a good step for physicians — which it is. Many physicians are easily persuaded to seek the IPE assessment and education, but some will resist. Illige says many of the program participants are not happy to be there, but they understood that the alternative was much worse.

"When I've represented hospitals in these cases, some of the cases involved physicians who had been problems at a low level for a long time," Spencer says. "The physician had become difficult to deal with, resistant to anyone questioning his practice. In cases like that, we've had to go to the extreme and say this is no longer an option. You must do this or lose your privileges."

The IPE staff and consultants work directly with the physician, who must travel to Colorado for the initial assessment. Scoles says the hospital or other provider is encouraged to provide as much background as possible on why the physician was sent and what problems are suspected. The physician must provide written permission for IPE to discuss its findings with the hospital.

The IPE program costs $7,500 for the two-day assessment, Scoles says. If a follow-up education program is necessary, the fees include $900 for devising a plan and $350 per month for monitoring the physician's progress, plus $2,300 for a post-education evaluation. The education program fees do not include any costs for preceptors, CME courses, texts, or educational activities that might be part of the plan. So for an assessment and a six-month education plan, the minimum cost would be $12,800.

That's a substantial sum, but many hospitals would find it a bargain when compared with the alternative of restricting or revoking a physician's privileges, Illige points out. The referring hospital or other organization usually picks up the tab or splits it with the physician. Few physicians come of their own accord and pay for the program themselves.

"We get a lot of fear that cost is a deterrent, but going through the adversarial process to restrict someone's privileges will cost a minimum of $25,000," she says. "When you add up the lawyers' time, the cost can go higher. And there's a huge investment in terms of time." ■

Remedial program good for those who can improve

The Institute for Physician Education program in Aurora, CO, offered by the Philadelphia-based National Board of Medical Examiners (NBME) is most appropriate for physicians who are having trouble in some areas but seem capable overall, and who are willing to improve. It's not for the truly bad physicians who should leave medicine and never look back.

Here are some situations in which the program can be a good option:

- **The physician is good overall but has had**

Physicians tested, observed, re-educated, if needed

The Colorado Personalized Education for Physicians (CPEP) program in Aurora is an intense assessment, often followed by a re-education program aimed at helping the physician overcome his or her problems. **Martha Illige**, MD, medical director of the program and an assistant professor at the University of Colorado Health Sciences in Denver, offers this example of how the program would help a typical physician:

The physician visits the CPEP offices and undergoes two days of testing and interviews. **(For contact information, see related article, p. 119.)** The testing includes a four-hour multiple-choice test in the physician's specialty, plus an hour-long computerized test that measures attention, concentration, memory, and learning ability. That test can help identify neurologic conditions such as Alzheimer's or Parkinson's disease.

Then the physician participates in role-playing scenarios in which actors impersonate patients coming to him or her for treatment. A video camera records the interactions, and a communications consultant observes from the next room. After the patient encounters, the physician writes up chart notes just as he would in the office.

Afterward, the physician is interviewed by three physicians in his specialty, drawn from CPEP's bank of consultants. Prior to the interviews, the consulting physicians review actual patient charts from the subject physician's practice.

The next day, the physician spends an afternoon treating "patients" at a computerized workstation, providing treatment and ordering tests as he would in normal practice while the computer keeps track of everything the physician does or doesn't do.

All of the testing results are reviewed, along with the peer physicians' assessments. Several weeks later, CPEP sends a report of about 15 or 20 pages to the physician and the referring hospital or other organization.

The report concludes that the physician has serious deficiencies in certain areas but could be helped by some remedial education. The referring hospital and the physician agree to a plan in which he submits cases to a preceptor for regular reviews, attends a number of medical conferences each year, and spends an hour each morning reading medical journals and discussing them with his preceptor.

A year later, the physician returns to Colorado for another two-day assessment, where it's determined that he is much improved but still lacking somewhat in specific areas. This time, CPEP recommends he continue working on those issues on his own, with no formal supervision. ■

one or more bad outcomes.

If so, the program may help the doctor uncover shortcomings in medical education or skills that can be improved, says **Martha Illige**, MD, medical director of the program and an assistant professor at the University of Colorado Health Sciences in Denver. The intense review can pinpoint the cause of the bad outcomes without going to the extremes of either dismissing them as unimportant or concluding that the physician has lost his or her skills completely.

