

HEALTHCARE BENCHMARKS

The Newsletter of Best Practices

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Mandatory patient safety training, from the board room to linen room

Lawyers may cringe, but upfront practices work

In early December, a patient in Seattle settled a lawsuit with the University of Washington Medical Center after its surgeons left a 13-inch retractor in his abdomen. Errors happen. In this case, the hospital readily admitted its error and is working to learn from the mistake.

The outcome in Seattle was much better than the outcome of a case of medical error that hit the press in 1995, when physicians at the Dana-Farber Cancer Institute (DFCI) in Boston discovered that a *Boston Globe* reporter had died from an overdose of chemotherapy. Another patient experienced a similar overdose and ended up in intensive care. The two incidents cast a decidedly unflattering spotlight on the facility. But from the start, DFCI decided to be forthright to the patients, their families, the staff, and the public at large about what happened and what would be done to ensure it didn't happen again.

James Conway, senior vice president and DFCI's chief executive officer, says that the facility, at the time, had a typical response to medical mistakes. "When significant events occurred, we captured them and incident reports were filed. A closed group of people saw the information, and it was investigated. It was viewed as a people problem, not a systems issue. Clearly it was a culture where errors were seen as the failures of individuals."

Extraordinary confidentiality, avoiding the press, and involving risk management were typical of the old style of dealing with adverse medical events. "There was not a major focus on disclosure and learning from incidents," Conway notes.

There were three things that led to a change when the story of the reporter, Betsy Lehman, was made public. First, Conway says, there were more than 30 separate front-page articles in the Boston papers about the mistake. Second, the patient's husband worked at DFCI.

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Last, Conway says that the board of trustees was greatly shaken up by the two overdosing errors.

The chairman of the board was a principal at one of the largest consulting firms in the country, Conway recalls. “He was responsible for quality and audits in that company, and he knew the role of systems in errors.”

No one denied that an error occurred. But the board decided a comprehensive evaluation and a change in the way it looked at errors were required. “They agreed to keep key constituencies involved in the process — patients, staff, the public. And they made a commitment not to go after staff.” Conway says board members believed, “they could have fired all the staff and done nothing to reduce the chance of a similar error happening again. But the board wanted to use the tragedy to leverage the organization to a different place. Our goal was to be seen within three or four years as a leader in cancer care.”

With the commitment from the board, Conway, and staff, DFCI has achieved that goal, Conway says. His leadership efforts on the patient safety front led the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) to present Conway with their annual patient safety award in November.

New processes at work, new data collected

Rather than look at individuals, the process for dealing with medical errors at DFCI now focuses on systems defects and conducting root cause analyses. “We instantly disclose to the patient and family what we know to be true, but we also point out that we don’t yet know all the facts,” Conway says.

Staff support is also key. “The nurse, the pharmacist, the physician — they are all in the middle of a nightmare when an error occurs,” Conway says. “We make sure they feel supported.”

A multidisciplinary team conducts a root-cause analysis, looking at environment, work load, and process factors. But discussions don’t only occur

when a mistake happens; data surrounding error are talked about regularly. Patient and family advisory committees and staff are provided with trending data at regular committee meetings.

Systems that once didn’t do anything to prevent error are now designed with error in mind. For instance, computerized chemotherapy order entry systems ensure that more than 85% of all drugs at DFCI are ordered by computer. Errors are also counted differently now. “We start counting at the pharmacy and end at the patient. We don’t just look at what happens on the patient floor,” says Conway. Indeed, an increase in error reporting is celebrated. “Reporting doesn’t scare us. Instead we are concerned when reporting numbers go down. And we know that what is reported is probably just the tip of the iceberg.”

Barbara Balik, EdD, chief executive officer at Allina Health System of St. Paul, MN, agrees that increased reporting of mistakes should be applauded. **Gordon Sprenger**, the now-retired former CEO at Allina — a delivery system with 16 hospitals, 60 clinics, home care, and an ambulance service — made patient safety and error reporting such a mantra that he, too, was awarded the JCAHO/NCQA patient safety award.

Three years ago Sprenger participated in a Harvard forum on the topic and decided that patient safety should be a strategic goal. He even named a senior staff person to lead the effort, which Balik took over two years ago.

“Like most hospitals, our standard approach to errors in the past was that we felt badly, we didn’t mean for it to occur, and we’d investigate,” Balik says. “And although we had moved away from disciplining people for errors, it was still more punitive a system than not. The emphasis was on individual responsibility and people were admonished to pay more attention.”

Data were simply collected as a list of where errors occurred and what kind they were. Then, about five years ago, a decision was made to move to a more open disclosure with the patient and family. In part this was accepted because even risk management at Allina’s predecessor organization

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had a real quality improvement bent to it. “It wasn’t just about avoiding lawsuits,” Balik explains.

