

HEALTHCARE BENCHMARKS™

The Newsletter of Best Practices

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Report cards don't make the grade with physicians or consumers

The good news: Organizations use info for quality improvement

For years now, health care organizations have been creating and touting programs that allow consumers to see how they do when it comes to a variety of quality measures — from preventive care and well-baby visits, to caring for those with chronic illnesses. Sometimes the data relate to physician groups, at other times to health plans. But regardless of the kind of data presented, consumers aren't using them to make health care choices, and physicians don't use them to determine to which specialists they should refer patients. Those are the findings of a new study published in February by RAND, a Santa Monica, CA-based research and development organization.

The good news from the study, however, is that health care organizations and hospitals seem to use the data as a stepping stone for quality improvement programs, says **Paul Shekelle**, MD, PhD, lead author of the report, a staff physician at the VA Greater Los Angeles Health Care System, and a RAND consultant.

"There was this idea that report cards were going to foster a consumerist approach to health care the [same] way there is a consumerist approach to buying a television or refrigerator," Shekelle says. "That hasn't panned out."

The reasons are manifold, he says. Topping the list is that those who create the report cards don't make them in a readily understandable format. "Another reason is that you often think about buying something like a television prospectively," he says. "But with health care, you don't have time to study the issue. It's not like you can postpone a heart attack until you have researched doctors and hospitals."

Also, says Shekelle, at the health plan level the unit of delivery of the information isn't as meaningful to patients as information about their own physicians would be. "Someone might say

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Cedars-Sinai is good for bypass surgery, but that message isn't nearly as powerful as someone saying that Dr. Jones is great for bypass surgery."

It isn't just potential patients who find health care report cards less useful than their proponents would have liked. Physicians, also, are not likely to use publicly available information when making decisions about where to refer patients.

"Although physicians tend to consider the information accurate," the RAND report states, "they seldom share it with patients. Moreover, many physicians believe that public disclosure of performance information encourages other physicians to refuse to treat those patients in the poorest health." The report goes on to say that there is no evidence that those beliefs have a basis in fact, but they still are a factor in physicians' decisions not to use publicly available data.

Positive response from plans

But there are groups that take report card data and make use of it: health plans and hospitals. The report notes one particular study that proves comparative data can have a positive impact. In the early 1990s, New York State began a reporting system for physician and hospital performance on bypass surgery. The data included mortality, choice of physicians, and hospitals. During the study period, risk-adjusted mortality rates improved dramatically.

"Plans and hospitals perceive this data as a big deal for one of two reasons," Shekelle notes. "Either they are worried about prestige, or they are worried about market share. But their public reaction is the same. If they score high, they tout their performance as a top hospital. If they score low, they say the data collection is flawed. Then they go back to their facilities and do whatever they can to make sure the numbers look better the next time around. That there is an agent of change at work here is clear."

There is a fear that in order to make the information more accessible and understandable to the consumer at large, those collecting it and

creating report cards from it may dumb it down too much. Shekelle thinks the future may lie in a multilayered version of a health care report card. Consumers could find out a simple score — based on stars or a number rating system — for their hospital or plan, but they also might be able to dig down deeper to find out more detailed information.

"I don't think [this report] is going to spell the end of report cards," he says. "They aren't going to go away. I think that it will continue to evolve down to smaller units of measurement — down to the individual doctor level that is of interest to patients."

What is less clear, Shekelle continues, is whether the data will become more comprehensive or continue to focus only on a few measures. "We would ideally like to see a much more comprehensive quality assessment that uses fewer people in the sample but more items."

Currently, most report cards are based on one of two data sets, the Health Plan Employer Data and Information Set (HEDIS) collected by the National Committee for Quality Assurance based in Washington, DC, and the Consumer Assessments of Health Plans Survey collected by third-party vendors. HEDIS, says Shekelle, focuses on just 14 items. Shekelle and his colleagues would like to see upwards of 200 different items collected.

