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Incentive-based data program and multiplan cooperation reap rewards

Rhode Island Medicaid patients see benefits from plan

Many states try to tie incentives — both negative and positive — to health plans meeting certain clinical and administrative goals for their Medicaid health programs. But only one, Rhode Island, has decided to forgo the stick and use only a carrot of cash bonuses for plans that meet specific requirements.

For the last five years, three health plans that serve the Medicaid population in that state have worked with each other and the state to collect 22 pieces of data and meet state goals related to it. The results are an increasing number of those goals being met and improved health care.

And all of this has happened without threat of financial penalty or embarrassing reports of failures by the press. Indeed, the financial rewards that the plans can reap — this year the total bonus pot is something more than $1 million — comes on top of what the state thinks are fair Medicaid reimbursement rates.

"We don't hold back money from the capitation rate and then provide the bonus," says **Tricia Leddy**, administrator of the Center for Child and Family Health at the Rhode Island Department of Human Services in Cranston. "We negotiate fair rates, and this is added value for quality work."

Leddy oversees RIte Care, the Medicaid managed care program in the state. She says that payments to the plans generally reach about $700,000 per year. In 1999, one plan alone earned more than $463,000. How much a plan can earn is based on a combination of performance and the number of Medicaid enrollees in the plan. The more members the plan has, the bigger the potential payoff.

The plans — Neighborhood Health Plan of Rhode Island (NHPRI), United Health Care, and Blue Cross/Blue Shield — are required to collect 22 data sets and ship them off to the state.

(For a list of the data collected and standards to be met for the incentives, see chart on p. 51.) The state then collates the data and presents them in aggregate to the plans both together and individually. When plans do well in aggregate, the state also holds press conferences to tout that fact, but Leddy says they don't single out any one plan for doing better than the others.

The measures are in three broad categories: administration and management, access, and clinical care. Some are items that the plans already collect for other organizations, and some are different. "We wanted to collect a mix of measures that goes across populations," Leddy explains. "We do use HEDIS [Health Plan Employer Data and Information Set] definitions when possible, but we are interested in other items, like lead screening, that HEDIS doesn't measure."

Access is something the state emphasizes in its data, in part, says Leddy, because "if you can't get into the system, then you can't even get to HEDIS measures." So the plans are required to provide data on whether new members are sent plan identification cards and benefits booklets in a timely manner.

The data sets collected are based on site reviews that prior to the program's inception indicated areas of importance, she says. "We wanted to find items that are actual indicators of something valuable. Administrative measures can indicate administrative capacity. But you also have to be careful to pick things that are available across all plans."

The plans were involved in the process, and Leddy says that was important to making the program something that they were whole-heartedly in favor of. "We also made use of our consumer advisor council, which is very vocal and involved." The consumers were the ones who wanted to put the emphasis on access to care, grievance and appeals procedures, and whether or not members have a primary care physician.

Since the program started, the same items have been measured, but Leddy says there are some pilot measures being considered. And in the future, once the goals have been attained and maintained for a period of time — perhaps five years — then some measures may be dropped and others added.

Plans see benefit . . . mostly

While the plans appreciate the endeavor to bring quality measures to a population that largely has been ignored when it comes to benchmarking, they do find some of the measures more valuable internally than others.

For instance, the clinical measures often differ from the clinical data being collected for the National Committee for Quality Assurance (NCQA) or other organizations, says **Beth Ann Marootian**, MPH, director of quality management at NHPRI. It has about 70,000 Medicaid members.

Some of the clinical measures are based on encounter data, and Marootian thinks that using encounter data and chart reviews in combination would provide more meaningful results. For example, looking at immunization rates based on claims data doesn't tell whether a child is getting his first or second MMR vaccine, just that the child had a vaccine. Only chart reviews can drill down to that more meaningful level, Marootian says. Most of the NHPRI quality improvement programs relating to clinical care require chart review, but the RIte Care incentive program does not.

Licensure and accreditation data are the most important statistics NHPRI collects, Marootian says. "I consider RIte Care statistics the third level," she says. "We measure a lot already for NCQA. Some of what the state wants us to measure makes sense, but there are other HEDIS data sets that are audited by certified vendors that they could look at. We are trying to promote that, but I think the state has invested a whole lot in encounter data."