But only the openness and disclosure changed. “For the rest, we were like everyone else, seeing error as episodic, and aren’t we happy it doesn’t happen more often,” Balik says. “Error was seen as inevitable when you have many systems, staffed by humans, working with sick people.”

Over time, an evolution in thinking occurred, thanks to Sprenger’s leadership, she notes. “We don’t have safe systems that sometimes fail. We have unsafe systems and that they are as safe as they are is a credit to incredible people.”

One of the first steps in fomenting change was to learn what was out there already, says Balik.

“There is a whole science of error and error prevention in industries like aviation and nuclear energy that we didn’t know about.” Understanding how human factors impact systems was also important. “Now we build those human factors into vendor and equipment selection.”

Changing attitudes is much harder. A recent culture survey sent to all clinics and hospitals in the Allina system asked respondents about the messages they heard from leaders, about the value of a safe environment, and why errors occur. A sample statement: “I understand that errors are the result of a complex system failure.” Staff members were asked to rate how strongly they agreed or disagreed. Half thought the statement was true; half didn’t.

“That’s in an organization where we have been talking about this for more than two years,” says Balik. “It obviously gives us an area to work on.”

That kind of data — what staff think about patient safety — would never have been considered important in the past, let alone sought out and tallied. Using the data has been easy. “Now there will be mandatory training in patient safety for everyone from the linen room to the board room. We want to have all eyes and ears open.”

Balik calls old reporting systems for patient safety “weak” and says one change has been to integrate patient safety and risk reports. “Now we collect information on an issue whether it reached the patient or not, whether it caused harm or not.” And to help in the culture change, errors that don’t reach or harm the patient are no longer called “near misses,” but “good catches” instead.

The label is positive and reporting them is to be viewed as positive. To a degree, it must be working, says Balik, who reports that one Allina hospital had a goal of collecting 400 patient safety reports in three months. “They got more than that

and want to use them to find out all they can about system flaws.”

The problem that remains in many other facilities, however, is that errors that don’t reach the patient aren’t seen as important, despite all they can teach a hospital and its staff about system problems. Allina is also trying to figure out the costs of errors. “We took a sampling of errors and did a severity adjusted comparison,” Balik explains. “The only difference is that in cases where a patient safety report was filed, the average length of stay was five days longer and charges per case were \$14,000 higher.”

It’s that kind of data collection, collation, and distribution that Balik thinks will assist in her ongoing efforts to make patient safety a priority.

Another data effort had patient safety data overlaid with length of stay data. That project showed that where there were opportunities for improvement in one area, there were opportunities in the other. They coincided beautifully, Balik says, providing an opportunity to integrate patient safety with care improvement activities. Medical directors were just starting to review the data at press time.

Letting it all hang out

Like Conway and DFCI, Allina provides the data to anyone who wants them — and probably many who don’t. “My role is to keep this in front of the medical staff,” Balik says. “I constantly educate peers and medical staff about it.”

And there is great appreciation for it too. For instance, at the nursing education day that Allina

9 things you should know about medical mistakes

1. You have plenty of errors and near misses.
2. Error reports will initially go up in your journey.
3. Firing staff and writing new policy will do little to reduce error.
4. Disclosure of error is good for all involved.
5. Patients often already know what’s going on.
6. Root cause analysis is more powerful than one-on-one investigation.
7. Very little is confidential.
8. You can talk openly about error, survive, and thrive.
9. The things you learned yesterday should inform, but not drive today. It’s a very different day.

Source: James Conway, Dana-Farber Cancer Institute, Boston.

has for nursing leadership and shop stewards, having good, hard, understandable data helps to promote change. “It reinforces to them that this is a systemic issue, not a people issue,” she says.

“Gordon deserves the lion’s share of the credit for this,” says Balik of her predecessor. “He got people involved and took on a real leadership role.” One of the loudest and most symbolic actions Sprenger took, says Balik, is that after those early Harvard sessions he asked risk management to phone him every time there was a serious injury or patient death.

“When he got that call, he’d call me, ask about what happened, ask how everyone — including the patient’s family and caregivers — were doing. No one wanted to get those ‘Gordy calls.’ But he was a good role model. He called staff at home. He put a lot of attention on this issue with a small act. And sometimes, those small things make a big impact.”

Error reduction not immediate

The work is never done. There hasn’t been any reduction in the numbers of errors reported yet, but Balik doesn’t want to see that anyway.

“We want to increase reporting and decrease the number of errors getting to patients,” she says. “Two years ago, I would have expected we would have seen error reduction by now, but now I’m patient to wait some more. But I will be disappointed if we don’t see reduction next year.”