"The biggest concern that consumers and organizations should have is whether the measures are giving a fair picture of quality," he says. "The individual items are just small samples of quality. Ask yourself: Are they reflective of the whole organism?"

Not that Shekelle thinks anyone should stop creating or using the report cards because they aren't perfect. "I think that if we continue to wait for more perfect systems, that is tantamount to endorsing the status quo. And everything we know about the status quo is that there are gaps between what happens and what should happen on the most basic of measures. We don't have to wait for a perfect cure. We use what we have even if it has faults and flaws. Then we work on

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making it better.”

The RAND study lists three things that can make the report cards more useable. First, make sure the data are presented in a readable manner. There are several ways this can be done, including the judicious use of clear headings, presenting information in several ways — such as graphically and in text — and making sure the information consumers will be most interested in is available to them without having to read through an entire report.

Second, educate the various audiences — the public, health care professionals, and the media — on the data and their importance.

Lastly, assess the impact of the public release of information. Find out who uses it and how. That, the report concludes, “will allow the creators of health care report cards to tailor the messages they present more effectively and to reach a much larger segment of the potential users.”

Shekelle hopes that data will continue to be available publicly, although there are some in the industry who would like to keep data distribution private. “There isn’t any proof of it, but I think there is an intuition that internally released data won’t have the same impact. Public release of quality information does provide an impetus for positive change.”

To see a complete copy of the report, visit the RAND web site at www.rand.org/publications/RB/RB4544.

[For more information, contact:

• **Paul Shekelle**, MD, PhD, Staff Physician, VA Greater Los Angeles Health Care System and consultant to RAND, 1700 Main St., Santa Monica CA 90407. Telephone: (310) 393-0411, extension 6669.] ■

Labor costs for knee surgery bend downward

Benchmarking study highlights best practices

It may be a recession, but labor costs always seem to go up. That, however, is not the case for participants in the latest survey of the Accreditation Association for Ambulatory Health Care (AAAHC), based in Wilmette, IL. Labor costs per procedure for knee arthroscopy with meniscectomy are down over the previous

year for organizations that participated in both surveys, says **Naomi Kuznets**, PhD, director of the AAAHC Institute for Quality Improvement. “It was the only surprise of the survey.”

Labor costs had a wide range, too, running from around \$15 per case to more than \$40. The bulk of those costs — for all but one of the 18 participating organizations — was RN time. Indeed, at one organization, four registered nurses were used for each procedure. The average wage for the RNs was just more than \$22 per hour. Technician time averaged out to \$9.72 per hour. **(For more on labor costs, see the graph on p. 40.)**

Procedure time lasted from 20 minutes to just less than 40 minutes, with a mean of 31 minutes. One significant finding of the study was that there was no statistical correlation between procedure time and the volume of cases an organization has. “This is good news for most organizations and supports performance measurement study findings that an organization does not need large volumes to be efficient; they only need to know and adopt the best practices,” the report states.

Only about half of all cases started on time, according to the survey. One of the most efficient of those organizations noted that it could start on time by making sure there are a minimum of supplies and that surgeons have adequate instruments available.

Some of the organizations reported a problem making sure that all but the first case of the day started on time, something the report notes may be due to not allowing enough time for each case or inadequate turn-around time. Those organizations that do start on time note the following strategies to stay on track:

- checking if lab work is complete and acceptable;
- pre-certification of insurance approval;
- ensuring the proper equipment and supplies are available;
- pre-operative education by appointment, phone, or written communication;
- having the operating room crew ready at least 15 minutes prior to start time;
- standardizing setup and equipment.