• **The physician's performance has declined recently.**

If an otherwise good physician has slipped in recent months, there could be any number of causes — everything from a physical or mental illness to distracting personal problems, such as a divorce. An assessment by uninvolved investigators may bring out problems that the doctor is unwilling to reveal to colleagues.

• **You keep seeing the physician's name come across your desk for problems, even if they're small ones.**

Many of the program participants are referred not because of any one major event but because someone got tired of seeing his or her name connected to lawsuits, complaints, or minor infractions. Those physicians often can improve their performance before they get involved with a major adverse event. Unfortunately, those physicians often are defensive from years of being accused and trying to protect their privileges, Illige says.

• **The physician is resistant to improving on his own.**

Some physicians are more willing than others to take criticism and improve their performance. Older physicians, in particular, can be resistant and refuse to acknowledge that they are not providing the best possible care, say Illige and **Bob Spencer**, JD, an attorney in Greenwood Village, CO, who represents both physicians and hospitals in peer review.

"With some, you can just give them the data and they'll say, 'Oh, I'm not treating my asthma patients right,' and then they'll go off and make the changes they need to," Illige says. "But those aren't the ones who are going to be problems for you. The people you worry about are the ones you give the information to and then they walk

off and don't change a thing."

• **The physician is not in any trouble at all but wants a thorough assessment.**

These cases are the minority, but Illige and Spencer emphasize that the program can be an excellent tool for someone who wants to be proactive in assessing his or her own skills.

"We had a rural physician once who was concerned that he wasn't keeping up in his skills and his education because of his isolated practice," Illige says. "He wanted feedback. We found that there were areas where he could use development, and [we] helped him seek that out, but we also reassured him that he was still a good doctor."

Spencer and Illige say the IPE program definitely is *not* appropriate in two circumstances:

• **Drug or alcohol abuse.**

There are plenty of other programs available for treating physicians with addictions, and they may be able to help a doctor save his or her career. But the IPE program does not address those problems, except that its assessment may uncover hidden drug or alcohol abuse as a causative factor.

• **Criminal conduct or serious wrongdoing.**

Though the IPE program can be a way to salvage a doctor's career, some careers should not be saved. When a physician has committed egregious conduct such as a criminal assault or misappropriating large sums of money, it is very likely that the IPE assessment will determine the doctor is too risky to be granted privileges. In those cases, there's no need to spend the money or the time.

The IPE program encourages health care professionals to contact its staff and ask if a particular situation is appropriate for intervention. The IPE name is not fully in use, so all listings are for CPEP, the original Colorado program. Contact the program at Colorado Personalized Education for Physicians, 14001 E. Iliff Ave., Suite 206, Aurora, CO 80014. Telephone: (303) 750-7150. ■

THE QUALITY - CO$T CONNECTION

Organization key to good project management

How to track the progress of quality projects

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

Do you ever wonder what it would be like to actually complete a process improvement project both on time and with a feeling of success? There is a way to keep your organization's improvement projects running smoothly and achieve project objectives.

The key is organization. This starts with project preplanning and ends with an evaluation of the project results. In the third and final part of this series on project management, you'll learn how to track the progress of projects to ensure deadlines are met. Then, once the improvement actions have been implemented, it's time to measure the project success.

The team leader of each improvement project or the support staff from the quality management department should continuously track the progress of all projects against the project plan. Project tracking involves monitoring and reviewing the project accomplishments and results against documented estimates contained in the initial development plan.

The time estimates for completion may need adjusting based on the actual accomplishments and results. A documented, up-to-date plan for the project is used as the basis for tracking activities, communicating status, and revising plans. Unexpected changes in the project scope and or status can have a cascading effect on the project. That's why it is important that the hospital's quality council (or other oversight group) regularly review the status of all projects. This oversight group should address any issues that are impeding project completion. The project plan that was developed serves as the tracking and management tool for the project. Without a plan, you have nothing to measure activity against. The project-tracking process should allow the oversight group to anticipate and deal with problems that occur during the project. Project-tracking tools such as flowcharts, program review and evaluation technique, charts, and Gantt charts can serve as visual-planning tools as well as project-tracking tools. Computerized project-tracking software also is available.

Whatever format you use to track projects, your

Team Member Project Status Report

Project Title: _____ Report Date: _____

Project Leader: _____ Reported by: _____ Date of Last Report: _____

Activities/Accomplishments
Since your last status report, what have you accomplished on your project work? Give specific details as needed for clarity. Reference additional documentation if necessary.

