AMERICAN HEALTH CONSULTANTS

HEALTHCARE BENCHMARKS

The Newsletter of Best Practices

IN THIS ISSUE

JUNE 2002
VOL. 9, NO. 6
(pages 61-72)

Agencies start TalkingQuality, give hospitals tools to educate public

But some still question its ability to aid patients

The Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare & Medicaid Services, and the U.S. Office of Personnel Management are banding together to help health systems and hospitals that want to provide consumers with quality report cards and other information regarding health care quality measurement. The web-based project, www.talkingquality.gov, was launched in late April.

Providing both guidance and real-world examples of quality measurement reports, the web site is supposed to give health plans, hospitals, and even providers some of the tools they need to create quality reports that consumers increasingly demand. The web site includes sections on what to say, how to say it, and how to get the information out to consumers. **(For a sample page from the web site, see graph on p. 63.)** Examples come from public and private health care organizations that already have started to measure and distribute quality data to consumers.

There are sections on getting started on a quality project, collecting and analyzing data, presenting and disseminating information, providing ongoing support for a quality reporting effort, and evaluating the project. There also is a feature called the Planning Workbook, a downloadable file to help develop customized plans for presenting quality health care information. Throughout the site, there are icons that remind users when this feature may be useful.

The site was developed through the Quality Interagency Coordination (QuIC) Task Force, established to ensure that all Federal agencies with health care responsibilities are working in a coordinated way to improve the quality of care.

One of the initial goals of the project simply was to have all of this information on how to create a quality measurement program

in one place, explains **Carla Zema**, PhD, a Kerr White Visiting Scholar at AHRQ who worked on Talking Quality.

So far, there has been some feedback from government agencies, which have had access to the site since December. Further reaction from others who use the site could lead to changes in the future, says Zema. For instance, there may be parts of the site that need more depth, and there is an acknowledged lack of information on giving consumers data at the provider level right now. "We hope we will be [updating] the site often," she notes.

Report cards the way to go?

But there are some who question whether quality report cards — particularly those that rely on simplistic measures such as mortality data — are giving consumers a skewed vision of how well a particular health care organization is doing or the quality of care they can provide.

In a study published in the March 13 edition of the *Journal of the American Medical Association (JAMA)*,[1] **Harlan Krumholz**, MD, an assistant professor at Yale's School of Medicine found that — at least when it came to one particular Internet-based report card site that looked at ratings for acute myocardial infarction (AMI) — the ratings "poorly discriminated between any two individual hospitals' process of care or mortality rates during the study period."

Krumholz and his colleagues looked at information from the Cooperative Cardiovascular Project that includes more than 141,000 Medicare patients hospitalized with AMI at more than 3,300 hospitals between 1994 and 1996. They compared the outcomes to ratings from HealthGrades. Based in Lakewood, CO, HealthGrades provides health care quality information and services to consumers, hospitals, insurance companies, and other health care agencies. Among the measures the researchers looked at were use of acute reperfusion therapy, aspirin, beta-blockers, ACE inhibitors, and 30-day mortality rates.

While patients treated at higher-rated hospitals significantly were more likely to receive aspirin (75.4% at a HealthGrades.com five-star rated hospital vs. 66.4% at a one-star facility on admission and 79.7% at a five-star hospital vs. 68.0% at a one-star rated hospital on discharge) and beta-blockers (admission: 54.8% at a five-star hospital vs. 35.7% at a one-star; discharge: 63.3% at a five-star vs. 52.1% at a one-star), the same wasn't true for ACE inhibitors. In that case, there only was a 2.3% difference between five- and one-star facilities. Acute reperfusion therapy rates were highest for patients treated at two-star hospitals (60.6%) and lowest for five-star hospitals (53.6%).

Krumholz also noted that there was a lot of difference within the rating groups, so some five-star hospitals markedly were better than others.