Make the most of pre-surgical time

Making sure things are in order prior to the start of a procedure can assist organizations in keeping to schedule. One of the best performers

Staffing

Source: Accreditation Association for Ambulatory Health Care, Wilmette, IL.

in this category had pre-procedure time at just more than 40 minutes — less than half the time of the worst-performing surgery centers. That organization uses practices such as:

- reviewing pre-operative information and making pre-operative phone calls well before patient arrival so that if testing or further consultation is necessary, the patient is ready on time.
- patients are brought to the operating room (OR) directly;
- personnel are not afraid to perform duties outside their usual area of expertise — garbage, mopping, and cleaning can be done by anyone;
- the instrument tech returns to help with turnover;
- the scrub nurse remains in the room during turnover and begins the clean up;
- anesthesia staff interview the patient while OR staff turn over the room;
- prior to the end of the previous case, supplies and instruments for the next case are placed on a clean prep table and left outside the OR by the instrument processing tech. As soon as the room is clean, the table is wheeled into the room.

Discharge time can be made more efficient by making use of regional anesthesia and minimal narcotics. One organization noted that it was able to perform well because patients were well prepared for their operation and were less nervous as a result. If anesthesia staff can anticipate a case's wrap-up, they also can reduce anesthesia so patients are awake and alert when the surgery is completed. Giving discharge instructions to the patient prior to the procedure also helps move the patient through the facility quickly.

Median discharge time was 93.5 minutes, and overall facility time was a mean of 223 minutes.

One of the most efficient practices was the Center for Special Surgery in Wall, NJ. It had the second best discharge time in the study at 60 minutes. "It's a question of having the right anesthesia in the right amounts," says nurse administrator **Marsha Silberman**, RN. "We have a great system in place and we do a tremendous amount of preoperative teaching, which makes discharge easier for patient and family."

Silberman agrees that there are dangers in

Shaver Blade and Wand

Source Accreditation Association for Ambulatory Health Care, Wilmette, IL.

aiming for an ever-lower discharge time. The trick is making sure you improve as much as you can while keeping a constant vigil on patient outcomes. Having anesthesiologists who are geared toward ambulatory tracking and use their agents accordingly helps, as does having experienced surgeons who are able “to go in and out with less trauma,” she notes.

Extrapolate the results

One of the nice things about this survey — and others that AAAHC does — is that it gives practices the ability to take some of the good ideas espoused by other top performers and implement them throughout an organization. In that way, says Silberman, what works for one organization in knees may prove a boon to another in cataract surgery. “You review the

studies and find new ideas,” she says. “You try things, maybe it works, maybe it doesn’t. But there are lots of ideas out there.”

Despite being a better performing surgery center, Silberman says there is no sitting back on her laurels. “I don’t think you can ever stop improving. There are so many facets to an ambulatory surgical center that there is always something you can do to improve.”

And the positive data have an added benefit of validating the previous efforts Silberman and her staff have made.

Kuznets says that it was gratifying to see that the organizations that participated in both AAAHC knee studies had improved in at least one area. “There was a great improvement in prep and operation time overall,” she notes. “And others found that they could get patients out faster if they checked on the patients more frequently. It

all comes down to time being money.”

Another area of improvement overall was a narrowing in the prices for equipment. “It looks like they have to be very vocal in negotiating prices and keeping up on what competitive prices are,” Kuznets says. “That will allow them to improve further.”

In the last study, draping costs varied from less than \$10 to more than \$50; shaver blade costs varied from less than \$50 to more than \$100; and arthro wand costs varied from \$20 to almost \$100. This year, while drapes still ranged from less than \$10 to \$70, the bulk of the participants had drape costs ranging from about \$15 to \$30. Median shaver blade cost was \$58, with most facilities hovering around the \$50 mark. Arthro wand costs were a median of \$148. Again, most organizations paid about \$150 each. **(For more on supply costs, see graph, p. 41.)**

“The thing is that some organizations are more aware than others, and some have obvious opportunities,” says Kuznets.

“We know that these are the issues our members are interested in,” she says. “One of the better performers was worried that she was moving patients through too quickly and that the patients felt hustled out the door. They took the information from the report and then looked at patient satisfaction. But the patients were doing so well that they didn’t see it in a negative light. That’s what this kind of data can teach you.”