_____
_____
_____

Challenges/Discoveries
In the course of doing your project work, what problems did you encounter and what discoveries did you make? Include both positive and negative events. (Your responses to problems and discoveries are documented in the next section.)

_____
_____
_____

Actions Taken
What did you do about the problems or challenges you encountered? What did you do about the positive discoveries your made? Document actions taken, results achieved, people informed, etc.

_____
_____
_____

Planned Activities
Between now and your next status report what do you plan to do to accomplish your project assignment(s)?

_____
_____
_____

monitoring plan should allow you to identify:

- differences between planned start dates and actual start dates for each activity;
- differences between planned finish dates and actual finish dates for each activity;
- percentage of completion for each activity and the project as a whole;
- activities performed out of sequence;
- milestones achieved or missed;
- differences between estimated costs and actual costs for activities and the project as a whole;
- activities, issues, departments, or individuals of particular importance or concern;
- corrective actions taken when the actual results and performance of the project deviate from the plans.

Your plan for monitoring the progress of projects also should clearly spell out what groups or individuals will be kept informed. This will include the oversight committee and various managers and other interested parties. Each of these groups or individuals may have a different "need to know" level that influences the type of reports created. For example, the hospital quality council may need all of the detail listed above, whereas managers of involved departments may just need to know general information about the progress of the project.

Both extra-project status reporting (from the project team to other parts of the organization) and intraproject status reporting (from team members to the leader) is critical to project success. Status reporting need not be a tedious or time-consuming process. In fact, the simpler the better.

(Continued on page 127)

PATIENT SATISFACTION PLANNER™

Good food in a hospital? Planning makes it happen

Make food service your goodwill ambassador

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 related article," p. 125.)**

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 patients 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.

Focus on customer service

"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 informed of our patient satisfaction scores and actively solicit ideas and suggestions from [everyone] we interact with," he says.

"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," Myers adds.

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.

[For more information, contact:

*• **William Myers**, Director of Nutrition Services, Champlain Valley Physicians' Hospital, 75 Beekman St., Plattsburgh, NY 12901. Telephone: (518) 561-2000.*

*• **Mary P. Malone**, MS, JD, Executive Director of Consulting Services, Press, Ganey Associates, 404 Columbia Place, South Bend, IN 46601. Telephone: (800) 232-8032.]* ■

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, which is 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.

"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." ■

Switching gears to improve patient education

Sometimes, patient education committees don't always end up where they started out.

The patient education committee at Shands at the University of Florida in Gainesville originally was implemented in 1996 to help the institution meet Joint Commission on the Accreditation of Healthcare Organizations' standards for patient and family education, but now its tasks evolve

according to the organization's needs.

For example, a couple of years after its founding, a patient satisfaction survey revealed a need for quality improvement in education.

The administration asked the committee to focus on continuous quality improvement (CQI), so it became a CQI team, says **Kathy Gamble**, ARNP, MN, coordinated care manager in the department of nursing and patient services and co-chair of the committee.

The committee, made up of 30 people representing the various services and departments throughout the health care system, came up with five overall recommendations.

Those recommendation included:

1. **Establish patient and family education as a priority across Shands health care.**
2. **Create an ongoing multidisciplinary team for patient and family education.**
3. **Develop a computerized systemwide index of materials available including samples of materials.**
4. **Provide consistent admission information to patients and families.**
5. **Develop a coordinated team approach to ensure an interdisciplinary treatment plan.**

To get work done efficiently, the committee prioritized tasks, first creating the ongoing multidisciplinary team for patient and family education by solidifying the committee.

The committee's second project was to create a computerized systemwide index of patient education materials.

Using the meetings to accomplish tasks

Because there is no one who coordinates patient and family education and the committee members have many other duties, the patient education committee at Shands is a working committee. Gamble explains.

"We decided that our meetings would be working meetings, and we would more or less do the work we needed to do within the meetings," she says. When legwork is required, such as the cataloging of patient education materials, health education interns from the university are used.

Some of the other quality improvement tasks the committee has completed include patient and family education as part of employee orientation and a policy to ensure consistency in the quality of internally developed materials. ■

Physician dissatisfaction grew over last decade

If Massachusetts reflects the nation, physicians' satisfaction with their professional lives has declined substantially in the last 15 years, according to a study sponsored by the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ) in conjunction with the Robert Wood Johnson Foundation in Princeton, NJ.