Marootian is happy to hand the information over to the state, but the usefulness of it is limited, she continues. "I don't use it for the clinical

Performance Goals for RIte Care

Area	Goal	Standard
Administration and Management	Temporary identification cards distributed within 10 days of enrollment, permanent ones within 45 days of enrollment	98%
	Member handbooks distributed within 10 business days of being notified of enrollment	98%
	Members without primary care providers (PCP) at enrollment are assigned a PCP within 20 days of enrollment, after being given the opportunity to select	95%
	Average speed of answer of calls is 30 seconds or less	100%
	Call abandonment rate is 5% or less	100%
	Grievances and appeals are resolved within state statutory time frames	97%
	Payment of "clean" claims is made within 30 days	95%
	Payment of claims for medical screening examinations in a hospital emergency room to determine if a medical emergency exists	100%
	Contractor notifies DHS of any potential source of third-party liability within 15 days of such source becoming known to contractor	90%
Access	Members seeking treatment of an emergency medical condition are offered and receive services immediately	100%
	Members seeking treatment of an urgent medical condition receive services within 24 hours	95%
	Members seeking treatment of a non-emergent, non-urgent behavioral health condition receive treatment within 5 business days	75%
	New adult members receive a first visit with a PCP within 90 days of enrollment	50%
	New members under age 18 receive a first visit with a PCP within 90 days of enrollment	65%
Clinical Care	Percentage of RIte Care children who turned 2 years old during the reporting year who were continuously enrolled for 12 months immediately preceding their second birthday (including members who have had no more than one gap of enrollment of up to 45 days during the 12 months immediately preceding their second birthday) and who have received appropriate immunizations	85%
	Members between 6 and 20 years old are provided early and periodic screening, diagnostic, and treatment age-appropriate screening	85%
	Pregnant members receive adequate or adequate-plus prenatal care services as measured by the Kotelchuk Index	85%
	Average length of maternity state is two days for a vaginal delivery and four days for a caesarian delivery	100%
	Readmission rates within 90 days for members hospitalized for behavioral health condition	20%
	Members who reach 18 months of age during the reference period who have had an initial lead screen within the preceding nine months	85%
	Female enrollees aged 16 to 20 continuously enrolled for a year have had one or more PAP tests during the past year	40%
	Female enrollees aged 21 to 64 continuously enrolled for a year have had one or more PAP tests within the past three years	80%

Source: Neighborhood Health Plan of Rhode Island, Providence, RI.

stuff that much. Where I do see value is in the operational data. And in the end, it's just very cool that they care about this. The orientation is just right. To provide incentives to the health plans is what they should do as stewards of the Medicaid program."

Marootian says she feels badly for the states where the positive incentives are either replaced with penalties or tempered by what are called nonfinancial incentives. Usually, that means public disclosure of the data. That's great if a plan does well, but it's hardly an incentive if a plan needs to work on a particular issue.

Leddy agrees. "We don't want to embarrass

plans or single one out," she says. "That doesn't go with our determination to make this a true partnership. If we had sanctions, it would change the flavor of our program. This way, it's always seen as a positive."

And even in tough economic times, it seems to be a cheap way to improve quality. The annual Medicaid budget in Rhode Island is a billion dollars. "This is less than 0.1% of that, and even in very tough times, I wouldn't be the one to take it out of the budget."

The word of the day: Collaboration

When a plan is found to be lacking in an area, the state uses a very collaborative approach, providing guidance to the plan on how it might do better next time. Often, the plans will work together to find solutions. Recently, an area in which all plans were found to be lacking was in providing interpreter services during office appointments. The plans found that one big reason was that physicians had different forms to fill out for each plan. They collaborated together to create a single form that physicians can use for the service no matter which plan a patient is on. That simplified matters for the doctors and made them more willing to comply with interpreter requests.

Marootian thinks the state could do more to foster that kind of collaboration. "It has been the next step of taking the data and bringing plans together to talk about best practices and key areas to work on that needs to be expanded."

It happens occasionally. Marootian says that post-partum care now is a pilot measure, in part as a result of the three plans coming together to talk about it. "We knew it was a problem in the Medicaid population," she says. "Our HEDIS data tells us that. But we, not the state, made this a priority. I think they could become more of a driver in fostering change." Part of the problem could be a continuing vacancy for a medical director at the agency. "They need the clinical leadership to make this happen," she says.

Despite that criticism, Leddy says she has been impressed with the willingness of the plans to work together on the program. And it has paid off. Plans meet more of their goals every year. "The only exception is when we have rapid growth like we did in 1999," says Leddy, noting that the number of enrollees increased from 75,000 to 105,000 during that year. "We can see how the large influx of new enrollees impacted the improvement." But considering the very high level of the goals, Leddy is happy with how it has gone.

