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Web site designed to give clinicians source to get info on near misses

Children's hospitals encouraged to share anonymously

There is consensus in the medical community that, along with documenting actual medical errors, there is a lot to be learned from capturing information about near misses — or as one health system in Minnesota calls them, good catches. But getting people to actually share their accounts has proven difficult. **(For more information on medical errors, see the cover story, *Healthcare Benchmarks*, January 2002.)**

Now, the Bainbridge Island, WA-based consulting company Medical Management Planning (MMP) is setting up a web site where hospitals — initially only children's hospitals, but in the future possibly adult facilities — can anonymously send stories about near misses that others might learn from.

"When we talked about this at our medical errors meeting in May 2000, it was clear that people weren't sharing stories about errors or near misses," says **Sharon Lau**, a senior consultant with MMP based in Los Angeles. "And if you don't share stories, you lose an opportunity to learn." **(For more information, see *HB*, October 2000, p. 109.)**

The web site, called SafeKids (ihighpoint.net/safekids), went live in mid-January and works by having clients e-mail a story to Lau first. She edits the story and posts it to the site, but not even Lau has any idea who sends the stories. "It comes to me as an e-mail from the web site," she explains. "We are hoping this helps people feel comfortable that their posting won't come back to bite them."

At press time, the site was loaded with some fictional sample stories. The site initially is limited to children's hospitals and to child-specific stories because the idea came from MMP's BENCHmarking Effort for Networking Children's Hospitals. If it proves popular, it may be expanded to include adult hospitals, or a separate site may be launched.

Other features of the SafeKids site include lists of resources and ways to share other stories. There is no cost to use the site, and users can sign up to be e-mailed whenever a new story is posted.

Lau still wonders how amenable people will be to posting their experiences. "I think that anonymity will help," she says. "And our clients tell us they are interested in reading about other facilities' experiences and potentially sharing their own." But there is still a sense that outside a risk manager's office, it's not OK to talk about mistakes and near misses.

But Lau is optimistic for a couple of reasons. First, she believes there is a growing sense that organizations understand the need to share information about errors. Secondly, at her company's web site (www.mmpcorp.com) clients can enter a secure site where they often do share what amounts to near-miss stories. They don't use those words directly, she says, but often post questions asking if others have had a problem with a particular drug or device. "I do hope that on the [SafeKids] web site people will be more circumspect," she admits.

The importance was driven home a week before the site went up when NBC's *Dateline* aired a show about a surgery error that led to the death of a boy. "Instead of injecting the boy with lidocaine, they gave him adrenaline — twice," she says. The error came about because the drug vials were emptied into sterile cups and mixed up. While the hospital owned up to its mistake, they emphasized that the problem was process related, not staff related. Still, despite their experience and the publicity it generated, the *Dateline* reporter found that other hospitals still are using that same process. "And there will always be those dangers until we start sharing our stories and learning from others," Lau says.

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Editor's note: To read the entire Dateline *story about the lidocaine error, see www.msnbc.com/news/657566.asp.]* ■

GUEST COLUMN

Improving patient flow: The Esther Project

By **Ann B. Gordon**
Wayland, MA

Esther is not a real patient, but her persona as a gray-haired, ailing but competent elderly Swedish woman with a chronic condition and occasional acute needs has inspired impressive improvements in how patients flow through a complex network of providers and care settings in Höglandet, Sweden.

Esther was invented by a project team of physicians, nurses, social workers, and other care providers who joined together to improve patient flow and coordination of care for elderly patients of a six-municipality region in Sweden. The productive work that has been done on Esther's behalf recently led the Jonkoping County Council, responsible for the health care of 330,000 residents living around Höglandet, to become one of two international teams participating in the Pursuing Perfection initiative. This program, launched by the Robert Wood Johnson Foundation in Princeton, NJ, is designed to help physician organizations and hospitals dramatically improve patient outcomes by pursuing perfection in all their major care processes. The Institute for Healthcare Improvement (IHI) in Boston serves as the national program office for the initiative.

"I think it is very important that we call this work Esther," says **Mats Bojestig**, MD, chief of the department of medicine at Höglandet Hospital, and one of the developers of The Esther Project, as well as an IHI faculty member. "It helps us focus on the patient and her needs. We can each imagine our own Esther and ask ourselves, 'What's best for Esther?'"

Esther proved inspirational for the team.

COMING IN FUTURE MONTHS

- Designing an outcomes management program
- Developing data skills
- How to use patient data registries
- What is a standardized performance ratio?