Despite that, there are visible successes. The Institute for Safe Medical Practices has a standard assessment on best practices. Allina has implemented those and so some types of errors are no longer an issue, says Balik.

Training has changed so that the focus is on the role of a team member, not the person. “In the [emergency department], it’s a nurse, a physician, and a tech person like an [emergency medical technician]. We tell people what the expectations are when they are in a certain role.” The new system was launched in October and will be rolled out to high-risk teams such as those in the emergency department and the ICU, Balik explains.

Conway says the engagement of executive leadership is critical in making such changes work. “They have to accept that patient safety and protection and reduction of harm is important,” he says. “All else will flow from that.”

In addition, getting patients and their families

Excerpt of Patient Safety Awareness Self-Assessment Tool

Editor’s Note: Use this list as a checklist. For a complete copy of the tool, contact the American Hospital Association at (312) 422-3000.

- Openly engage with medical staff, nursing, and other leaders in patient safety planning.
- Continuously articulate the business case for safety improvement.
- Personally participate in a significant incident investigation/root cause analysis.
- Tell “my story” around incidents/errors that I have been involved with and the systems improvements that could have prevented them.
- Routinely involve myself, all levels of our staff, and our patients and family members in direct and ongoing communications around the patient safety work of our institution and areas for improvement.
- Routinely bring patient safety matters, trending data, and specific cases to the board and other hospital leadership committees.
- Routinely probe staff perceptions of risk areas from existing or proposed systems and take immediate actions wherever possible.
- Openly support staff involved in incidents and their root-cause analysis.
- Ensure that there is ongoing prioritization and achievement of safety improvement objectives.
- Ensure that articles on patient safety matters regularly appear in my organization’s communications vehicles.
- As part of annual budget preparation, ensure resources are funded for priority safety areas.
- Request and routinely receive reports on facility utilization of and comparison with best-practice information from the American Hospital Association, National Patient Safety Foundation, and Institute for Safe Medical Practices.
- Ensure self-assessments from the AHA and others are completed and used internally for quality improvement activities.
- Cultivate media understanding of patient safety and my organization’s efforts to improve safety.
- Ensure effective systems are in place to assess individual accountability and competence.

Source: James Conway, Dana-Farber Cancer Institute, Boston, and the American Hospital Association, Chicago.

involved helps to change the culture at a hospital. “The patient needs to know that you are interested in them and hearing what isn’t working well. They are a real key in risk management. Often when we bring up an issue we think is new, they tell us it’s about time.”

Suggested Readings on Patient Safety

- ***To Err Is Human: Building a Safer Health System***, Kohn LT, ed, Corrigan JM, ed, Donaldson MS, ed. Washington, DC: National Academy Press; 1999.
- ***Human Error***, Reason JT, Cambridge University Press, 1990.
- ***The Psychology of Everyday Things***, Norman D, Basic Books, 1988.
- ***Managing the Risks of Organizational Accidents***, Reason JT, Ashgate Pub. Co., 1997.
- ***Normal Accidents: Living with High Risk Technology***, Perrow C, Basic Books, 1984.
- **Lucian Leape’s seminal articles:**
 - The nature of adverse events in hospitalized patients: Results from the Harvard Medical Practice Study II. Leape L L, Brennan T A, Laird, et al. *New Engl J Med* 1991; 324:377-384.
 - Error in medicine, Leape, L. L. *JAMA*, 1994, 272:1851-1857.
 - “Systems analysis of adverse drug events,” Leape L L, Bates D W, Cullen D J, et al. *JAMA* 1995; 274:35-43.
 - Out of the darkness, Leape L L, *Hlth Sys Rev* 1996; Nov/Dec:21-24.
 - Promoting patient safety by preventing medical error, Leape L L, Woods D, Hatlie M, et al., *JAMA* 1998; 280:1444-1447.
 - Why should we report adverse incidents?, Leape L L, *J Eval Clin Pract* 1999; 5:1-4.
 - Safe health care: Are we up to it?, Leape L L, Berwick D M, *BMJ* 2000; 320:725-726.
 - Reducing adverse drug events: lessons from a breakthrough series collaborative, Leape L L, Kabcenell A I, Gandhi T K, et al., *Jt Comm J Qual Improv* 2000; 26:321-331.
- ***Human Factors in Aviation***, Wiener, EL, Nagel, DC (eds), Academic Pr (1989).

Source: James Conway, Dana-Farber Cancer Institute, Boston, and the American Hospital Association, Chicago.

Convincing the lawyers — and even some hospital executives — that openness in discussing and reporting errors isn’t bad can be difficult. “But we talk about errors and patient safety all the time and nothing terrible happens. We have this notion that when you disclose an error, someone sues you or someone will tell the paper. But we have six years of experience saying that is largely not the case.”