In general, Marootian gives the state high marks for the program. "We have a very collaborative Medicaid agency, and one that has the member in mind. They are working to improve health care, not make the life of the HMO a living hell. Because of that, the Medicaid health plans are willing to participate in this program, and we have become more collaborative ourselves in our approach to this work."

[Editor's note: A report on Medicaid incentive programs was released in March by the Center for Health Care Strategies (CHCS) in Lawrenceville, NJ. To view the report, which covers the Rhode Island program along with others in Iowa, Massachusetts, Wisconsin, and Utah, visit the CHCS web site at www.chcs.org/publications/pdf/ips/bailitperformance.pdf.

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AHRQ releases data on patient experience

First-year data to act as benchmark for future

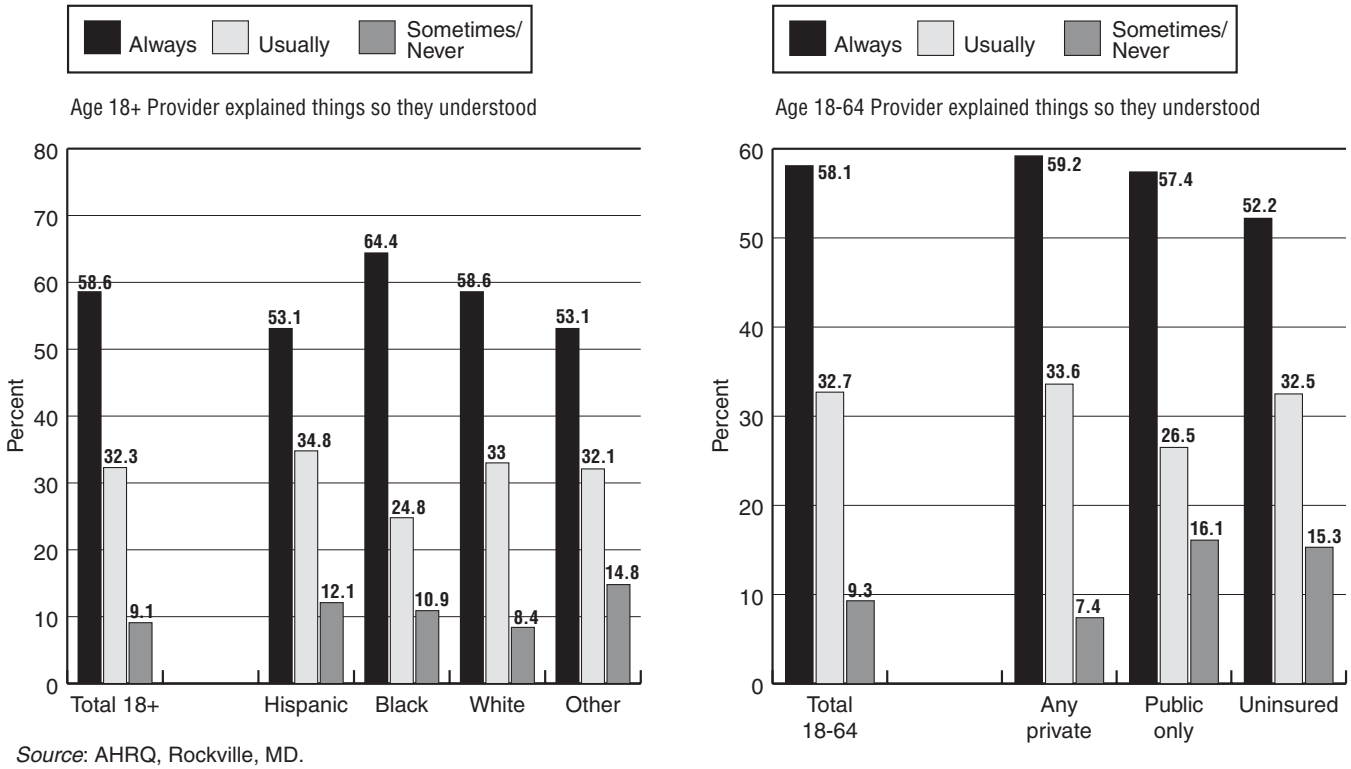
It's only the first year, but the Agency for Healthcare Research and Quality (AHRQ) hopes that data collected on patient experiences in the health care system will prove useful to health care organizations in the future.

The data, taken from a questionnaire incorporated into the AHRQ Medical Expenditure Panel Survey, cover issues such as how fast patients get needed urgent care, how quickly they can get an appointment with a physician, and how patients felt about their experience. How a patient felt about the visit includes whether the physician spent enough time with them, whether they felt their doctors listened to them, how respectful the care giver was, and how well their care was explained.