The study compared findings from surveys of Massachusetts primary care physicians in 1986 and 1997 (*Journal of General Internal Medicine* 2001; 16:451-459). By 1997, fewer than two-thirds of physicians were satisfied with most areas of practice, and fewer than half were content with the time they spent with patients, the amount of leisure time they had, and incentives for providing high-quality care, as compared with physicians in 1986.

However, respondents in both 1986 and 1997 said they were satisfied with the quality of care they were able to provide, says **John M. Eisenberg**, MD, director of AHRQ.

"This important research shows that changes in the way health care is delivered affect those who are dedicated to providing care to their patients," Eisenberg says. "Both the public and private sectors need to work together to help health professionals adapt to the changes in the structure and organization of the American health care system."

The study also examined differences in the experiences of physicians working in different types of medical practices. Nearly half of physicians in practices that contract with multiple insurers reported one or more insurance company denials of patient care in the prior year.

Physicians in these practice arrangements were highly dissatisfied with the procedures required for obtaining health plan authorization for patient care, as opposed to physicians who work exclusively with one health plan. In addition, fewer than half indicated that they would recommend the health plans with which they were associated to family members or friends. ■

(Continued from page 122)

This is an excellent application for e-mail. Simply post a status report form and designate where it should be sent. Team members can fill it out, hit "send," and be done with it. **(A sample status report format is shown in the box, p. 122.)** The key is consistency; project status needs to be collected regularly, in writing, from everyone working on the project.

Status reports form the basis for overall project monitoring. Projects usually get behind schedule a day at a time, not a month at a time. Having a means of documenting and tracking these delays is important for spotting the trends that lead to major setbacks. Weekly status reports from team members are recommended. As the project nears completion, it is important to evaluate the impact of process changes. Performance measures relating to the original goals of the project are used to measure the effectiveness of actions plans.

The following questions should be addressed when evaluating the impact of the improvement project:

• Were project goals achieved?

It should first be determined if the goals established at the start of the project were achieved. If the goals were not achieved or were modified, then the reason or reasons should be documented. **In the box on the right** is an example of the measures used to evaluate the success of a performance improvement project aimed at improving the outpatient care of people with asthma.

If some goals were not met, have the project team reconvene to answer the following questions:

— Were the goals achievable?

— What were the limiting factors?

— What modifications in the action plans need to be made?

— Are the performance measures used to evaluate the success of the project still appropriate?

— Did the project produce any unanticipated outcomes?

Sometimes there are unanticipated consequences to changing a process. Whatever the outcome, it is important to understand the benefits and/or address any new issues that may have arisen.

— What lessons were learned?

Everyone involved with the project, including teams members and people who were impacted by the process changes, can participate in the lessons learned discussion. Ask people to identify the key factors that led to success or failure of the project.

Effectiveness of an Asthma Care Improvement Project

- ✔ Percent of patients seen in clinic for treatment of asthma with documentation of action plan.
- ✔ Percent of patients with persistent asthma who are referred for asthma education within six months of initial diagnosis.
- ✔ Percent of patients with persistent asthma who know when to contact primary care physician about signs and symptoms.
- ✔ Percent of patients with asthma who know the difference between long-term control and quick-relief medications.
- ✔ Percent of patients with asthma with documentation of asthma trigger assessment.
- ✔ Percent of patients with persistent asthma with documented flu vaccinations in previous September to January period.
- ✔ Percent of patients with asthma who are 12 years or older who smoke.
- ✔ Percent of patients with asthma under 18 years of age who live in house with a smoker.
- ✔ Annual unscheduled clinic visits per 1,000 asthmatics.
- ✔ Percent of patients presenting to ER/urgent office visit who have a pulse oximetry.
- ✔ Percent of patients presenting to ER/urgent office visit with FEV1 or PEF less than 70% of baseline who are given $beta_2$-agonist.
- ✔ Percent of patients with asthma who seek emergency treatment or are admitted to the hospital within 10 days of calling in to clinic for treatment advice.

It may be difficult for people to document and openly share those things that did not work. However, sharing what worked and what was less than successful is important. The knowledge gained during all phases of the performance project should be shared with others who may benefit from the lessons learned.

Performance improvement projects require staff time and other resources that typically are in short supply in health care organizations. The use of effective project management strategies will help to ensure that project resources are not wasted. Be sure that project pre-work is done and that project teams have a clear understanding of the goals. Next, use project-planning tools to "chart the course" for the project.