It’s just one of many myths that Conway is constantly challenging. **(For more information on some of the unlikely truths about errors that Conway has learned, see box on p. 3.)** “I get the question over and over again about how we can do it this way. But it was easy for us. We had an opportunity to reinvent ourselves and learn from this tragedy. We had the tension for change thrust upon us. For others, it might be harder to create that tension. Leaders like what we are doing, they respect it. They don’t necessarily think I’m nuts any more. But they have the problem of how to move it forward when there are other concerns guiding the organization.”

Conway even created a tool to help facilities make the changes necessary to improve patient safety and error reporting. **(An excerpt of that tool appears on p. 4, and a complete version is available from the American Hospital Association by calling (312) 422-3000.)**

But despite a change in the body language that Conway sees when he gives talks on patient safety, there is still a long way to go. Balik says that when *US News & World Report* did a story on patient safety last year, the reporter told her that no one else in the country wanted to talk about it. “We were seen as loony for talking about this and owning up to our mistakes,” she says. Maybe next year it will be different, Balik says, noting that the Harvard sessions that so influenced Sprenger are now being held outside Harvard for the first time. “We are replicating it here in Minnesota. So far, we have had two sessions, and leaders are acknowledging that safety isn’t a competitive issue. We don’t have to be secretive about what we know and don’t know.”

[For more information, contact:

• **Jim Conway**, Senior Vice President, Chief Operating Officer, Dana-Farber Cancer Institute, 375 Longwood Ave., Fifth floor, Boston, MA 02215. Telephone: (617) 632-2158.

• **Barbara Balik**, EdD, CEO, Allina Health System, United Hospital, 333 N. Smith Ave., St. Paul, MN 55102. Telephone: (651) 220-8816. ■

Natural disaster reaction averts a Houston disaster

25 feet of water showed what one hospital is made of

Memorial Hermann Hospital in Houston had some 540 patients in its 650-bed facility on June 9. Each of its 150 critical care beds were filled. Much of the city had heaved a sigh of relief when Tropical Storm Allison had passed away into the Gulf of Mexico. Then it doubled back.

Shortly after midnight, the hospital had water in the basement, which housed lab and pharmacy services, among others. “Over two hours it got so forceful it blew the hinges off of steel doors,” says **Juanita Romans**, vice president and chief operating officer.

By 2:30 a.m., the lights were out. And not just the main lights, but the backup generators, too. “There was no light. Ventilators, IV pumps, running water, even our toilets were down. We had no monitors working.”

As a level-one trauma center, Romans says the hospital is prepared to handle external emergencies. But over the next 30 hours the hospital, its staff, and its patients would be sorely tested. The experience, while frightening and grueling, would show Memorial Hermann at its best. Indeed, the Joint Commission on Accreditation of Healthcare Organizations features the facility and its reaction to a natural disaster in the *Lessons Learned* section of a special emergency preparedness issue of its newsletter. **(For more on the special issue, see story, p. 12.)**

The first order of business was taking care of patients who needed respiratory assistance. “We had residents, respiratory therapists, and even secretaries hand bagging patients,” says Romans. “We monitored drips the old-fashioned way. We used flashlights.”

Streets were flooded and impassible, so the CEO was flown in by helicopter. Romans walked into the facility after driving as near as the flooded streets would allow. Contractors were immediately called in to estimate the damage, and light sources, batteries, and flashlights were flown in during the wee hours of the morning. By 8 a.m., a command center was set up.

Several teams were created. The medical triage team was headed up by the on-call trauma surgeon who happened to be the director of critical care. “She walked from floor to

floor to triage patients to determine who had to be transferred first.” By about 8:30 a.m., when it was apparent the electricity wouldn’t be up quickly, it was that physician who made the call to start transferring patients.

A courier team was created to ferry messages and supplies from floor to floor, and once adequate telephone service was created — partly through the use of cell phones — the staff began the arduous task of finding beds for patients. As the day progressed, Romans says that experts told her the electricity would be down for days, forcing the CEO to call for the complete evacuation of the hospital.

It was clear the facility would be closed for some time. There was 34 feet of water in the sub basement, and in an atrium that connects some of the buildings on the 2 million square foot campus, there was 25 feet of water — complete with a grand piano floating in the midst of it.

‘It was like an elaborate dance’

Romans says that once the streets were cleared, both air and ground were used for patient transfers. “The command center was used as a warehouse of information about where patients were and where they were going,” she explains. “A medical transfer team for both pediatric and adult patients determined who had to go first by level of acuity. A dispatch team was stationed at the emergency room calling for patients, who were carried down dark flights of stairs on backboards with flashlights.”

Each patient came with his or her chart and a sheet of stickers that were used to identify where they were going. The stickers were placed on a board in the command center, as well as on the patient.