Silberman says doing a good job is a matter of learning to put systems together for a specific patient population. “We are focused on the limited amount of time we will have the patient, and we streamline everything according to the patient’s need. It affords us great satisfaction to know that what we are doing, when compared to others nationally, bears up so well.”

The AAAHC now is readying its next reports: a return to the cataract study and tumescent liposuction. A second study on colonoscopy also is pending.

[For more information, contact:

• **Naomi Kuznets, PhD**, Director, AAAHC Institute for Quality Improvement, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Telephone: (847) 853-6079.

• **Marsha Silberman, RN, CNOR, CAPA**, Nurse Administrator, Center for Special Surgery, 1902 Highway 35, Wall, NJ 07719. Telephone: (732) 974-3727.] ■

On-line tool kit makes PI meetings obsolete

(Editor’s note: A flood of information crosses the Healthcare Benchmarks desk every month, much of it touting new technology that help users to improve performance in a variety of areas. Every quarter, we take a look at some of these.)

When Los Angeles-based Medical Management Planning’s (MMP) benchmarking group of children’s hospitals shares information, there always is something that strikes one or more members as worthy of further investigation and quality improvement efforts. “In our quarterly benchmarking, some things are bound to jump out, whether it is a really great performer, or someone who just isn’t there yet,” explains MMP senior consultant **Sharon Lau**. “We may target a couple areas, hold some meetings, and everyone has to travel so we can lay the ground work for investigation.” Six months of data collection and work to solve whatever problem is being investigated follows. It can be a slow process, and a costly one during a recession.

But the children’s benchmarking group is about to try something completely different: an on-line program that uses a suite of performance improvement (PI) toolkits to help users work together at their leisure on a project without the need for travel. “We hope this will eliminate the travel and meetings we used to have to schedule,” says Lau. “We can do all the investigation with the on-line software, have people input their ideas, and then get everyone into one chat room at a given time to discuss what we have found. Face-to-face contact is great, but there isn’t any money. We’d hate to have people not do investigations because they can’t send someone to a meeting. This is a way to continue with the dialogue.”

The program, produced by the software company Skymark, is called Pathmaker. It already exists in a Windows format, but this is the first time the company is experimenting with an Internet-based product, says **Steve David**, the Pittsburgh-based company’s president and CEO.

The program includes a variety of tools, including force field analyses that point out the influences that push one toward a specific action, and that which discourage such action. Pathmaker also has voting modules, consensus

analyses, and control charts. "The control chart feature is really great," says Lau. "You can draw them right after you input information, too." There is a brainstorming module that contains an affinity diagram tool for easy organization of ideas. There also is a cause-and-effect diagram that users have access to.

For the use of the beta version, each hospital in the group is paying \$2,000 per year. "But that also gives them access to the same software for internal performance improvement projects," Lau explains.

The decision to use Pathmaker came after MMP considered developing its own software that would allow similar functions. "But one of our members had seen this," says Lau. "We called, and have worked on this ever since."

A typical project might go something like this: A group wants to look at medication cost reduction, says David. Each hospital working on the project can put its data on costs, distributors, and any other relevant information on-line to compare. Then they brainstorm — on-line, either at the same time in a chat room, or individually with a certain deadline date for input — on potential reasons for the high costs. "They can put that into an affinity diagram or a cause-and-effect tree," he explains. "This allows them to drill down to what the root causes might be, and what they can attack." Using the voting feature, members could vote on alternatives. Then the group tries the potential solution, collects information, posts it, and sees if it worked.

A demonstration project just started, and focus groups were due to begin using the program at press time. Among the first topics being studied are controlling the utilization of high-cost drugs, encouraging nonpunitive reporting of medication variances, and pain management in pediatric hospitals.

Lau thinks the benefits of the program will go beyond just saving money in the travel budget. "When you are at a meeting, you only have the resources you can bring with you. But when you are at your own site and working on-line, you have all the resources and information of the whole hospital on hand."