During the three-year project, the team was able to achieve the following improvements:

• Hospital admissions for heart failure fell from approximately 580 in 1998 to 460 in 2000.

• Hospital days for heart-failure patients decreased from approximately 3,500 in 1998 to 2,500 in 2000.

• Waiting times for referral appointments with neurologists decreased from 85 days in 2000 to 14 days in 2001.

• Waiting times for referral appointments with gastroenterologists fell from 48 days in 2000 to 14 days in 2001.

The Esther project arose from a need shared by many American health systems: Improve the way patients flow through the system of care by strengthening coordination and communication among providers.

Bojestig tells Esther's story this way: "Esther is 88 and lives alone in a small apartment. During the past few nights her breathing has become worse and worse, and her legs have edema severe enough that she cannot lie down, but sits up all night. She knows she needs health care. She phones her daughter in a nearby town, who tells her to call her home nurse. The home nurse visits and says she needs to see her physician. But Esther lives on the third floor and can't manage the stairs.

"So the nurse calls an ambulance, and Esther goes to the doctor, who says she needs to go to the hospital. Now three hours have passed. An ambulance takes her to the emergency room (ER) where she meets an assistant nurse, and waits for three hours. She meets with a doctor, who examines her and orders an X-ray, and says she will have to be admitted. She comes to the ward and meets more nurses." Here Bojestig smiles. "Most days Esther is a little lonely, but today she is happy because she has already met 30 people."

The Swedish health system is designed in a traditional, functional way: Each link in the care-giving chain — the primary care physician, the hospital, the home-care providers, the pharmacy — acts independently according to its function. "But Esther needs it to all fit together," says Bojestig. "It needs to flow like an organized process," he says, so each care provider can take advantage of what has been or will be done by others.

Esther's objectives

Out of this need grew the Esther Project, which has six overall objectives:

1. security for Esther;
2. better working relations in the entire care chain;
3. higher competence through the care chain;
4. shared medical documentation;
5. quality through the entire care chain;
6. documentation and communication of improvements.

The Esther project team was divided into two subgroups: the strategy group and the project management group.

To establish a clear picture of where the problems existed, team members conducted more than 60 interviews with patients and providers from throughout the system. Together they analyzed the results, which included such statements as: "Patients in a nursing home rarely see their doctor," and "A patient getting palliative care at home was in contact with 30 different people during one week."

According to Bojestig, the interviews also furnished providers with valuable information about how their individual work processes did or did not fit with the work of their colleagues in the care chain. Interviewers frequently found that efforts were being duplicated.

The result of this lack of coordination is repetition. While Esther's social worker knows all about how Esther lives, Bojestig says, "Still her GP [general practitioner] asks her how she lives, and she tells it. The hospital asks her, and she tells it again, and so on." Lack of coordination of information, particularly where medications are concerned, causes considerable redundancy and waste. In the worst case, it can lead to medical errors.

So the team devised an action plan that spelled out six main projects designed to correspond to the six goals. The projects the team identified were:

• develop flexible organization with a focus on patient value;

• design more efficient and improved prescription and medication routines;

• create ways in which documentation and communication of information can be adapted to the next link on the care chain;

• develop efficient IT support through the whole care chain;

• develop and introduce a diagnosis system for community care;

• develop a virtual competence center for better transfer and improvement of competence through the care chain.

Bojestig says that as part of its work, the team examined demand and capacity within the system, and saw that the inadequate capacity for planned

care was forcing patients to seek urgent care in inappropriate settings. "If Esther complains of headaches, and her GP says she should see a neurologist, in our system that referral would take three months. For Esther, this is not acceptable. So she goes to the ER, and the doctor there knows that if he puts her in the hospital, the next day there will be a neurologist in to visit her."

So, although it appeared that the demand was for inpatient admissions, it was really demand for better access to specialty care. So the team tested a process in which the queue for care was redesigned from two queues to one for acute care and one queue for planned**.** "Instead of having acute care go into the wards, it goes to the team," Bojestig says.

The team, which includes the primary care physician, specialists as appropriate, nurses, and home nurses, has a more collaborative relationship through which it decides what's best for each patient. When a patient presents with acute care needs, says Bojestig, the primary care physician can page a specialist on the team, who is expected to respond within two minutes. A telephone consultation still can result in an inpatient admission, but it allows the patient to be admitted directly to the ward without having to endure a visit to the ER, which can be costly in both human and financial terms.