Among the findings of this first-year data:

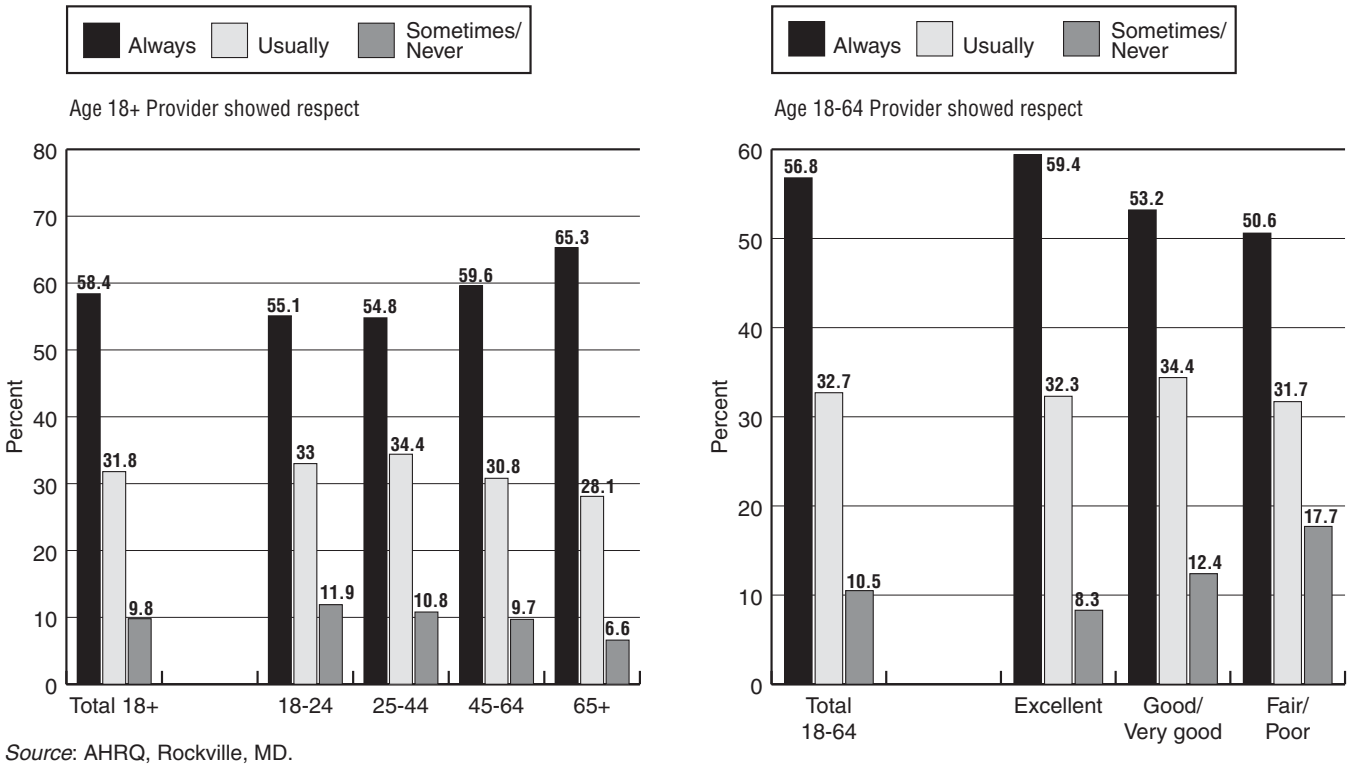
(Continued on page 54)

Graph 1: Percent Distribution with Providers Who Explained Things so Patients Understood



Source: AHRQ, Rockville, MD.

Graph 2: Percent Distribution with Providers Who Showed Respect for What Patients Said



Source: AHRQ, Rockville, MD.

• **Timeliness of urgent care.** Slightly more than half of Americans age 18 and older (53.8%) who do not live in institutions or serve in the military always received urgent medical care as soon as they wanted it in calendar year 2000.

There was minimal difference in this between African-American and white patients, but only 41.2% of Hispanic patients reported receiving urgent care when they wanted it.

Those without insurance are more likely to report not getting urgent care when they wanted, and those with public insurance such as Medicaid, also lagged behind their privately insured counterparts in this area (28.6% of the uninsured, compared to 19.1% of the publicly insured, and 16.1% of those with private insurance).