"I am strongly committed to trying to improve accountability and want to develop indicators of quality," Krumholz says. "I want to help the larger health care system get to a place where there is competition on quality. But right now, there isn't a lot of good information that can help people choose between hospitals and physicians."

Krumholz says that many organizations that are interested in health care report cards rely on billing data, and that concerned him, spurring his decision to investigate further. "Although these efforts are in the right direction — that of full disclosure of organization performance — it can lead to misperceptions about differences between specific hospitals."

He and his colleagues on the study chose HealthGrades not because of who the company is, but because of the strategy it employs of using billing data and mathematical billing models. "What we found is that on average, when you cluster all the five-star hospitals together, they were better than the one-star facilities," says Krumholz. "But there was a lot of heterogeneity between hospitals in the various groups. The data they provide is better than nothing, but not

COMING IN FUTURE MONTHS

- Hospital's mortality rates among MI victims beat expectations
- E-mail system 'triages' messages from patients to their physicians
- Music therapy employed as treatment adjunct in university hospital ICU
- AHRQ report evaluates systems that rate quality of research evidence
- Physician-assisted suicide: Challenge to Oregon law re-ignites the debate

much. It's not as good as it might appear, and we have to find better ways of providing consumers with quality information."

The information Krumholz found was what he would expect from billing data. "It just can't capture chart information well. It's not bad as a surveillance method, and there is often some signal of quality in that data. But that's different than trying to draw conclusions about a facility."

HealthGrades doesn't agree with Krumholz's conclusions, citing flaws in several aspects of the study. First, a prepared statement from the company notes, "to validate a methodology, it is essential to use the same patients, the same time period, and the same rating system. Krumholz et al. use a different time period, a different rating system, and then systematically excludes certain types of patients that HealthGrades includes, thus rendering their results invalid."

The company says using different patient populations introduces a bias in the ratings assigned to hospitals, and differences "become blurred, and therefore the categories would become less distinct."

The company also criticized the study's use of only 18 months of data, compared to HealthGrades' 36-month sample, and the researchers' decision to exclude patients readmitted for AMI, and those who were transferred to a hospital — some of whom may have been transferred to a different facility for reperfusion therapy.

How-to tips from talkingquality.gov

To Get	Do This
HEDIS measures	Purchase results from the National Committee for Quality Assurance (NCQA). Web site: www.ncqa.org **OR** Ask plans to report their HEDIS measures directly to you.
Measures of members' experience and satisfaction	Conduct a survey of your audience. The Consumer Assessment of Health Plans (CAHPS) survey (www.ahrq.gov/qual/cahpfact.htm) is a standardized tool for doing this. To get comparative data, you may want to participate in the National CAHPS Benchmarking Database (NCBD). Even if you don't participate, you can get National benchmarks and averages from the NCBD's annual report. **OR** If your plans report HEDIS, ask NCQA or the plans themselves for the results of their CAHPS surveys. HEDIS includes an expanded version of the CAHPS survey. **OR** Conduct a survey of patients with chronic conditions, in order to assess the quality of chronic care. The FACCTONE survey can help you gather this kind of information (www.facct.org/measures/ FACCTONE.htm).
Other information, such as disenrollment rates and grievances	Ask your state's insurance commissioner for information such as complaint or grievance rates, licensure data, and financial information, which can tell you something about the stability of the plan. **OR** Ask the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), for quality information (including HEDIS results) for the health plans serving Medicare beneficiaries. (Go to CMS's data at www.medicare.gov.) **OR** Request the information directly from the plans from which you purchase services, possibly as a stipulation in the contract.

Source: www.talkingquality.gov.

HealthGrades also noted that Krumholz evaluated an older system that has a five-star rating system. HealthGrades now uses a three-star system, which the prepared statement notes may increase the distinctions between hospitals.

Krumholz tells *Healthcare Benchmarks* that the editors and peer reviewers at *JAMA* saw all of HealthGrades' criticisms before publication, and they agreed not with the company, but with the researchers' approach. Besides, he notes, although the study focused on HealthGrades, Krumholz says that most such programs for quality measurement reporting have the same limitations.