For their part, the specialists began working toward open access scheduling in which patients could be seen on the same day they or their primary care physician calls. Closer cooperation among specialists and other providers meant that primary care physicians and home care nurses were able to do for patients some of the things specialists previously had been doing.

Additionally, patient education was recognized as a critical element in keeping patients out of the hospital. Nurses were trained to educate heart patients, for example, about how to take vital measurements at home, and how to tweak their medication accordingly.

Bojestig says that all 250 providers in the network received training in the project's goals and processes. And the investment paid off. "We have closed about 20% of our bed capacity," he says, "and moved that capacity to where the need is bigger."

The continuing focus of the team's work was how to create value for Esther. He says that the project changed the attitudes among those who work for Esther. "The focus is on her now," he says.

"The important thing for us as leaders or workers in the health care system," says Bojestig, "is can we still continue to work in systems that are not integrated? Is it fair to our knowledge? Is it what we want to do? Is it best for Esther?"

(Editor's Note: This article is reprinted with permission from the November 2001 issue of the Institute for Healthcare Improvements (IHI) Continuous Improvement *newsletter. For more information on the Institute or its many publications, visit its web site at www.ihi.org.*

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Press, Ganey winners are best in customer care

Share success with employees to keep patients happy

For years, officials at the East Alabama Medical Center (EAMC) in Opelika, AL, looked at their Press, Ganey of South Bend, IN, patient satisfaction reports as something to read and file away every quarter. The results weren't widely discussed or shared, and action wasn't taken to improve the 352-bed hospital's 40th-50th percentile scores.

But that changed in 1998 when officials attended a Press, Ganey client conference and were inspired by the ideas other customers had. The result has been a series of programs that not only improved the patient satisfaction scores, but in December of 2000, led *Fortune* magazine to name the hospital one of the 100 top companies to work for in America.

One of the programs that the hospital implemented was a "gainsharing" program that financially rewards the 2,000 employees for meeting or exceeding patient satisfaction and financial goals, says **Susan Johnston**, director of human resources at the hospital. "When we started, we tied the rewards to cost, profit, and satisfaction goals," Johnston explains. Since then, the cost piece has been dropped. Financial goals are based on net income, and patient satisfaction scores are based on minimum acceptable scores from twice yearly Press, Ganey reports.

Initially, the patient satisfaction piece related only to the inpatient report, but this year, EAMC will add outpatient and emergency department surveys to the mix, too. Inpatient is weighted at

80% and the other two at 10% each. The goals, says Johnston, are meant to be achievable, but still a stretch.

Since the program was initiated, scores have increased from the 42nd percentile to the 99th percentile as of August 2001. "We used to communicate in raw scores because 83 looked better than the 70th percentile, but now we use the percentile," she explains. The minimum score for the next payout is the 92nd percentile. "That's huge from where we started."

There are two payouts per year for the program, which makes up about 5% of the typical employee's pay. The average is about $1,000 per employee, per payout.

The financial and satisfaction award pools are separate, and most of the money comes from the financial piece. For the coming year, if net income reaches $8.5 million, the award pool for the financial piece will be $950,000. Not every member of the staff gets the same portion, however, Johnston explains. Employees who make less than $20,000 per year are brought up to that level for the share purposes. Those who make more than $50,000 per year are brought down to that level. "The less you make, the higher the percentage of the pool you can get." The pool for patient satisfaction is $500,000 for each six-month period.

Johnston says employees have made as much of an effort for the financial effort as for patient satisfaction. "They can have an impact on net income based on the kind of instruments you use. You can ensure patients come back to our facility by being nice to them." Eliminating cost from the mix was done in part because it was so much harder to explain to employees. "When you tried to break it down, their eyes glazed over. The bottom line is a good, simple idea."

Employees are reminded of the gainsharing program every year through a brochure. Initially, explaining the program took 12 pages, Johnston recalls. This year, it's down to one page. "They want to know when they will get a check, how much it will be, and when they will be eligible. We do a really good job of explaining that."

The CEO does a quarterly video for employees, too, where financial information and the Press, Ganey scores are discussed. "We do a constant bombardment of information that talks about this," says Johnston. "It is something that employees live and breathe."

Gainsharing isn't the only effort made to increase patient satisfaction. "Our patient satisfaction scores have skyrocketed and we are making money. Our net income targets have increased every single year," she says. "But we think all the programs together have achieved this. Gainsharing is just our way of saying thank you to our employees."