• **Patient experience during treatment.** Nearly three fourths of the adult population in the United States visited a doctor or clinic in 2000. And the vast majority (82.6%) reported no problems receiving the care they or their doctor believed was necessary. Even more (89.8%) said their health care providers always or usually listened carefully to them; and 84% said their health providers always or usually spent enough time with them.

There were racial differences in the latter category, however. African-Americans were the most likely to say their providers explained care well to them. White patients felt this was true 58.6% of the time, and 53.1% of Hispanics thought so.

More than half (58.6%) of patients say that their care was adequately explained, but nearly 10% felt that their providers sometimes or never explained care in a manner that they understood. Older patients seemed happiest with the explanations they got. **(See Graph 1 on p. 53.)** And those without insurance also were less likely to get adequate explanation of their care.

Patients surveyed said caregivers nearly always treated them with respect, with more than 90% of patients saying that was so always or usually. Only 9.8% of patients reported that physicians sometimes or never treated them with respect. And the older the patient, the greater the respect accorded to him or her, says the survey. **(See Graph 2 on p. 53.)**

• **Access to care.** Fewer than half of all those surveyed (43%) said they always received an appointment at a clinic or doctor's office as soon as they wanted. But people age 65 and older (54.7%) were more likely to say they always obtained an appointment as soon as they wanted than those age 18-64 (40%). Those with private insurance also cited fewer problems getting appointments when they wanted, with 84.5% saying it wasn't difficult getting needed care, compared to 71.5% of those with public insurance, and 72.9% of the uninsured.

No surprises — yet

Because this is the first year the data were collected and published, there weren't really any statistics that caused surprise, says **Steven Cohen**, PhD, director of AHRQ's Center for Cost and Financing Studies. "What we found seems to compliment other studies that have been done," he says, noting this particularly is true for what the statistics say about the uninsured.

Cohen says he was gratified to see that the elderly seem to have a fairly consistent pattern that shows they are getting more time with their care and have adequate access to it. "But what will really be informative is when we do this again next year and see if there is any consistency and what the direction of trends are."

The goal of this data is to provide national standards for health care delivery systems that are interested — and should be interested — in the experience patients have within the broader health care system. "This survey is a national resource," Cohen says. "After we have data on more than one year, we will be able to determine what actions need to be taken. You have to remember, too, that this is a perception of care from patients. But we will see what the trends are and benchmark."

Among the things he hopes health care organizations will look at is the access data compared to emergency room utilization data. If emergency department use is increasing, and access is declining, then organizations will have to look and see if there is a link.

While this set of data related solely to adults, Cohen notes that in the next month or so, AHRQ will have similar data available for pediatric patients. Meanwhile, a second set of data on adults covering 2001 visits will be available next February.

[Editor's note: The entire survey can be found at the AHRQ web site at www.meps.ahrq.gov/papers/st2/stat02.htm.

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Hospital security a top issue says survey

Sept. 11 brings changes to priorities

A decade ago, the most pressing security issue at most hospitals seemed to be infant security. Baby-snatching cases brought a spotlight onto hospitals and led to changes in the way most maternity wards operate. But after the events of last September, a different set of security issues seems to be emerging, say security experts, not all of them truly relevant to the everyday operations of a hospital.

A new health care security benchmarking study conducted by Burns International — a division of Pinkerton — done prior to Sept. 11 reported that while security remains a top issue, security budgets are being squeezed, leaving managers with more to do and less to do it with. The result: more emphasis on technology and less on manpower.

The study was conducted at more than 1,200 hospitals, both by phone and via mail. A response rate of 27% included hospitals of all sizes and types — from teaching hospitals and trauma units in urban areas, to suburban and rural hospitals. Respondents were asked to rate their most pressing concerns, explain policies and procedures, identify the technology they used or were considering using, list staffing levels, and explain training procedures.

Among the findings:

• Security staff represents about 1% of hospital personnel. Three quarters of that staff is hospital based, 12% contracted, and 10% a hybrid. Fewer than three in 10 hospitals said they planned to increase proprietary and contract staff in the future.

• Patient security is of most concern, followed by employee and visitor safety. Crimes against people caused the most worries, the study reports. And although most view the infant areas as very secure, baby security remains the highest departmental area of concern, followed by pediatrics, pharmacy, and the psychiatric areas.

• Nearly all the respondents have a security management plan, 86% have a workplace violence policy in accordance with Occupational Safety and Health Administration guidelines, and 84% of the hospitals provide general security training and health care security as well as facility-specific training. In the future, about 30% of respondents plan to improve their security management plan or update their workplace violence policy. Twenty-two percent plan to improve the general security training, while 30% plan to improve health care and facility-specific training.