David says there aren't any programs out there — at least not Internet-based software packages — that provide all the tools necessary for a performance improvement project in one place. "There are good brainstorming packages, good flowcharting packages, and other good tools. But they don't integrate it all in one place.

They don't solve the problem of getting things done fast, sharing information, and demonstrate their thinking process throughout."

The program is platform- and browser-neutral, although it currently works better with Internet Explorer 5.0 or higher than it does with Netscape. It's not hard to learn, David says, and the system makes it possible for groups to collaborate more easily. "Before, you had to fly people in from all over the country for a meeting," he says. "Work didn't get done between meetings, and if it did, it was hard to share results. With this, progress doesn't depend on everyone being in the same place. You can collapse the time and get better results sooner. Say you were going to do a project that was going to save your hospital a million dollars a year. If you can achieve those results this quarter rather than in the third quarter, that's a half a million dollars to your bottom line. Who's not interested in that?"

[For more information, contact:

• **Sharon Lau**, Consultant, Medical Management Planning, Los Angeles, CA. Telephone: (323) 644-0056.

• **Steve David**, President and CEO, Skymark, 7300 Penn Ave., Pittsburgh, PA 15208. Telephone: (800) 826-7284.] ■

Improved accuracy from point-of-care heparin tests

Promise medical technicians ease of use and better results from testing supplies, and promise administrators they can expand services because of it and you're on to a surefire winner of a performance improvement (PI) project. That's just what happened at Tulane University Hospital and Clinic in New Orleans when staff there tried a new point-of-care heparin management test. The new test improved accuracy reduced testing variation from $\pm 25\%$ to $\pm 10\%$. It also was easy to use, easy to train operators in, and allowed the 353-bed hospital to open a new clinic based on the point-of-care tests.

In the past, the hospital used several instruments from different companies — among them Medtronic and ITC — to monitor activated clotting time (ACT), explains **Gale Gelston**, MPH,

assistant lab director and point-of-care coordinator at the hospital. But inconsistent results created difficulties in meeting proficiency tests. Gelston obtained a demonstration unit of the Rapidpoint Coag, manufactured by Bayer Diagnostics in Walpole, MA. She found that the consistency of the results provided by the new unit is substantially higher than what had been achieved in the past.

Another advantage, according to Gelston, is that the unit's ease of use makes it possible to place units throughout the hospital and easily train new operators. Indeed, training took just 30 minutes, with no resistance from the staff.

"All the users love it, and have from the moment they saw how easy it was to use," says Gelston. "And we have confidence that our results are accurate and repeatable and no longer have difficulty passing proficiency tests. This makes it possible to provide immediate feedback that can have a major positive impact on patient outcomes."

Consistency and accuracy are key

The instruments used in the past were based on ACT analysis methods that are performed on whole blood and measure the time to clot using either celite or kaolin as an activating agent. They were located in the extra corporeal membrane oxygenation (ECMO) area, the cardiac catheterization laboratory, the surgical intensive care unit, and the critical care unit. Technicians used a cuvette containing magnetic rod, baffle, and a contact activator for the blood. The blood was added and a timer was started. The tube was heated while slowly being rotated. The formation of a clot constrains the magnet and signals the end of the test at which point the time is recorded.

Tulane used two instruments from different manufacturers, and had difficulty correlating the results of the instruments to each other and to standards. The problem is that operator technique, temperature, hemodilutions, and coagulation abnormalities — among other factors — can cause the results to vary. For that reason, the instruments were highly dependent on the skill and consistency of the operators, especially in the way that they prepared the samples for analysis.

Using an internal standard, Gelston found that results varied about 25% from day to day. The previous instruments also required a

considerable amount of skill to operate, about 15 minutes to prepare the samples for these tests, and another five minutes or so to run the test. To minimize problems, operators went through a lengthy training process with the goal of increasing the consistency of the sample preparation process. Operators that had not used the instrument for a few months went through a refresher course. The cost of operating the analyzers was increased by the fact that quality control tests frequently had to be re-run because they didn't pass the first test.