Implement several types of rewards

Another program implemented by the hospital was a mystery shopper who went through the emergency department, was admitted, had a series of tests, and was discharged after a day. She came with a "family member" who wandered the halls taking note of customer service. She even went to the human resources department and asked about applying for a job. The program, when divulged to the staff, got the employees' attention. Employees who performed well under the test were rewarded with a steak dinner. Problem areas were addressed with immediate action plans.

EAMC also has a "Behavior of the Month" program where a positive behavior — such as service recovery to fix a situation that has gone bad with a patient or employee, whoever the customer is — is emphasized. The behaviors often are developed from the satisfaction reports' priority index. Each new behavior is communicated in a monthly Customer Service Forum that is videotaped and distributed to all employees.

Employees who can recite the Behavior of the Month when asked get to select a goodie, such as chocolate, potato chips, or other snacks from a goodie basket. "It sounds silly, doesn't it?" says Johnston. "But it's one of the most popular things with the staff. They really look forward to it. They chase you down the hall to recite the behavior. I even have an employee who can tell me the last 12 behaviors in order."

Frontline employees are rewarded for exemplary service, and there also are monthly awards for the Best Department based on Press, Ganey scores. These "GRID" awards (Great Rewards in Devotion) also include a Best Supporting Department nominated by the Best Department to include those who were instrumental in helping a department win. Department members are given a pizza party and a trophy.

All of these elements help to keep employees as satisfied as patients, and Johnston says that keeping employees happy is certainly a way to impact patient satisfaction. "We do employee surveys, our vice presidents have feedback sessions with employees sans management," says Johnston. "Every quarterly meeting results in five or six things to focus on for improvement, and we

require the manager to create an action plan. We put as much stock in employee satisfaction as patient satisfaction."

It appears to be working. The hospital has low turnover, and doesn't have to use temporary or contract nursing staff. "We want our employees to understand that patient satisfaction affects the bottom line," says Johnston. "If you go to a hotel where you get bad service, you won't go back. And we are very much a service industry. Patients have more choices now. We have to corner our market or lose it."

Patient satisfaction and the bottom line

For proof that patient satisfaction can impact the bottom line, look no further than Memorial Medical Center in Johnstown, PA. The facility was losing $2 million a month a couple of years ago. Consultants recommended a redesign, and the leadership redesigned every process imaginable. "We continued to lose money and struggle with low employee morale," says **Suzanne Ross**, MSN, MBA, director of performance improvement resources and outcomes management at the 566-bed hospital. "We knew that drastic action was required and we needed help"

The hospital management decided to focus less on financials and more on clinical excellence, customer satisfaction, and cost-effectiveness.

The hospital restructured its Hospitality Team, which developed a list of golden rules that all employees were supposed to exemplify. **(See the list of hospitality golden rules, p. 19.)** Those who do are rewarded through the Gold Star program. Staff, physicians, and volunteers are nominated for awards. Winners receive a gift certificate to the gift shop and a gold star for their name badge. Quarterly winners get a bigger gift certificate and a three-month parking pass to the hospital garage (where parking is at a premium, says Ross). Annual winners get a $500 gift certificate and a gift basket.

Over the months, the criteria have become more stringent for selection. The most recent winner was a telecommunications worker who learned that a trauma patient from out of the area had no visitors. "She visited every day since the family couldn't come and communicated with the family regularly," Ross explains. But when the program started, just escorting lost patients could win one the prize.

The hospital also developed a new performance improvement program that emphasizes interdepartmental communication. "No one used to talk to each other," says Ross. "They just tracked their own departments." Now, every administrative director and a physician counterpart (if it's a clinical area) are on a Council for Performance Improvement (PI). The departments talk about their PI initiatives on a rotating schedule, allowing for departments to share strategies and information that may relate to a particular initiative. For instance, the med/surg nursing areas were working on patient restraints, but the behavioral health department previously had done a project on that topic and now is restraint free. "One didn't know the other was working on it," Ross says. "Now they are working together so that med/surg can become restraint free. That benefits the patients."

With the changes that the PI and hospitality teams were implementing came the realization of the need for national patient satisfaction benchmarking. Memorial scrapped its internal patient satisfaction survey and turned to Press, Ganey. The initial score: the 22nd percentile.

Ross says PI teams took the data back to their departments immediately to find areas for improvement. One area the hospital scored low in was courtesy and friendliness of staff. "We had education sessions at every management meeting. One of the members of our hospitality team looked at why it is so hard to greet a stranger and did a program called Hello Therapy." That program was brought back to the staff, and even expanded to Smile Therapy, Ross says. Smiley face signs were posted around the hospital as a reminder to staff to smile. Scores dramatically improved and now are in the 90th percentile.