• Technology use is high, compared to other industries in the United States, according to the survey. Nearly all hospitals use radio communications and closed-circuit television systems, while 88% use video recorders and security alarms. Among the other findings in this area: 83% use occupant identification systems; 81% have access-control systems; 69% have monitoring systems; and 27% have metal detectors. Another 4% plan to install metal detectors in the future.

Security is now a regular part of the operations of the typical health care organization, the study notes. "This is evident in every regional market segment, regardless of size, location, and provider, clinical expertise, or organizational growth," it says. "Security issues and concerns are identified and addressed daily by all levels of management. Mitigating liabilities and improving patient, visitor, and employee safety is critical to the performance of health care providers today. The level of industry understanding and participation is evident throughout all types of facilities and regions surveyed."

Health care: a breed apart

Health care is a different kind of business and has different security needs, says **Walter Pry**, a senior consultant with Pinkerton. "Other businesses aren't so open or welcoming," he notes. "They don't have to let in everyone. In a hospital, the public is invited. How welcoming you are determines, in part, whether you have the business or you don't."

Pry, who spent the greater part of his career as director of security for a large Baltimore hospital, says the dilemma is coming up with adequate funds to keep a hospital safe, yet welcoming. "Security is a nonrevenue producing area, and that means the director has a tough battle to fight. He wants to hire more people and buy more equipment, but he has to convince the board it's a good thing to spend on."

In the aftermath of Sept. 11, there is a little more willingness to spend, but it isn't always on the right thing, says **Ron Long**, managing director at Pinkerton. "You have to identify the areas that really need programs and know where to spend money and where not to."

Since September, more hospitals have been requesting security reviews from Pinkerton, but there are many stories about less-than-appropriate expenditures that people are willing to make in the name of security. For instance, a lot of hospitals became frightened of opening mail and beefed up their security in the mailroom or changed the way they received packages.

"Given the statistics of where the anthrax scares were, it was more a panic approach than anything else," says Long. "It probably was money that could have been better spent elsewhere." Other hospitals called simply looking for "people with guns" to patrol the facilities, he says — another panicked reaction based more on fear than reality.

Few hospitals would be actual terrorist targets, Long adds. Most would be affected because of the number of casualties they would see coming through their doors. The only exception would be for hospitals that are close to potential terrorist targets. In those cases, a plan of what to do in case of another attack is prudent. Research centers that have potential biological weapons also should consider revamping their security plans, says Long.

Where hospitals do need to spend money is where they are vulnerable to crime, says Pry, and most of the time that is in the parking lots and areas where people often walk alone. "In a time where there is a nursing shortage, security of your nurses becomes a critical issue," he says. "Something like 85% of a hospital's staff are women, and they come in 18 shift configurations throughout the day. You want them to be safe so you can compete for their work. If you don't provide a safe environment, how can you recruit and keep your staff?"

Also consider beefing up security to restricted areas, says Long. "We do intrusion surveys where we pose as a visitor coming into the hospital and see if we can get into restricted areas," he says. "That really shows where you have holes."

Most hospitals aren't subject to major incidents such as terrorist acts, or even baby snatching these days. Where they are vulnerable, says Pry, is the kind of bad publicity that comes from high-property crime rates in the parking lots or violent crime in the emergency department.

Hospitals should consider the overall crime rates where they're located, Pry adds. A hospital in an affluent suburb where there isn't a high crime rate doesn't need to make the same security arrangements as an inner-city public hospital.

"If you walk into a hospital in a suburb and see a lot of security, you wonder what's wrong," Pry says. "The same uniformed presence in a high-crime area makes you feel safe. You have to know the difference."

[Editor's note: To view the entire Pinkerton Security benchmarking survey, visit the web site at www.pinkertons.com/security/vertical/healthcare/benchmark.asp.

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Simple solutions: Clinical training for the whole staff

Rural hospital puts all staff at the bedside

In 1995, the 20-bed East Adams Rural Hospital in Ritzville, WA, needed to cut about $200,000 from its budget. After consolidating its hospital and primary care clinic in one facility, administrator **Jim Parrish**, FACHE, started looking for other areas to trim expenses.

The hospital district, which serves a population of about 4,400 residents and 25,000 vehicles passing along Interstate 90 every day, has an average daily patient census of just 1.5-2 people per day. Yet it had two RNs and one nurse's aide on duty for each 12-hour shift.

It seemed to Parrish a natural place to look for savings. "We decided to cut back to one nurse per day, but that created a problem of how to get things done with only one person," he recalls. Thus was born the Acute Care Assistance program, which since 1995 has cut nursing costs by nearly $200,000.