Three Hermann-owned helicopters and several National Guard Blackhawk helicopters used a blocked off street as a landing pad. “It was like a valet service for helicopters,” she notes. “It was like an elaborate dance.” Four ambulances were backed up into the bay at once, loaded with patients, equipment, and nursing staff, and then dispatched. Then another four were called in.

For 30 hours, this went on, says Romans. Not a single person was hurt — either staff or patient. Not a single patient died. There were no significant complications among patients. The worst that happened was one woman got stuck in an elevator for a few hours. She was shaken up, but not hurt, Romans says.

“Everyone did whatever they had to do without complaints or questions,” notes Romans. “There was a real esprit de corps.” Local residents and area Boy Scout troops — even patients’ families — pitched in acting as runners to bring bottled water up the stairs to staff.

It took a week to get temporary electricity back on, but it wasn’t enough power to turn on the air conditioners in the middle of a Texas summer. It took a week to pump the water out of the basement. And as a result, the hospital was down for 37 days.

Winging it, in a way

“If you ask whether what we did was written down in some book, it wasn’t,” admits Romans. “But we have disaster drills on a routine basis. All we did was take our disaster plan and put it in reverse. Rather than triaging patients coming in, we were triaging them to go out. We still created our command center and triage team. The only unanticipated thing was that we needed an internal transport system.”

The best measurement the hospital has of its success was that outcomes were positive. There are other, more subjective measurements that the facility is starting to take, too, that look more at how people feel about the incident. Press Ganey conducted a satisfaction survey of all the patients and families that were in the hospital at the time. There were no special questions on the form about the flood — just the standard survey. While there were some who weren’t happy with how the hospital did, overall, the scores were excellent, says Romans.

Morale is the best measure of staff feelings, and the hospital leadership did what it could to keep morale high during a difficult period. “We tried to keep our staff in mind by sending them to different hospitals [within the Memorial system] to work so they would still have a paycheck,” Romans says. After the event, daily meetings were called to let staff talk about their feelings. “We call them heroes and even had a heroes’ dinner.”

How the hospital performed when under the gun was also discussed through focus groups and at manager meetings. And while Romans says with conviction that the hospital should get an “A” for its performance, there were still some lessons learned. First and foremost: Only put services that aren’t critical to patient care in the basement, says Romans.

It’s probably not a good idea in flood zones

to keep backup electrical systems there, either. Generators that used to be kept in the basement at Memorial Hermann have been moved to the first and fourth floors. Extended life batteries for flashlights and IV infusers have been purchased. The hospital had some red, external line phones that weren’t connected to the electrical system. But many of these had been unplugged and moved to other locations, rendering them useless when the electricity went down. Now they are all kept attached to those external lines. The hospital recognized a need for fully charged hand-held radios and oxygen powered aspirators, ventilators, and suction machines.

One key element to patient safety that Memorial Hermann has is machines that distribute medications on the units. But the keys to those machines weren’t on the floor. When the electricity failed, the machines went into lock-down mode. Staff had to send couriers to look for the keys and unlock all the machines. For a couple of hours, certain medications weren’t available.

Typically, when Memorial Hermann sends patients out of the hospital, their charts don’t go with them. “The way you identify patients now is they have these cards and you run it through an identifier. But it’s all electric. Without electricity, you don’t know who is in the house.” Romans recommends that census reports be run hourly in busy hospitals. What saved her facility from losing anyone was the impromptu sticker system. “The label told how they were moving and their destination. One sticker was taken and put on a board, one went with them.”

Another lesson learned the hard way was that managers should each have a copy of the emergency phone list and disaster manual both at home and at the office. “If you’re on call but at home, what’s the use of a disaster manual that’s at work?” she asks.

Lastly, Romans says having a single point of contact for the media frees up other managers and hospital leadership for more important tasks. “Use your marketing and communications personnel,” she recommends. “We used the radio, television, and newspapers to communicate with our patients’ families and our staff. Having one person in charge helps you control the message while still providing information to the media. They’re hungry for the story, and if you don’t feed them, they’ll come looking for information when your time could be better directed elsewhere.”

Romans knows her facility did well, but she

doesn't feel invincible. "Mother Nature can be really wicked," she says. "If we weren't part of a strong system, if we weren't a level one trauma center, I don't think we would have done as well."

Watching hospitals in New York and Washington, DC, go through the horrors of Sept. 11 and its aftermath brings another thought to mind too. "There is a huge emotional component to disaster. At the start, you are strong, you are running on adrenaline. But the aftermath is hard. And while I think we feel very positive about the outcome of our disaster, I don't think New York and Washington, DC, feel the same way."