Gelston says she was concerned about the accuracy of the instruments used in the past. She earlier had spearheaded the establishment of a point-of-care committee that included the lab administrative director, the pathologist, nurses from adult and pediatric critical-care units, the emergency department nurse coordinator, a clinic nurse, and the respiratory therapy manager. The committee met monthly to determine what new point of care tests to bring in, whether any methods needed changing, and how to handle problems that arose in point-of-care areas.

It was while working on this committee that Gelston suggested seeking out an instrument that could increase accuracy while being easy enough to use that it could be located at the point of patient care.

While she had read articles about the Rapidpoint Coag, and had requested information from Bayer about it, Gelston didn't know anyone who had used it. "But I did phone some users to get their opinions." She was impressed with the reported ease of use.

How it works

The system is based on a novel dry-chemistry method in which paramagnetic iron oxide particles move in response to an oscillating magnetic field. The paramagnetic iron oxide particles are combined with test reagents for clotting assays and formulated as dry reagents within a capillary test chamber located on the surface of a disposable test card. The card is first passed through the magnetic code reader to transfer the test information to the analyzer and then is placed on the instrument, where it is maintained at 37°C. A drop — which doesn't need to be precisely measured — of blood or plasma is placed into a sample well on the test card. The sample is drawn into the reaction chamber by

capillary action. The sample dissolves the reagent, and the paramagnetic iron oxide particles begin to oscillate. This movement is monitored by the analyzer, which automatically measures the time period that clotting occurs.

The committee was an easy sell on the new technology, Gelston says. She also had to convince the chief nursing officer to go with the Bayer unit, and reports that she easily was able to do so.

Reducing variability

The Bayer technical representative came in and trained the staff members in the use of the instruments, which were provided on a demonstration basis. "It was immediately clear that much less training was required to operate the instrument, and also that there is lot less room for human error," Gelston says. "The process of sample preparation has been essentially eliminated. All the operator has to do is swipe their test card, insert the test card into the instrument, enter their operator ID, select the sample type, enter patient ID, add a sample drop, and walk away until they hear a tone that indicates the results are ready."

She says the use of the test card eliminates the variability that previously entered into the analysis, such as how much sample was used, how well the sample was mixed with the reagents, and whether the mixing was done with the cuvette in the vertical position.

"Right from the very beginning, we saw that everyone who tried the instrument was able to get very consistent results, whether or not they had a lab background," Gelston says. "Our correlations studies on 32 samples were also satisfactory, even though they were hampered by variability in the older instruments. All in all, we felt that the Rapidpoint analyzer was the right instrument to move us forward into the future."

Tulane University Hospital installed eight of the new devices in the cardiac catheterization lab, critical care unit, surgical intensive care unit, dialysis, ECMO, and two in the operating room. One instrument remains in the point-of-care lab for training purposes.

The most important advantage has been the improved performance internal test and CAP proficiency tests — results have been within $\pm 10\%$ in every case so far. The simplified operation of the new instruments has made it possible for the

main operator to train every nurse in the areas where they are used, a total of 75 people so far. Operators now have no difficulty using the instrument, even if it has been a while since their last use.

Tulane saves money because there is no longer any need to re-run the QC testing. The laboratory staff perform quality control testing of dry chemistry instruments daily with a special electronic quality control test card. For quality control of the analyzer and test cards, wet testing is performed upon receipt of each new batch of test cards.

The ability of the Rapidpoint Coag analyzer to handle a variety of test cards also is making it possible for Tulane to measure prothrombin time (PT) in a new coumadin clinic it is about to open with the same instrument. Traditionally, PTs are performed in the laboratory on conventional laboratory instrument/reagent systems.

Central laboratory testing generally is batched, resulting in longer turnaround times for specific test results. Patients have to schedule follow-up visits for dose adjustment and re-test if necessary. In the mean time, the patient continues taking what may be an inappropriate dose. The Rapidpoint will provide PT results within a matter of minutes, making it possible to adjust patients' coumadin dosage if required, while they still are at the clinic.