"We decided to train everyone to assist on the floor," Parrish explains. The entire staff of the hospital went through training to become certified nursing assistants. "There are 16 people who are not usual caregivers who are trained as acute-care assistants," he says. Everyone from the chief financial officer and Parrish to X-ray technicians and telephone operators receives training. They do everything a nurse's aide can do: take people to the restroom, give bed baths, distribute meals, feed patients, clean rooms, make beds, change adult diapers, and take vital signs.

The only exceptions made to the training were

the lab technicians, who have enough work to keep them busy at all times, Parrish says, and three people who were exempted for health or personal reasons.

The trained staff — with the exception of Parrish — all received a 50-cent per hour bump in their pay for taking on the new role. Everyone is required to be on call as a nursing assistant for three shifts of less than eight hours per month.

Just how well the program can work was made clear last summer, when a two-bus accident brought 11 patients to the hospital. "We had a certified nursing assistant for each of those patients while the doctor on call assessed them. We can have 10 caregivers in the emergency room within minutes. Before, the most we would have had was three."

Initial fears calmed

Parrish says that there was little concern — even among the nurses — that the program would lead to diminished care.

"They weren't worried about providing high-quality care, but about what would happen if we got 'slammed' with four or five patients at once," he says. "They were able to alleviate those concerns by pointing out that three days a week, there was an additional nurse in the facility working at the primary care clinic, as well as a backup nurse who was never more than 30 minutes away from the hospital and always available by phone.

"Nursing here isn't a matter of having someone at the bedside constantly," he says. "We don't have open-heart surgery here. We are a med-surg facility. Do you really want to pay someone $30 an hour to sit around for part of the day?"

Parrish says about three quarters of what nurses at East Adams Rural Hospital were doing before the program started wasn't nursing care. "Do you need a license to deliver ice or get someone water?" he asks. "Those mundane duties are better done by someone who is lesser paid and lesser-trained." Indeed, he thinks he has improved the working conditions of his registered nursing staff by eliminating those kinds of tasks.

If the hospital hadn't cut the nursing aide and second nurse back in 1995, he estimates the 2000 budget for nursing would have been a little more than $600,000, rather than the $295,000 he spent.

The program easily could be copied in other small rural hospitals, but does Parrish think a bigger hospital could mimic it? "You bet," he says.

"They could do this on med-surg units. If you look at most patients on those wards, about 70% of them are like our patients and can be taken care of well, safely, and with more attention than if they use only RNs. Expanding the non-nursing base of people who can take care of folks also frees up nurses to do more of what they are supposed to do," he says. "They didn't spend $70,000 on four years of schooling to change adult diapers."

Over the seven years the program has been in place, there has been no claim or lawsuit from any patient, no injury claims from employees, and no settlements made. "People who say you can't do this and be safe only have to look at our seven years of experience. We have excellent state surveys and great patient satisfaction reports from our in- and outpatient population."

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NEWS BRIEFS

Nursing home info available to the public

Consumers in six states now have access to comparative quality data about nursing homes. It is part of a pilot project that will be rolled out nationally by October.

For now, consumers in Colorado, Florida, Maryland, Ohio, Rhode Island, and Washington will have information on data including: use of restraints, bedsores, infections, pain management, and use of anti-psychotic medications.

PRO-West, a Seattle-based nonprofit health care quality improvement organization, will collect the data, which also will include information on pneumonia, respiratory infection, septicemia, urinary tract infection, viral hepatitis, wound infection, fever, and recurrent lung aspiration.

Currently, only 20 states publish nursing home quality data. The new data will be available on the Medicare web site at www.medicare.gov. ▼

RAND looks at standards for e-prescription systems

A team of researchers from the Santa Monica, CA-based think tank RAND is working on a set of standards for electronic prescription writing. The group reported in March that there are several issues that need to be addressed, including:

- privacy and security of patient data;
- full disclosure of the criteria used to label drugs;
- full disclosure of funding source for product;
- the quality and completeness of the data on which assessments of drug interactions or drug safety are based;
- user interface design.

An independent panel of nationally recognized experts is providing guidance in developing the standards and will review the final recommendations. The panel, chaired by **Donald M. Berwick**, MD, president of the Institute for Healthcare Improvement, also includes leaders from medicine, nursing, pharmacy, medical informatics, health policy, and law.

In the last three years, dozens of new electronic prescribing products have appeared on the market, including programs for hand-held devices, Internet-based applications, and systems designed to interface with office management software and electronic medical records.