Everyone should know what activities must take place, when, and who is responsible. Lastly, closely monitor the progress of performance improvement projects, objectively measure success, and pass along lessons learned to future project teams. ■

Group asks hospitals to report on quality efforts

Efforts targets nonrural facilities

The Washington, DC-based Leapfrog Group, a national coalition of major employers and public purchasers, is asking U.S. hospitals to voluntarily report whether they have implemented or plan to implement three "leaps" in the prevention of medical errors that researchers say can save up to 58,000 lives a year.

The on-line survey on the status of the standards is available to all hospitals but targets nonrural facilities. In California, the effort is spearheaded by the San Francisco-based Pacific Business Group on Health (PBGH), California's largest health care purchaser coalition. PBGH members and other employers will use the survey results to recognize leading hospitals and to educate their employees about how to use this information when choosing hospitals. "We've contacted more than 350 nonrural hospitals in California, urging them to complete the survey," says **Peter Lee**, president of PBGH. "Consumers need this information so they can make informed decisions about where to receive treatment."

The three patient safety standards endorsed by Leapfrog are:

- **Computerized physician order entry.** Eliminates medication errors by having physicians in hospitals order tests and prescription drugs by computer instead of handwritten orders.
- **Evidence-based hospital referral.** Encourages patients to go to hospitals with better outcomes and, when outcome results are not available, uses volume of selected procedures where supported by science.
- **Intensive care unit (ICU) physician staffing.** Reduces ICU deaths by more than 15% by having ICUs staffed by physicians certified in critical care medicine.

Research conducted by John D. Birkmeyer, MD, of the Dartmouth Medical School in Hanover, NH, indicates that these three improvements could save up to 58,300 lives per year, and prevent 522,000 medication errors, if implemented by all nonrural hospitals in the United States. The not-for-profit Sutter Health network already has endorsed the Leapfrog initiative and is encouraging its 25 hospitals to complete the survey. "It will take time to accomplish all of the Leapfrog standards for eliminating preventable mistakes," says **Van Johnson**, president and CEO of Sacramento, CA-based Sutter Health, "but the standards are scientifically valid and worth pursuing."

In the survey, hospitals are asked whether they have implemented the standards or have made any plans to do so. Hospitals will be credited for interim steps toward implementation. The survey results will be published on the Leapfrog and PBGH web sites, and promoted by many individual Leapfrog purchasers.

"Many hospitals are putting in place new systems to address patient safety gaps," Lee says. "With Leapfrog, we look forward to recognizing the efforts of these hospitals as they work to reduce preventable mistakes."

The Leapfrog Group is a growing consortium of 82 Fortune 500 companies and other large private and public health care purchasers, providing benefits to 25 million Americans with more than $45 billion in health care expenditures. To learn more about the Leapfrog Group or participate in the survey, which is sponsored nationally by The Business Roundtable, visit www.leapfroggroup.org. ■

Evidence-based practices outlined for patient safety

First government effort to respond to concerns

A new report from the Rockville, MD-based Agency for Healthcare Research and Quality (AHRQ) described dozens of evidence-based practices that can improve patient safety. The federal agency says the report is the government's first major effort to respond to recent concerns about medical errors.

AHRQ investigators said 11 of the practices represent "clear opportunities" to improve patient safety, but they are not being performed regularly. These practices include administering antibiotics before surgery to prevent infections, using ultrasound to help guide the insertion of

central intravenous lines and prevent punctured arteries, and giving surgery patients beta-blockers to prevent heart attacks.

The review of best practices is "a first effort to approach the field of patient safety through the lens of evidence-based medicine," the researchers wrote. "Just as [the Institute of Medicine (IOM) report] *To Err is Human* sounded a national alarm regarding patient safety and catalyzed other important commentaries regarding this vital problem, this review seeks to plant a seed for future implementation and research by organizing and evaluating the relevant literature."

The 640-page report is the result of a thorough review of the scientific literature to identify practices that are proven to be effective and thought to represent a significant opportunity for improvement. The report focused on hospital care, but also included information on care delivered in nursing homes, at ambulatory care sites, and by patients themselves in managing their care.

Public concerned about patient safety

Patient safety has become a major concern of the general public and of policy-makers largely because of the IOM's 1999 report *To Err is Human: Building a Safer Health System*.