[For more information, contact:

• **Juanita Romans**, Vice President, Chief Operating Officer, Memorial Hermann Hospital, 6411 Fannin St., Houston, TX 77030. Telephone: (713) 704-6614.] ■



Proper comparisons are key to hospital benchmarking

The poisonous 'apples-to-apples' comparison

By **Shelley Burns**

Knowledge Management Director
Healthcare Management Council, Needham, MA

In the last several decades many industries such as manufacturing, financial services, and hospitality have used benchmarking to identify quicker, more enhanced ways to improve their products, processes, and systems. But the hospital arm of the health care industry hasn't embraced the benchmarking bandwagon and hasn't changed significantly in years.

Why? Largely because it lives under the false pretense that benchmarking must occur with identical medical facilities. Otherwise comparisons would be useless. Hospital research philosophy has twisted "apples-to-apples" comparisons to mean that certain performance/structural criteria are required before cross-company learning can occur. This misleading and inaccurate assumption leads to the

decreased efficacy of healthcare benchmarking results.

The 'apples-to-apples' myth

Top executives and managers in business know it is not only acceptable but also necessary to benchmark with other industries to obtain process improvements. For example, a major hotel chain desires to improve guest services. This chain not only has other hotel chains to examine for comparisons, but can and should look at theme parks, retailers, restaurants, and others. Instead of comparing hotels to hotels, it's the guest services that should be compared. Valuable lessons can be gleaned from function-specific benchmarking. While the industries may function very differently, their fundamental guest service processes are common and provide learning opportunities for all parties.

Similarly, inventory/supply management processes lend themselves to cross-industry learning. Retailers have made major improvements in inventory acquisition, warehousing, distribution, and tracking. Hospitals haven't typically studied these improvements in other industries, citing the uniqueness of health care and hospital operations as the reason. As a result, many hospitals continue to practice outdated and nonintegrated supply transactions, as opposed to making strategic supply management a priority. Numerous processes are similar enough across industries for health care managers to learn and adapt improvements from others.

Even though health care professionals downplay cross-industry benchmarking because of the industry's uniqueness, they also tend to believe that health-care-to-health-care benchmarks are valid only with organizations that are exactly alike with respect to structure, size, scope, culture, affiliations, physical layout, etc. For example, an outpatient clinic wants to improve its cardiac rehabilitation services, but only wants to be benchmarked against clinics offering cardiac rehabilitation services that use Saturdays to deal with overflow — just as they do. This perspective, however, eliminates potential benchmarking partners and reduces the benchmark's value. Organizations must step out of their comfort zone and embrace these practice differences for what they are — learning and improvement opportunities.

It is virtually impossible for a hospital to find

an identical apple. Using criteria for learning partners such as only 500-bed, nonprofit, teaching hospitals in a suburban location with three remote outpatient clinics, an SNF unit, and an operating margin of at least 3% would eliminate virtually all other hospitals as benchmarking partners.

Hospitals are complex operations. There are an infinite number of differences among hospitals and there isn't one exactly like another. **Eric Franz**, manager of financial services at OSF Saint Francis Medical Center in Peoria, IL, agrees. "There is no twin hospital out there," says Franz. "It just doesn't exist. We are unique and we want to be unique."

It makes no sense for hospitals to proclaim their uniqueness, while at the same time developing lists of acceptable criteria that must be met by benchmarking partners. For hospitals to use benchmarking effectively, they must accept the fact that a twin doesn't exist. Then they can use their resources to learn instead of wasting resources benchmarking their level of uniqueness.

Narrowing lessens benchmark value

Consider this example of how the value of a benchmark decreases as the hospital attempts to narrowly define acceptable benchmarking partners:

- **Apples-to-apples:** Benchmark the cost of medical transcription functions at hospitals.
- **McIntoshes to McIntoshes:** Benchmark the cost of medical transcription functions at hospitals with centralized transcription departments that outsource at least 60% of their transcriptions.
- **New England McIntoshes to New England McIntoshes:** Benchmark the cost of medical transcription functions at a systemwide set of hospitals with centralized transcription departments that outsource at least 60% of their transcriptions, writing at least 40 different types of reports and an average TAT for history and physicals of 24 hours.

Similar benchmarking requirements surface in many situations. System-based hospitals only want to be compared to other systems and preferably one with a similar structure and size. Why? How will they know if the structure of their systems is a competitive advantage if they don't compare themselves to different structures or stand-alone hospitals? These highly selective criteria result in a less useful benchmark and less value for the facility that does the benchmarking. For example, attempting to benchmark with a similar transcription department obscures the impact of in-house vs. outsourced transcription, centralized vs. decentralized transcription, and stand-alone vs.

corporate systems on turnaround time, cost, and accuracy, among others. This is the exact opposite result expected from a good benchmark.