Some of these systems simply provide printed prescriptions; others recommend drugs based on a patient's insurance coverage or warn about potentially dangerous drug interactions. The most sophisticated systems suggest drugs tailored to the patient's medical condition and even initiate lab tests to monitor the patient's response to therapy.

Whether this powerful decision-support technology actually improves patient care depends on how it is implemented and how it is used, says RAND's initial report on the topic. For example, the order in which drug names appear in a menu of choices or the wording in alert screens may bias doctors' drug choices or introduce new types of prescribing errors. The RAND team currently is classifying existing systems and will choose six to 10 exemplary systems that span the range of available features. In-depth review of these systems will be the basis for developing standards, which should be ready for dissemination within 12 months.

This study is being underwritten by a grant from Pfizer Inc. For more information, including a listing of the expert advisory panel members, visit the project web site at www.rand.org/health/eRx. ▼

AHRQ's releases 1998, 1999 hospital statistics

The federal Agency for Healthcare Research and Quality (AHRQ) released 1998 and 1999 hospital inpatient data for the country, regions, and selected states this month. For the first time, it also includes statistics from the Kids' Inpatient Database — the only hospital administrative data set specifically designed for analyzing the use of hospital services by newborns, children, and adolescents. HCUPnet enables users to identify, track, analyze, and compare statistics on the inpatient care of Americans.

Since its launch two years ago, the tool has

provided answers to thousands of questions about hospital care, including the leading reasons for admission, the most expensive surgical procedures, the proportion of stays for diabetes that are covered by Medicaid, the proportion of children's stays that are not covered by insurance, and the trend in the number of coronary artery bypass grafts over the past several years.

AHRQ also announced three further upgrades to HCUPnet. These are:

- Instant Tables — commonly requested statistics users can obtain instantly without having to go through HCUPnet's query system.
- The National Bill — quick access to aggregate charges for diagnoses and procedures, telling users the total national bill for specific diagnoses and procedures.
- The ability to specify ranges of ICD-9-CM codes instead of having to request each ICD-9-CM code individually.

The National estimates used in HCUPnet are based on data from the Nationwide Inpatient Sample (NIS).

The 1998 and 1999 NIS data are available on CD-ROM with accompanying documentation for $160 each from the National Technical Information Service at (800) 553-6847 or (703) 605-6000. The 1998 NIS product number is PB2001-500092 and the 1999 NIS product number is PB2002-500020.

(For more information on recent AHRQ survey data, see story, p. 52.) ▼

JCAHO to create six patient safety goals

Starting next year, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) annually will establish six national patient safety goals as part of its efforts to reduce errors in health care.

The first set of goals, derived from existing issues of JCAHO's patient safety newsletter *Sentinel Event Alert*, will be announced this July. Each goal will include one or two succinct, evidence-based, or expert recommendations.

Beginning Jan. 1, 2003, health care organizations providing relevant care will be surveyed for compliance with the recommendations or implementation of an acceptable alternative. Noncompliance will result in a Requirement for Improvement or Type I Recommendation.

The application of National Patient Safety Goals will replace an earlier effort to survey compliance with all *Sentinel Event Alert* recommendations, a practice that was discontinued in Oct. 2001.

A *Sentinel Event Alert* advisory group comprised of physicians, nurses, risk managers, and other health care experts will guide the identification of the national patient safety goals. The advisory group also will assess the evidence for and validity of past and future *Sentinel Event*

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Alert recommendations, as well as the practicalities of implementation. Goals and recommendations will be reevaluated each year. In succeeding years, certain goals and recommendations likely will be continued, while others are replaced with higher priority goals.

Aggregate data on achievement of the goals will be made public each year, but individual organization compliance information will not be disclosed until 2004 when the reformatting of JCAHO organization performance reports should be completed.

In other JCAHO news, the Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS) recently announced that Medicare+Choice organizations licensed as health maintenance organizations and preferred provider organizations accredited by JCAHO will be "deemed" for meeting Medicare certification requirements.

This authority allows the JCAHO-accredited HMOs and PPOs to be deemed in six categories: anti-discrimination, access to services, quality-assurance programs, confidentiality and accuracy of enrollee records, information on advance directives, and rules regarding provider participation.

In addition to Medicare+Choice HMOs and PPOs, deemed status options are available for Joint Commission accredited ambulatory surgical centers, clinical laboratories, home health agencies, hospice organizations, and hospitals.

[For more information about JCAHO's Medicare+Choice deemed status for HMOs and PPOs, please contact Gina Val Zimmermann at (630) 792-5293.] ■