"What patients want and need to know is are providers doing the right thing and are patients satisfied with their care. Whether or not a hospital has a PET [position emission tomography] scanner isn't a good measure of quality. Even something like nursing ratios may not be. You really want to know how good the nursing care is and how the nurses are deployed."

In the future, using some of the Joint Commission's core measures as a basis for quality data reporting will be more meaningful, Krumholz says.

In the end, Krumholz says he hopes his study, and its criticisms of the current state of consumer data reporting will lead to better efforts in this area. "I would like full disclosure of information at the hospital level, and also full disclosure of measurement systems. I'm not suggesting that in the meantime, you don't publish this kind of information, but there has to be a warning about its limitations. We need to be looking for more meaningful measures of quality."

Reference

1. Krumholz HM, Rathore SS, Chen J, et al. Evaluation of a consumer-oriented Internet health care report card: The risk of quality ratings based on mortality data. *JAMA* 2002; 287(10):1,277-87.

[For more information, contact:

*• **Harlan Krumholz**, MD, Associate Professor of Internal Medicine and Cardiology, Co-Director of the Clinical Scholars Program and Epidemiology/Public Health, Yale University Medical School, New Haven, CT 06520. Telephone: (203) 737-1717.*

*• **Carla Zema**, PhD, Kerr White Visiting Scholar, AHRQ, 6011 Executive Blvd., Suite 200, Rockville, MD 20852. Telephone: (301) 594-1364.*

*• **HealthGrades**, 44 Union Blvd., Suite 600, Lakewood, CO 80228. Telephone: (303) 716-0041.]* ■

QI focus leads to IT solutions systemwide

Hospital system improves patient care through IT

Technology never was the starting point for quality improvement projects at Community Health Network in Indianapolis. But in making good use of it as a tool, the four-hospital network has ended up with a bang-up patient database, improved safety programs, and the potential for many of its units to end up being paperless.

It all started in 1995, when brainstorming sessions focused on how to get clinical staff back to the bedside. "One part of that is technology," explains **Lynne Royer**, RN, MSN, clinical director and medical informatics specialist for the network. "The goal isn't to be paperless, or even to be safe, but to provide better care. One way to do that is to provide information to a lot of people simultaneously. But you aren't going to buy 50,000 printers to do that. You have to find a different approach."

Getting chart information to people's fingertips became a stated goal, says **Jeff Rush**, director of information for the network. That meant putting it on-line. That created an additional opportunity to build a data repository, he notes. "We wanted to capture all admissions, all lab results, all X-rays, and all dictations. We wanted nursing documentation to become a component of that information."

A small Ann Arbor, MI, company, SEC, came in as a consultant to help develop the idea. It so happened that the company had a software tool that could help. "We decided to see what they could do rather than look at the big players right away," explains Rush. "We ended up developing software together and now have data on every admit since 1996."

General Electric (GE) bought SEC two years ago, and the product, Centricity, is available for others to use. But Community Health Network remains a development partner, and is working to expand its capabilities with a dose charting and physician-order entry. At a new heart center being built for the network, the program will allow for a completely paperless and filmless environment.

The program has been rolled out to various nursing units one at a time. According to Royer, nurses and physicians either use wireless laptop computers on carts or in-room, wall-mounted

devices to make their notations and access patient data. For some units, the needs are different. For instance, on the med-surg unit, physicians didn't want to be in the room with a walking, talking patient while taking notes on a computer. So they tend to use PCs stationed elsewhere. However, in an intensive care unit, there are more devices in the room for providers to use.

The only time patient data aren't automatically entered into the system is if the patient leaves a unit for some procedure or therapy. "If a respiratory therapist comes to the floor, then it's documented on the computer," Rush says. "But if the patient leaves the unit for physical therapy, then it's documented on paper."