A hospital team also visited a more successful Press, Ganey client to learn from their successes. "We learned that we really did need to focus on the patients. We knew it all along, but the financial focus seemed to still creep to the forefront now and then." The hospital then created nine multidisciplinary teams that use Press, Ganey data to facilitate broad-based organizational change. For example, staff now make post-discharge courtesy calls and send thank-you cards. There also is an enhanced infant bereavement process.

The impact of Memorial's programs has been dramatic. "Overall, our nurses section started at the 44th percentile and our most recent ranked us at the 97th," says Ross. "And our dietary department started at the 16th percentile; last time it was at the 90th."

The consulting and benchmarking company Solucient named the hospital a top 100 hospital for cardiac and orthopedic care. Admissions

increased more than 6% in fiscal year 2001, and are up 9% so far this fiscal year. And that $2 million per month loss? It has turned around to an average monthly income of $400,000.

"At first, we didn't believe that we should put less emphasis on financials," Ross says. Consultants were brought in and recommended cutting staff, but that didn't work. "But when we put patient satisfaction at the top of the list, our finances turned around. That was a hard lesson to learn. We listened to our patients and staff, and suddenly things are better. All this from a change of emphasis and priorities."

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Tracking cost and info: An affordable solution

50-bed unit gets big program at small price

Knowledge is power, and to succeed, information is key. But for a small hospital, affording the kinds of systems that provide the best data often is overly expensive and close to impossible. But one small facility in rural Washington state has found the critical operational and quality information it needs. Samaritan Healthcare, a 50-bed acute care hospital in Moses Lake, located between Seattle and Spokane, knew that with lower Medicare and private reimbursement rates, understanding where money went and how to reduce costs without sacrificing quality of care was vital.

The facility had been using PACE, a product of the Computer Sciences Corporation (CSC) of El Segundo, CA. But CSC dropped the PACE system and after a year of trying to function on its

Learn to follow the hospitality golden rules

Patient satisfaction leads to profit

1. Extend a welcome: Make eye contact, smile, say hello, introduce yourself, call people by name, and extend a few words of concern.

2. Notice when someone looks confused: Stop and lend a hand.

3. Take time for courtesy and consideration: Kind words and polite gestures make people feel special.

4. Keep people informed: Explain what you are doing and what people can expect in terms they will understand. People always are less anxious when they know what is happening. Continually communicate.

5. Anticipate needs: Often you'll know what people want or need before they ask. Don't wait. Act.

6. Respond quickly: When patients are worried or sick, every minute seems like an hour. When customers/coworkers need information or help, they find delays frustrating.

7. Maintain privacy and confidentiality: Knock as you enter a room. Watch what you say and where you say it. Protect personal information.

8. Handle with care: Slow down. Imagine you are on the receiving end.

9. Maintain dignity: Give choices in interactions with patients. Provide privacy. That patient/customer could be your child, your spouse, your parent, or your friend.

10. Take the initiative: Just because something is "not your job" doesn't mean you can't help or find someone who can help. Follow through — do what you say you will do. Take advantage of opportunities for improvement.

11. Treat everyone with respect: Be approachable. Your words, tone, and nonverbal communication should reflect consideration. Address the patient/customer by name and include them in your conversation.

12. Listen and act: When people complain, don't blame others or make excuses. Hear them out, do all you can to respond to the problem, and make things right.

13. Help each other: When you help your coworkers, you help customers, too.

14. Keep it quiet: Noise annoys. It also shows lack of consideration and concern for patients.

15. Apply telephone skills: Speak clearly, giving an appropriate greeting, name, and department when answering the telephone. Sound pleasant. Be helpful. Listen with understanding. When you're on the telephone, our reputation is on the line.

16. Look the part: Professional dress and demeanor build people's confidence in all of us.

Source: Memorial Medical Center, Johnstown, PA.

own, Samaritan executives decided to seek out a new system.

It didn't help that the region between Spokane and Seattle has experienced some of the fastest growth in the nation, leading Samaritan to start a $20 million construction project to keep pace. Money was tight, says **Glen Stambaugh**, RRT, director of quality at the hospital, and the typical six-figure intelligence software offerings were completely unaffordable.