In its report, the IOM highlighted the risks of medical care in the United States and shocked many Americans, in large part through its estimates of the magnitude of medical-errors-related deaths (44,000 to 98,000 per year) and other serious adverse events.

The report prompted a number of legislative and regulatory initiatives designed to document errors and begin the search for solutions. The AHRQ, the federal agency leading efforts to research and promote patient safety, promised to develop and disseminate "evidence-based, best safety practices to provider organizations."

To initiate the work, the agency in January 2001 commissioned the University of California at San Francisco-Stanford University Evidence-based Practice Center (EPC) to review the scientific literature regarding safety improvement. To accomplish this, the EPC established an editorial board that oversaw development of this report by teams of content experts who served as authors.

The EPC began its work by defining a "patient safety practice" as "a type of process or structure whose application reduces the probability of adverse events resulting from exposure to the health care system across a range of diseases and procedures." With that definition, the researchers identified evidence-based practices. In its report, the AHRQ notes that National Quality Forum plans to use this report to help identify a list of patient safety practices that consumers and others should know about as they choose among the health care provider organizations to which they have access.

Of the 79 practices reviewed in detail, 11 patient safety practices were most highly rated by the researchers in terms of strength of the evidence supporting more widespread implementation. These are the 11 recommended practices in descending order, with the most highly rated practices listed first:

1. appropriate use of prophylaxis to prevent venous thromboembolism in at-risk patients;

2. use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality;

3. use of maximum sterile barriers while placing central intravenous catheters to prevent infections;

4. appropriate use of antibiotic prophylaxis in surgical patients to prevent perioperative infections;

5. asking that patients recall and restate what they have been told during the informed consent process;

6. continuous aspiration of subglottic secretions to prevent ventilator-associated pneumonia;

7. use of pressure-relieving bedding materials to prevent pressure ulcers;

8. use of real-time ultrasound guidance during central line insertion to prevent complications;

9. patient self-management for warfarin (Coumadin) to achieve appropriate outpatient anticoagulation and prevent complications;

10. appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and surgical patients;

11. use of antibiotic-impregnated central venous catheters to prevent catheter-related infections.

The AHRQ explained that the list generally is weighted toward clinical rather than organizational matters, and toward care of the very ill, rather than the mildly or chronically ill. Although more than a dozen practices considered were general safety practices that have been the focus of patient safety experts for decades (i.e., computerized physician order entry, simulators, creating a "culture of safety," crew resource management), most research on patient safety has focused on more clinical areas.

The agency also identified another 12 items

considered high priority for research because they offer the potential for improving patient safety. These are the items the AHRQ urges researchers to focus on:

- improved perioperative glucose control to decrease perioperative infections;
- localizing specific surgeries and procedures to high-volume centers;
- use of supplemental perioperative oxygen to decrease perioperative infections;
- changes in nursing staffing to decrease overall hospital morbidity and mortality;
- use of silver alloy-coated urinary catheters to prevent urinary tract infections;
- computerized physician order entry with computerized decision support systems to decrease medication errors and adverse events primarily due to the drug-ordering process;
- limitations placed on antibiotic use to prevent hospital-acquired infections due to antibiotic-resistant organisms;
- appropriate use of antibiotic prophylaxis in surgical patients to prevent perioperative infections;
- appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk;
- appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and post-surgical patients;
- use of analgesics in patients with an acutely painful abdomen without compromising diagnostic accuracy;
- improved hand-washing compliance (via education/behavior change, sink technology and placement, or the use of antimicrobial washing substances). ■

CE questions

9. What is the cost of the two-day assessment portion of the Institute for Physician Evaluation program?
   A. $7,500
   B. $2,300
   C. $900
   D. $350

10. According to Patrice Spath, RHIT, a project monitoring plan should allow you to identify which of the following?
   A. differences between planned start dates and actual start dates for each activity
   B. activities performed out of sequence
   C. milestones achieved or missed
   D. all of the above

11. List one of the three "leaps" in the prevention of medical errors that the Washington, DC-based Leapfrog Group claims can save 58,000 lives per year.
   A. increased use of physician assistants in the emergency department
   B. selected strategies to reduce the incidence of patient falls
   C. computerized physician order entry
   D. lower caseloads for hospital-based case managers

12. A recent report from the Rockville, MD-based Agency for Healthcare Research and Quality identified how many best practices that represent "clear opportunities" to improve patient safety but are not being performed regularly?
   A. 3
   B. 11
   C. 15
   D. 44

NCQA releases draft for DM accreditation

Health systems turning to DM in quality efforts

The National Committee for Quality Assurance (NCQA) in Washington, DC, has released for public comment its draft standards for the accreditation and certification of disease management programs. Peer review professionals may find the standards of interest because many health plans and leading employers contract with disease management vendors to provide focused assistance to patients with specific illnesses and conditions.