What do health care organizations learn from the search for and the results from their hospital twin? The search process teaches them that if they add enough criteria, they can reduce their learning pools and maintain the status quo because, as they might say, "There's no one like us." If they happen to find a few twin hospitals for comparison, they'll find their solutions are similar, again reducing the learning opportunities. Organizations that are interested in learning recognize that the perceived differences likely point to improvement opportunities. It is ridiculous to let nonrelevant differences eliminate cross-organizational learning opportunities. According to Franz, there are enough similarities among hospitals to determine where improvements can be made. "The comparison hospitals we used for benchmarking were 80-85% similar, which is enough to get a good start on this process," says Franz.

In addition to searching for twins, hospitals similarly search for best practices, which are thought by many managers to be the holy grail of process improvement. Unfortunately, there's not a single best practice for most health care operations. A recent survey of hospitals found that many hospitals previously outsourcing transcription were now bringing the function in-house, while in-house operations were looking for transcription vendors.

Why? Changes in the way the transcription functions fit with their cultures, their work forces and their environments. The make vs. buy decision is very dependent on the individual organization. So, while buying transcription services is a best practice for Hospital A, it might be a miserable failure for Hospital B. Thus, the job of managers is to sort through their options, coalesce good ideas from multiple sources, and come up with the most effective practice for their organizations.

One hospital cannot simply implement another hospital's method without adaptation since the cultures, layouts, and environments of each are different. Since hospitals claim to be unique and therefore cannot be compared in a benchmark, why would they willingly presume an outside source knows the best practice for them? Instead, hospitals must take bits and pieces from the successful practices of others and formulate the most effective practices for their organizations.

The hospitals and health care systems that will be the fairest in the land are those that can avoid the common benchmarking mistakes. First, they

must figure out what they want to benchmark. If a hospital wants to improve costs, it will benchmark costs and avoid poisoning the functional “apples to apples” comparisons with non-relevant criteria such as payer mix, physical layouts, or corporate structure on the way to determining cost-control opportunities.

Hospitals that use benchmarking as an effective tool will not waste their precious labor resources trying to find twin hospitals. This is because they realize such an effort reduces learning opportunities and encourages managers to accept the status quo. Filtering the list of acceptable learning partners narrows the value and usefulness of the benchmarking results.

Savvy hospital professionals know that slavishly mimicking the best practices of others, without consideration of their own cultures, strategies and needs, is managerial malpractice. The health care organizations that will benefit from benchmarking are the ones who realize the relevant points of difference are driven by their own practices, structures and choices, and they will make changes accordingly. They will gather many effective practices and blend them into strategies that are customized to meet the needs of their organizations.

Rather than compare New England McIntoshes to New England McIntoshes, hospitals that understand the importance of benchmarking will use a variety of apples to identify gaps in their performance and sample an assortment of apples to customize solutions to mesh with their own unique organizations.

Shelley Burns is director of knowledge management at The Healthcare Management Council Inc., a benchmarking and consulting firm in Needham, MA. For more information, call (781) 449-5287 or visit the company web site at www.HMC-benchmarks.com. ■



IHI announces grants to pursue perfection

The Robert Wood Johnson Foundation (RWJF) of Princeton, NJ, and Boston’s Institute for Healthcare Improvement (IHI) announced grants to a dozen health care organizations around the nation as part of the a \$20.9 million initiative, Pursuing Perfection: Raising the Bar for Health Care Performance.

The program hopes to inspire health care organizations to apply proven systems developed in other industries to improve quality and performance.

The 12 health care organizations are: Cambridge (MA) Health Alliance; Children’s Hospital and Health Center of San Diego; Children’s Hospital Medical Center in Cincinnati; Hackensack (NJ) University Medical Center; HealthPartners Medical Group and Clinics in Minneapolis; Henry Ford Medical Group of Detroit; Luther Midelfort - Mayo Health System in Eau Claire, WI; McLeod Regional Medical Center of Florence, SC; Mission St. Joseph’s Health System of Asheville, NC; Scripps Mercy Hospital of San Diego; St. Joseph Hospital, PeaceHealth of Bellingham, WA; and Tallahassee (FL) Memorial HealthCare. Each will receive grants to develop comprehensive plans to systematically improve health care quality.

During the first phase of the initiative, each recipient will pursue perfect health care in at least two areas of care and initiate similar efforts in five other care areas, while working to establish a

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culture that fosters improvements throughout the organization.

At the end of the seven-month planning phase, up to six of the 12 organizations will be selected to receive grants between \$1.5 million and \$3.5 million to help implement their plans.

The Pursuing Perfection program was launched in May with the release of a survey showing that more than half of health care providers and administrators believe the overall quality of health care in the United States is not good. The survey also indicated that 80% of health care providers believe fundamental changes are necessary in the health care system.