"They had wonderful capabilities, but required high front-end investment in licensing, hardware, and dedicated employees to maintain and operate the infrastructure," he explains. He did some research and asked others what products they used. There were two companies — which Stambaugh declines to name — that offered great products, but that would have required between $60,000 and $100,000 to start for the capabilities the hospital needed. That was beyond what Samaritan could afford, and more than three times what they paid for the defunct but highly capable CSC product. "It would have been out of the question even in a good year," he says.

New company is like old reliable

Lucky for Stambaugh, the old PACE sales representative he used was working for a start-up company called Net-Fast based in Billerica, MA. "He offered a newly developed solution with capabilities similar to more expensive packages, but at a price we could afford." The price was a relatively mere $25,000 per year.

Not that Stambaugh wasn't concerned about using a product from a new company. "But then again, CSC was established and they quit offering a service, so the risk is inherent in the industry whether a company is new or old," he says.

Net-Fast takes routinely generated transaction data and puts it in a form that is readily available to hospital decision makers. The system is designed to be simple to understand and use, but allows for thorough analysis of the factors impacting profitability and clinical effectiveness. All of the data and the required software reside on Net-Fast's secure web site, enabling hospitals to easily access their information without additional infrastructure, software, or hardware costs.

The source data used in the system is extracted by the user hospital and uploaded to Net-Fast on a regular basis. In the case of Samaritan, Stambaugh says, "Our source data is maintained by a consortium of regional hospitals using a shared information system. We alert them when our quarter is completed and they forward it to Net-Fast. Net-Fast works with them to make it a smooth and simple process."

The reporting module Samaritan uses, Net-Fast (NF) Blue, supports a number of clinical and financial applications, says Stambaugh. "We can get information on any procedure, diagnosis, or charge master population. We can analyze for utilization, revenue, and outcomes." The data isn't real time, but it is available within a couple of weeks of transferring it to Net-Fast — something faster than many products that are out there. "It's as close to real-time data without going day-to-day as we can get," he says. "We could have gone for cheaper options that use state and other public databases, but the data is old and limited by the time you get it."

Stambaugh found NF Blue extremely easy to learn and used it right away to explore revenue-challenged laparoscopic procedure service lines. "We knew changes in Medicare reimbursement had resulted in lost revenue, and it was important to identify waste and potential variances in care which could be addressed to restore viability." Stambaugh used the wide range of data elements available in NF Blue to comb through the procedures and break out charge categories where utilization varied by physician. NF Blue again was applied to rank variances by average value and to compare clinical outcomes.

"We were able to validate that our laparoscopic service line was efficient and safe, with physician practice-related variations in some charge items and missed charges in others," he said. "We shared the variations with the physicians for their consideration, and the missed charges with the surgery department to improve the charging process and eliminate, for example, over $3,000 in a single category of lost laparoscopic surgery charges."

In another project, Samaritan tracked pneumonia readmission rates as a quality-of-care measure. NF Blue made the task easy. "We found that re-admissions were primarily associated with one physician, and that a change in the formulary using a newly available drug was very effective at eliminating the high rate of re-admissions," says Stambaugh. "If we had had to use chart reviews and manual methods for tracking, it just wouldn't have happened for lack of time and resources. But with access to our data through a powerful application to find the outcome information, it leaves time for the chart reviews

when they are occasionally needed."

Samaritan Healthcare sees this approach as necessary to survive and improve while some other smaller hospital systems may be folding for lack of information. Says Stambaugh, "We are excited about having the same capability as larger systems and are ready to focus it on the next area of need." That area: looking across major DRGs for utilization outliers and working with medical staff to update clinical outcomes indicators. "This system allows us to look into any question that comes up immediately."

The system still is evolving, with Net-Fast actively seeking input from users on how to improve the system. "PACE had excellent drill down, but this is more flexible," Stambaugh says.

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AMA, JCAHO, NCQA create pain management project

Three of the nation's leading professional organizations in the health care field are teaming up to develop a common set of evidence-based measures for evaluating the appropriateness and effectiveness of pain management for patients suffering from cancer, back pain, and arthritis.

The two-year project, sponsored by the American Medical Association (AMA) in Chicago, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, and the National Committee for Quality Assurance (NCQA) in Washington, DC, will help physicians, health plans, hospitals, and other health care organizations determine how well they are doing managing patients' pain.

The initiative represents a major effort to improve the quality and consistency of pain management across the country. The March 2001 Institute of Medicine report, "Crossing the Quality Chasm," identified back problems, arthritis, and cancer among 15 therapeutic areas prioritized for improvement in care.

in the coming months, AMA, JCAHO and NCQA will convene a panel of practicing physicians, pain management experts, and performance measurement experts that will define important aspects of pain management that should be measured. The panel then will develop a set of standardized pain management performance measures. The final phase of the project will involve testing the measures across multiple-care delivery settings.