To a nurse or physician, the need to change the way information is presented is obvious, says Royer. Episodes of care are great for billing purposes, but not for clinical care, she notes. "If I'm taking care of a renal patient, I don't care when he came in and left. I care about his creatine levels over time." Now, clinical records can be optimized to view patient information over time.

"Nurses are often shift thinkers, and physicians think across time," she continues. "Now, I can put relevant data side by side so that clinicians can always easily see important information." For example, a patient's neurological status might note that he was normal at 8 a.m. and 9 a.m., but at 10 a.m., pupil size was unequal. "In a paper world, that information is disjointed and hard to find. Assessments in this program are next to each other — noting that he was normal, normal, and then different. That can help clinicians determine what the problem is and what to do about it."

IOM report reinforces need

Rush notes that the administration at the network has been willing to spend money on this system from the start. "This was never about the cost, but about having to do this, about being where we wanted to be. We never wanted to be on the leading edge, but we have ended up being just that."

When the Institute of Medicine report on medical errors came out two years ago, Rush, Royer, and others involved in the program felt an even greater sense of justification for the new system. "We did a video presentation that documented true stories of mistakes made," says Rush. "We displayed physician orders and asked people if they could read them. That really helped to drive it home to people. They would start to wonder what if that was their mom, dad, wife, or child."

More than 60 presentations were made, says Royer. "We never concentrated on what we were doing, but on why we were doing it — on what it meant to patients, families, and clinical staff to have information at the ready, to not have to wait for a chart. The goal was to create enough cognizant dissonance in a room that when we left, people believed we had to do something. And if we had that, we knew that this kind of program provided the answer."

All of that made providing a return-on-investment report or defining a cost center where the benefit would accrue less important to the network's board. "We know that we can reduce overall costs in the operating budget by using this kind of technology," Rush says. "And it also didn't hurt that the cost of PCs was going down. But we haven't had to show them where the savings were going to come from."

The capital investment is just one part of the cost, Royer notes. "There are soft dollars you spend through training, through having to teach some people basic skills like typing. And when you have nurses in training, you have to back-fill the staff and pay another nurse to be on the floor. But in the end, you improve the quality of care."

Figuring out how well the new system is working is based on both quantitative measurements — how many physicians are accessing the system to view patient records, how much faster it is to get a patient record — and qualitative goals. "It's easy to figure out if people are spending less time on documentation and how many fewer people you need now that no one is always running off to find a chart," says Royer. "But qualitative goals are harder. We want to know if nurses perceive that they are spending less time on documentation. We want to look at whether consistency is improved because you have some standardized definitions of conditions. On paper, a rale to one person may be a rasp to another. But on the computer, it's standardized."

Not-so-official signs of improvement

Rush says he still is interested in the quantitative goals, and is paying attention to whether usage of on-line documentation is increasing. However, the increased usage brings another set of problems. "If a patient comes into an emergency room and you needed his chart in the old system, that was a minimum of an hour before you would

get it," he says. "Now it's 15 seconds. But I find I'm getting voicemail and e-mail messages that it's taking the system 16 seconds, and can't I fix it. That 15 seconds becomes the benchmark."

Patients seem to recognize the benefits the technological improvements are making, too. Within two weeks of implementing the system in an obstetrical unit, patient satisfaction scores went up two percentage points, says Royer. Other less-scientific evidence of success includes voicemail messages from physicians telling Rush how great the system is because they can get a page about a patient in one facility, look up his or her record while at another facility, and call back with instructions without having to leave the patients to which they are currently tending.

Royer says she got a letter from the wife of a patient in one of the intensive care units "telling me how much difference it made in her husband's care that staff knew so much about him, his condition, and were so ready for him when he was transferred from a local hospital. In a paper world, you just don't have that immediacy."