Tulane's coumadin clinic will focus on maintaining each patient's target level of anticoagulation in order to prevent adverse events caused by clotting such as strokes, heart attacks, and blood clots in the legs, while at the same time avoiding hemorrhages. Recent studies have shown that adverse effects, such as incidence of thromboembolism and major hemorrhage, were significantly reduced with patients monitored by anticoagulation clinics.

Patients monitored by anticoagulation clinics also had anticoagulant levels within the therapeutic range for a significantly longer time, representing better management of anticoagulation levels, says Gelston. "We expect that our coumadin clinic will help our patients to avoid many emergency room visits."

[For more information, contact:

• **Gale Gelston**, MPH, MT(ASCP)SC,
Assistant Administrative Director-Laboratory,
Tulane University Hospital & Clinic HC49, 1415
Tulane Ave., New Orleans, LA 70112. Telephone:
(504) 584-1788.] ■

NEWS BRIEFS

COLA expands base with chart extraction efforts

COLA, a health care, physician-directed, non-profit accreditation organization based in Columbia, MD, made a name for itself in laboratory accreditation. But it's working to expand its client base with a concerted effort to develop a chart abstraction service. In January, it signed three new contracts for that program. Cape Health Plan of Southfield, MI, Cimarron Health Plan of Albuquerque, NM, and Preferred Health Partnership of Knoxville, TN, all signed contracts with COLA to have the company perform Health Plan Employer Data and Information Set (HEDIS) chart collection and abstraction services. Between the three health plans, COLA will be extracting information from 9,000 charts beginning this month.

According to COLA's product and services manager **Susan Foreman**, MBA, the company has won eight such contracts since beginning the service three years ago.

Health plans and managed care organizations can opt for either on- or off-site data collection, depending on their level of comfort in sending charts through the mail and the amount they want to spend, she notes. "We can do this more efficiently than health plans," Foreman adds. "They don't have to worry about deploying resources, spending money on expensive information systems, or recruiting and training staff to do this."

Charges are based on the number of charts

abstracted, Foreman says. COLA staff looks for the 15 HEDIS measures on the charts, fill out paperwork, and return it to the managed care organization. The plan then enters the data into a computer system, runs rates programs, and calculates the number of "mets" for their entire population. That data are then sent to the National Committee on Quality Assurance (NCQA).

Foreman notes that there isn't yet a computerized method of reporting HEDIS data, and it would take a "huge commitment" in information systems for it to work electronically. "We don't have the systems to do statistic sampling right now," she says. Besides, the NCQA still requires hard copies of paper charts.

The HEDIS program at COLA is part of a "deliberate process of diversification," Foreman says, and they hope to get more of that business in the future. In addition, COLA is trying to get into the HIPPA compliance market and is developing Internet-based courses for lab personnel. For more information on COLA's services, visit www.colas.org. ▼

DM program is first to be accredited by JCAHO

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited the Los Angeles County Department of Health Services Clinical Resource Management (CRM) Program in February, the first disease management program to be certified under the Disease-Specific Care certification program.

The program is the first of its kind to certify disease management protocols that serve patients suffering from specific chronic illnesses — such as asthma, diabetes, and congestive heart failure —

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isolate ways to improve outcomes, identify at-risk individuals, and promote prevention programs.

The Los Angeles County program covers pediatric asthma and involves close collaboration with the Asthma and Allergy Foundation of America (AAFA) Southern California Chapter, and the Los Angeles Unified School District. Through their joint efforts, asthmatic children in Los Angeles have accounted for fewer emergency department visits and inpatient hospitalizations. According to JCAHO, the pediatric asthma program accomplished those results by using multidisciplinary teams of physicians, nurses, respiratory therapists, and patient service workers. Working closely with school nurses, these health care teams use a network of mobile clinics to reduce barriers to care and bring preventive health care to children at their school sites. An integrated computer information system supports patient tracking, health care delivery, education, and program evaluation.