The resulting measure set will be designed to give physicians, health plans, hospitals, and other provider organizations consistent messages about the important aspects of pain management and will help to identify opportunities for improving the quality of care provided to these patients. The AMA, JCAHO, and NCQA also are committed to working together to reduce duplicative data collection activities that are burdening a health care system already beleaguered with rising medical costs.

"Unrelieved pain has profound physiological and psychological consequences that result in significant costs to patients and families, to the health care system, and to society as a whole," says **Yank D. Coble Jr.**, MD, president-elect, AMA. "Unfortunately, a variety of barriers impede the use of appropriate treatments, causing many patients to suffer needlessly. We have an important opportunity here to provide relief for patients by promoting consistency and quality in the management of pain."

"Pain is the most common reason that patients seek medical care, yet we don't always know whether the treatments provided are effectively meeting patient needs. This must change," says **Dennis S. O'Leary**, MD, president, JCAHO. "Working together, I am confident that we can make significant strides in addressing this serious public health issue."

"One of the major precepts of caring for patients is to always strive to relieve pain and suffering," says **Greg Pawlson**, MD, executive vice president, NCQA. "These measures will help us quantify how we're doing in that area, while at the same time driving improvement in the care delivered to a large, diverse patient population."

The AMA, JCAHO, and NCQA have worked together to coordinate performance measurement development activities since 1998, and earlier this

year unveiled Coordinated Performance Measurement for the Management of Adult Diabetes — a new approach to measuring performance in the delivery of care to diabetes patients.

Purdue Pharma in Stamford, CT, is providing unrestricted funds to support development of the pain management measure set. Control and responsibility for the design and content of the measure set rest solely with the AMA, JCAHO, and NCQA. JCAHO will function as the administrative center for the project. ▼

NCQA releases its final standards for DM programs

The National Committee for Quality Assurance (NCQA) in Washington, DC, today announced the release of final standards for its Disease Management (DM) Accreditation and Certification programs. The programs, the first targeting the wide variety of organizations providing disease management, have drawn extensive support from industry leaders. Even prior to their release, 20 organizations of various types already have committed to reviews. The health care industry increasingly is looking to focused disease management as a critical part of the solution to health care costs that are again on the rise.

"NCQA's new disease management programs are designed to ensure that the enormous promise of disease management is fulfilled," says NCQA President **Margaret E. O'Kane**. "Accreditation and certification will give health plans and employers an indication of which organizations have what it takes to take better care of the chronically ill."

"The rapid proliferation of organizations offering disease management services has led to confusion in the market," says **David B. Nash**, MD, MBA, associate dean, Jefferson Medical College in Philadelphia. "NCQA is the right organization to help identify those DM organizations that can deliver better health outcomes for the seriously or chronically ill."

Managed care organizations (MCOs), managed behavioral health care organizations, and preferred provider organizations (PPOs) contracting with accredited or certified DM organizations will receive automatic credit for parts of the most rigorous NCQA quality improvement standards, thus facilitating their own accreditation efforts. Organizations electing to achieve DM Accreditation themselves will also receive credit on these standards.

Employers, whose backing encouraged the growth of NCQA's accreditation programs for MCOs and PPOs, are demonstrating support for DM Accreditation and Certification.

NCQA will deliver the DM Accreditation and Certification programs in a newly redesigned, web-based review process that emphasizes efficiency. The updated process shifts much of the review to electronic formats, focusing on increased use of the Internet and the advanced data capabilities of participating organizations. It also minimizes the on-site review portion of a survey, thus reducing costs and increasing efficiency.

To meet the needs of a diverse range of potential participants, NCQA has devised a number of different accreditation and certification review options. They are:

Accreditation Options

• Patient and Practitioner Oriented Accreditation is the most comprehensive review option. It includes 32 standards. This option is designed for organizations that work with both patients and practitioners, and conveys the most automatic credit to health plans that contract with an accredited DM program.

• Patient Oriented Accreditation is designed for comprehensive DM programs that focus exclusively on patients and do not have regular contact with practitioners.

• Practitioner Oriented Accreditation is designed for comprehensive DM programs that work through practitioners.

Certification Review Options

NCQA's DM Certification programs essentially are subsets of the DM standards that are appropriate for organizations that provide specific services such as designing, but not operating DM programs. NCQA offers three types of certification for these organizations:

• DM Program Design Certification includes a review of DM content — such as printed, electronic, and in-person methods for working with patients and practitioners — according to clinical guidelines.