So much to do with the data

In the future, the system will include medication-dose charting and will be able to measure near-miss and error rates, Rush says. He hopes that initial rates will be high, indicating the system helps providers at all levels to avoid mistakes. When physician-order-entry systems are on-line, Rush and Royer will look at delivery time for drugs, and turnaround time for orders.

"There is so much we can and want to do with the data," Royer says. "Maybe I'll be able to be alerted automatically to the nine of my 17 patients that have pain scores of nine or more," she says. "I'm sure that there is a lot more mining of this great data that we can do."

It all ends up providing better and safer care. Royer gives another example about chemotherapy. "We know that chemotherapy patients are at higher risk if they are on floors that don't regularly give it. Now we have a system where if a patient has chemotherapy ordered, the information goes into a pager so a clinical nurse specialist knows if the treatment is ordered for another floor and can monitor that situation."

The new heart hospital, which should open in the next year, will feature some technology perks that eventually will expand to other units. For instance, when they log into the system every morning, managers will be given a single screen of items they need to handle that day. "When they log on, there will be a specific view that will guide them through what they need to do that day, based on what the system is telling them has happened or is due to happen," Rush says.

And the computer program doesn't just provide opportunities for new uses of data, either. It also can give managers data that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires facilities to collect. "We can look at issues like patient restraints," he notes. "But I can do more than what they ask, too. I can look at who does it and what kinds patients are being restrained."

Before, a lot of the data JCAHO, the federal government, and other agencies required the network to collect were labor-intensive projects. Now, says Rush, it can be done quickly, and even daily, providing real-time information.

All of the nursing units are due to be on-line by 2005, by which time Rush says the system will include physician order entry, physician documentation, most charting, and possibly even specimen and blood collection.

He says such systems may be expensive — although as a development partner with GE, Community Health Network is getting something of a break on the price. But in the end, it pays off. There is no additional full-time staff needed to run it, and the benefits are obvious to the providers. "If one person is looking at a chart, another person in another unit, in another hospital can still access it if necessary."

As long as a system or facility is "rooted in the why and has a fair amount of quality improvement work as a foundation," such a program can be successful, says Royer. "You also have to make sure it isn't driven by any one group —— either nursing, medicine, or information technology. You all have to sit around the table together." She says that when she makes site visits to other facilities and sees groups without a single nurse at the table, or where only the IT staff are present, she can be pretty sure it won't be a successful program. "You have to create a common vision across functions. And you have to design for the different needs that different providers have. Nurses use the data one way, physicians another."

Rush has one other piece of advice: Don't hook such a program on something such as the Institute of Medicine report on patient safety or what The Leapfrog Group says is important. "You might be successful, but you might not," he

says. "That won't necessarily hook your people, and they have to feel the incentives, too."

Both Rush and Royer also warn that such a project is not a sprint, but a marathon. "This takes a long, long time to create, and you don't always feel like you are making progress," Rush says. "We had to sit down and actually write down what we did in 2001 to realize its impact: we brought eight units live, started on the physician order entry project with 10 physicians actively helping the program, and put through a four-year plan with a budget that didn't include a return on investment. That is very successful. And if you don't take time to recognize your successes, the team will dry up."

[For more information, contact:

*• **Lynne Royer**, RN, MSN, clinical director and medical informatics specialist, and **Jeff Rush**, director of information technology. Community Health Network, 1500 N. Ritter Ave., Indianapolis, IN 46219. Telephone: (317) 355-5737.]* ■

The patient is the winner in the pursuit of perfection

Grants used to improve health care quality

Given $2 million to improve health care quality, what could a hospital do with the money? That question is being answered now as the second stage of the Pursuing Perfection program of the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Quality (IQI) gets under way.

Seven facilities were selected in April to receive grants of $1.9 million. They are: Cambridge Health Alliance of Cambridge, MA; Cincinnati Children's Hospital Medical Center; Hackensack (NJ) University Medical Center; HealthPartners Medical Group and Clinics of Minneapolis; McLeod Regional Medical Center in Florence, SC; St. Joseph Hospital in Bellingham, WA; and Tallahassee (FL) Memorial Healthcare.