Margaret E. O'Kane, NCQA president, says the committee will issue its final requirements by the end of the year. Surveys will begin in January 2002.

"Disease management programs can substantially improve care for the sickest patients," O'Kane says. "Through planning, outreach, education, coordination, and tracking, we've seen how focused disease management efforts can

help ensure that people get the right care at the right time."

Disease management programs identify patients with chronic conditions or other ongoing health care needs and provide them and their doctors with the tools to improve health outcomes. The programs support patients in better managing their health, maximizing their quality of life, and preventing complications.

Members of the Washington, DC-based Disease Management Association of America (DMAA) were among those who helped develop the program, says **Richard Vance**, MD, senior vice president and chief medical officer of CorSolutions in Buffalo Grove, IL, and chair of the DMAA Accreditation Committee.

"The DMAA believes the industry has matured to the point where adopting standardized accreditation is a critical next step," he says. "It will help show the value of quality disease management initiatives. NCQA has been extremely proactive and inclusive in developing the program so far."

Typical disease management tools used with patients include telephone contact with nurses for coaching and reminders about staying on a treatment plan, biometric devices for home monitoring of conditions such as high blood pressure and diabetes, and patient information that might be printed or placed on the Internet. For physicians, typical tools include clinical guidelines and reminders about their patients' needs for checkups and testing. Disease management relies heavily on information systems to identify and track patient progress and to produce data on clinical performance.

The health care system increasingly is turning to disease management as part of the solution to its quality challenges, says **Rhonda Robinson-Beale**, MD, executive medical director of medical and care management programs for Blue Cross Blue Shield of Michigan.

"NCQA accreditation and certification of these programs will help point health plans and others to the best disease management vendors," she says.

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

Although most participants likely will be freestanding disease management organizations contracting with a managed care organization or employer, other organizations providing disease management services — including behavioral health care organizations, medical groups, and others — are expected to participate as well.

Health plans and other organizations contracting with NCQA-accredited or certified disease management programs will receive automatic credit on related quality improvement standards that they otherwise would 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, coordinating care, and measuring clinical performance. Certification, on the other hand, focuses just on one or more of those functional areas. ■

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Hospital halts research after volunteer's death

Johns Hopkins investigating oversight process

Following the death of a healthy 24-year-old research volunteer, federal regulators forced Johns Hopkins University in Baltimore to halt all research on human subjects.

The university was allowed to resume its research under strict oversight, but many questions remain about the oversight process that allowed the volunteer's death.

A Johns Hopkins internal review committee chaired by **Lewis Becker**, MD, reported that Alkis Togias, MD, had not submitted an Investigational New Drug application to the Food and Drug Administration (FDA) for using hexamethonium as an inhalant. Once used as an intravenous antihypertensive, hexamethonium is no longer on the FDA's list of approved drugs.

The Johns Hopkins committee points out that hexamethonium has been used as an inhalant in several lung function studies without incident, but it concluded that the Institutional Review Board (IRB) should have asked Togias for an opinion from the FDA about the use of the drug.

The death of the young, healthy woman has led to a barrage of criticism against Johns Hopkins' oversight of its physicians and their research.

FDA has cited physician involved

Ellen Roche died after taking part in an asthma study in which she inhaled hexamethonium to assess its effect on the lungs. Within a month, she died of progressive hypotension and multi-organ failure. The FDA already has cited Togias for what it says was a failure to disclose the woman's adverse reaction.

In addition, the FDA cited Togias for failing to seek the agency's approval prior to conducting the clinical trial, as well as changing the study protocol without permission from the IRB. Togias did not return a call seeking comment.

Furthermore, the Hopkins committee says the volunteer was not fully informed of the risks involved in the study. The committee concludes that the informed consent form signed by Roche and other healthy volunteers was "inadequate" and "should not have been approved" by the IRB. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review*, CE participants should be able to meet the following objectives after reading each issue:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and / or based on independent recommendations from clinicians at individual institutions.

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