• DM Systems Certification reviews the design of clinical information systems, such as those used to identify patients, to support DM.

• DM Contact Certification addresses patient contact, and covers such areas as patient program information, patient participation, and access to health care professionals.

The 20 organizations that have applied for a DM review represent all of the accreditation and certification options. Eighteen other applicants were announced in December 2001.

The 2002 DM Standards and Guidelines for Accreditation and 2002 DM Standards and Guidelines for Certification are available as printed or electronic publications. To order, or for more information, visit www.ncqa.org or call (888) 275-7585. ▼

New accreditation for Critical Access Hospitals

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has launched a new accreditation program for Critical Access Hospitals, and the first surveys were conducted in December. JCAHO is seeking deemed status for the program from the Center for Medicare & Medicaid Services (CMS).

Critical Access Hospitals, as outlined in the Balanced Budget Act of 1997, are designed to provide limited, but essential health services to rural communities. These small facilities — patient census of less than 25 — are certified by the Secretary of the Department of Health and Human Services as eligible for cost-based reimbursement from the Medicare program.

More than 400 existing hospitals nationwide already have converted to Critical Access Hospital status, and as many as 1,100 organizations may be eligible for this designation.

The new accreditation program is designed to meet the performance improvement and business needs of these particular hospitals, many of which are currently accredited by JCAHO as acute care hospitals. Critical Access Hospitals will be surveyed for compliance with standards specifically adapted for these organizations and those that are in conformance with the Medicare requirements for these special hospitals. JCAHO also developed a cost-effective survey process based on the pre-survey review of relevant information and a focused on-site review of compliance with standards.

"JCAHO is sensitive to the special issues of Critical Access Hospitals. We are also mindful that most Critical Access Hospitals will likely seek insurance reimbursement from sources other than the Medicare program. JCAHO accreditation can be a tremendous asset in that process," says **Kurt Patton**, executive director, Hospital Accreditation Services, JCAHO.

The new accreditation program is based on JCAHO's own experience in evaluating small and rural hospitals and on extensive field input and test surveys. JCAHO also sought feedback from its Hospital Professional and Technical Advisory Committee and the Work Group on Accreditation Issues for Small and Rural Hospitals.

Critical Access Hospitals must meet a specific set of federal participation conditions in order to participate in and receive payment from the Medicare program. National accrediting bodies,

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such as JCAHO, which successfully demonstrate to CMS that they are meeting federal requirements, may be granted deeming authority. If JCAHO is successful in achieving deeming authority for Critical Access Hospitals, such JCAHO-accredited hospitals would not be subject to the Medicare survey and certification process. JCAHO has had deeming authority for hospitals since the inception of the Medicare program in the 1960s. ▼

Web site helps hospitals spot anthrax, smallpox

A new web site funded by the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, teaches hospital-based physicians and nurses how to diagnose and treat rare infections and exposures to bioterrorist agents such as anthrax and smallpox.

Designed by researchers in the Center for Disaster Preparedness at the University of Alabama at Birmingham (UAB) under a contract from AHRQ, the web site is the first of its kind to offer free continuing education credits in bioterrorism preparedness to clinicians. The site currently offers five on-line courses through the UAB Office of Continuing Medical Education for emergency department clinicians, including physicians, nurses, radiologists, pathologists, and infection control practitioners. Improvements to the site are planned. The address is www.bioterrorism.uab.edu.

"This web site is an important new tool to help doctors and nurses identify rare infections that also could be potential bioterrorist threats," says AHRQ Director **John M. Eisenberg**, MD. "The evidence-based information presented on this web site will help front-line clinicians in our nation's hospitals be better prepared in the event of further bioterrorism attacks."

Courses cover identification of six potential bioterrorist agents and commonly associated syndromes, including anthrax, smallpox, botulism, tularemia, viral hemorrhagic fever, and plague. There is no cost to take the courses, and each offers one hour of continuing education credit.

Courses include case-based scenarios and photos followed by multiple-choice questions and answers, according to **Margaret Tresler**, program manager for UAB's Center for Disaster Preparedness. "If a wrong answer is selected, an explanation follows telling why the answer is incorrect. The interactive modules are designed to be easily accessible and user-friendly, keeping in mind that clinicians are busy."

Courses were developed by researchers and clinicians representing various fields, including emergency medicine, health administration, public health, nursing, and education. ■