More than 200 hospitals and physician organizations from across the country applied for Pursuing Perfection grants. A national advisory committee, comprised of business and policy leaders, selected the first phase recipients on the basis of a series of criteria, including their ability to develop:

- A strategy for training their organization's administrative and clinical staff to redesign their processes based on what they learn from pilot tests;
- A strategy for building partnerships outside the organization, necessary to pursue perfect care for patients;
- An internal financial analysis of how net revenue will change as a result of the improvements;
- Plans for directly involving organizational leaders, responsible for assuring continued dramatic quality improvement.

As part of the program, IHI is developing an Internet-based network that will enable all those interested in pursuing perfect health care to benefit from the experiences of the grantees. ▼

New prevention quality indicators from AHRQ

Hospitals, health systems, and providers now have access to a free tool to detect inappropriate hospital admissions for diabetes and other illnesses. Created by the Agency for Healthcare Research and Quality (AHRQ), the tool allows users to measure and track hospital admissions for uncontrolled diabetes and 15 other conditions using their own hospital discharge data.

According to federal data from the Department of Health and Human Services, 7.2 hospital admissions per every 10,000 people ages 18-64 in

the United States are for uncontrolled diabetes. Officials want that to decline to 5.4 per 10,000 people by 2010.

The Prevention Quality Indicators represent hospital admission rates for common condition that also include bacterial pneumonia; pediatric gastroenteritis; urinary infections; congestive heart failure; and chronic obstructive pulmonary disease, which if adequately treated by primary care providers, generally do not require hospital inpatient care. The rates are population based and adjusted for age and sex.

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Editor: **Lisa Hubbell**, (425) 739-4625.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
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Editorial Questions

For questions or comments, call Lisa Hubbell at (425) 739-4625.

The AHRQ Prevention Quality Indicators can be used to answer a wide array of questions regarding the quality of primary care in a community or region. For example, if a state health department or hospital association wants to know the quality of primary care provided to people in the state for a condition such as diabetes, officials would select the AHRQ Prevention Quality Indicators for that illness and use them to measure their state's hospital discharge data on admissions for diabetes. They would then compare these admission rates for communities within their state with benchmarks such as their state average or national and regional averages that will be available AHRQ's HCUPnet (www.ahrq.gov/data/hcup/hcupnet.htm).

Upcoming additions to the AHRQ Quality Indicators include the Inpatient Quality Indicators, a set of 29 provider- and area-level indicators relating to utilization, mortality and volume, and the Patient Safety Indicators, a set of indicators that provides information on potential in hospital complications and patient safety concerns following surgeries, other procedures and childbirth. The Patient Safety Indicators are expected later in 2002.

To download the Prevention Quality Indicators and accompanying software, go to www.ahrq.gov/data/hcup/prevqi.htm. Users must access the SAS statistical software package to run the programs, which they will then have to apply to their own databases that contain information on hospital discharges. ▼

JCAHO responds to Sept. 11 tragedy

Along with the horror of Sept. 11, there were thousands of stories of heroism and how individuals and organizations came together to respond to tragedy. Now, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has put together a special edition of its newsletter, *Perspectives*, that covers issues raised by the terrorist attacks in New York, Washington, DC, and Pennsylvania. Among the topics covered in the special issue of the newsletter are:

- **Using JCAHO standards as a starting point to prepare for an emergency.** Learn about the modified emergency management standard requirements, including the focus on mitigation, preparedness, response, and recovery.

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- **Revised Environment of Care Standards for the Comprehensive Accreditation Manual for Hospitals.** Language of standards and intents on emergency management has been clarified.

- **What the survey process expects of your organization.** This article includes sample questions that may be asked during a survey.

- **Analyzing your vulnerability to hazards.** A hazard vulnerability analysis identifies the disasters that are most likely to strike your organization, your community, and their probable impact if they were to occur.

- **Adapting tools to the task ahead.** A failure mode, effect, and criticality analysis, essentially a proactive risk analysis, can be modified to fit an organization's needs to analyze risks that could disrupt care or services.

- **Developing practical emergency management education programs.** Six priority education areas are identified and explored.

- **Preparing for a mass casualty event.** Includes an emergency management checklist.

- **Lessons learned.** Includes sections on how to manage people and resources effectively; being prepared; communications needs; caring for your own staff during and after an emergency; decontamination; common symptoms to exposure to contaminants; and dealing with a natural emergency. **(For more on the latter, see story on Houston's Memorial Hermann Hospital, p. 6)**

The newsletter also lists informative web sites and other emergency management resources. To view a copy of the newsletter, visit the JCAHO web site at www.jcaho.org. ■