Children who participate in the program usually are able to control their disease and participate in normal activities, even if they have a severe form of asthma. These children have 15% fewer emergency department visits, 30% fewer hospitalizations, and between a quarter and a third fewer missed school days — depending on the school level — due to illness within the first year they participate in the program.

Los Angeles County's CRM Program has provided care for more than 4,000 pediatric asthma patients and was awarded certification following a thorough on-site evaluation. JCAHO's new certification program standards emphasize attention to those aspects of care that most directly impact patients. The evaluation includes an assessment of compliance with consensus national standards, the demonstrated effective use of established clinical guidelines to manage and optimize care, and the measurement and improvement of health processes and outcomes.

For more information on the disease management certification program, visit the JCAHO web site at www.jcaho.org.

In other JCAHO news, the organization has launched an initiative to identify a basic set of outcomes-based measures for assessing the quality of hospital intensive care units.

In conjunction with the Washington, DC-based Leapfrog Group, JCAHO will convene an expert panel having both clinical and methodological expertise to determine an ICU measurement framework and formulate an initial set of specific performance measures. As part of this process, JCAHO is

looking for outside input on existing measures that address care in medical, surgical, and medical/surgical intensive care settings. Other intensive care settings will be addressed in the future.

The initiative will take 12 - 18 months. Those wishing to submit potential sources of ICU core measures can visit a special section of the JCAHO web site at www.jcaho.org/perfmeas/corneas/cm_frm.html. More information also is available from the associate project director, Nancy Lawlor, at (630) 792-5937. ▼

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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: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).

Associate Managing Editor: **Chris Delporte**, (404) 262-5545, (christopher.delporte@ahcpub.com).

Production Editor: **Emily Palmer**.

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Editorial Questions

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

New CD-ROM service cuts document search times

Looking for a document? Instead of spending hours, find it in seconds. That's the pitch of a new CD-ROM service being launched by Healthcare Data Exchange Corp. (HDX), in Exton, PA.

The service combines the archiving capabilities of microfiche with the speed and convenience of an on-line application. The service's indexing software, from Metafile Information Systems Inc. of Rochester, MN, enables users to locate, display, and print data in seconds — a process that previously took hours with microfiche.

CD-ROM technology provides an efficient and cost-effective solution for storage, retrieval, and distribution of computer-generated reports and documents. Unlike microfiche solutions that require fiche viewers, HDX's CD-ROM service is accessible from a browser, which speeds and simplifies data access.

According to HDX, users gain high-storage capacity, rapid data retrieval, long-term media durability, browser-based accessibility, and compact size for convenient use, storage, and distribution. For more information, visit the HDX web site at www.hdx.com, or the Metafile web site at www.metafile.com. ■

Audio Conference Alert

To learn more about how quality must change to address patient safety concerns, call now and sign up for American Health Consultants' (AHC) exclusive audio conference *Patient Safety: How Quality Professionals Must Respond*, to be held April 30 at 2 p.m. ET.

A great value at only \$49, this 50-minute audio conference, presented by *Hospital Peer Review* consulting editor Patrice Spath, RHIT, will feature expert advice on how to update your quality improvement efforts to tackle patient safety. During the audio conference, Ms. Spath will take questions from participants.

Invite as many participants as you wish to listen to the audio conference for the low introductory facility fee of \$49. The facility fee includes one hour FREE CE for all participants. To register, call AHC at (800) 688-2421. ■

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The publisher of *Hospital Case Management*, *Hospital Peer Review*, *Healthcare Risk Management*, *Hospital Access Management*, *Compliance Hotline*, *ED Management* and *Same-Day Surgery* announces:

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American Health Consultants is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 14814 for approximately 1 contact hour. At the conclusion of this audio conference the participant will be able to list strategies for improving physician and staff documentation efforts.

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