James M. Anderson, Cincinnati Children's Hospital Medical Center president and chief executive of the only children's hospital in the group, calls the Pursuing Perfection project "the engine that drives the transformational change that is necessary for us to become the leader in improving child health."

Their hospital had two pilot projects that were reviewed as part of the grant process. One focused on bronchiolitis and the other on cystic fibrosis.

The bronchiolitis project included providing better access for parents to their children's charts, better managing patients so that they can be discharged faster, and better use of evidence-based approaches in determining which children needed to be hospitalized for the condition. For the latter two initiatives, there has been significant improvement. There has been a 71% decrease in discharge times, and Cincinnati Children's now is below the national average in admissions for bronchiolitis.

Cystic fibrosis (CF) patients benefited by having more say in their daily schedule. Outpatients and their parents now are part of a goal setting process that has improved satisfaction, and the program achieved a staggering 50% increase in the number of CF patients getting flu shots, up from 36% last year to 86% this year.

For the next two years, the grant will fund several additional goals:

— to extend the comprehensive redesign of inpatient and outpatient care delivery for chronic care to diabetes and juvenile rheumatoid arthritis;

— to give patients and parents more input into when they have outpatient clinic;

— to minimize pain for newborns and children with cancer, fractures and lacerations, as well as postoperative pain;

— to dramatically improve efficiency and safety for patients preparing to undergo surgery; and

— to extend to acute conditions beyond bronchiolitis the extent to which care is family-centered and based on the best medical science.

At St. Joseph Hospital in Bellingham, WA, a team involved in the first phase of the grant concentrated on improving care for diabetic and congestive heart failure patients and their families through the development of a shared care plan, creation of care teams, and the redesign of services in the hospital, clinics, and community. Further work on these two areas will continue in phase two, in part because the conditions are so prevalent in Whatcom County. In 2000, St. Joseph Hospital had almost 700 admissions related to diabetes and almost 900 admissions related to congestive heart failure. The Pursuing Perfection project goals are to reduce both admissions and readmissions by creating chronic-care services programs that help patients learn to manage their own care.

Among the key items to achieve success will be changing the way care is delivered. According to

project executive **Marc Pierson**, MD, delivery changes will focus on evidence-based protocols to support continuum-based care; disease registry functionality for providers and patients; using leading-edge technology to improve the flow of information between patients and providers; and patients self-managing their care in collaboration with virtual care teams that are based throughout the care continuum.

The project team also will target improving the safety of the medication-management process between providers and patients.

Overall improvement

Pierson and his team hope to demonstrate improved access to care, increased patient self-management and satisfaction, and a decrease in medication errors associated with care at different points in the health care system. Areas for improvement include increased monitoring of critical factors such as glucose levels for patients with diabetes and weight fluctuations for patients with congestive heart failure. One of the specific goals is that every single diabetes patient will meet his or her personal goal for glycohemoglobin levels. Overall, it is expected that hospitalization, re-hospitalization, and inpatient mortality rates significantly will decrease.

Hackensack (NJ) University Medical Center in used its grant money to work on community-acquired pneumonia, heart attacks, and stroke. A team of physicians, advanced practice nurses, and pharmacists worked to streamline the care while achieving near 100% compliance with the performance measures from the Centers for Medicare and Medicaid Services Quality Improvement Project.

"This team approach is integral to the success of these projects," said **Peter A. Gross**, MD, chairman of the department of internal medicine and project leader for the grant. "The seven areas the medical center has chosen to tackle involve some of the most pressing health care issues in our society."

The pilot programs include: improving function in patients with heart failure, reducing complications of atrial fibrillation by improving anticoagulation safety, providing better access to appropriate care models for geriatric patients, reducing medication errors and improving safety, reducing stroke complications and speeding up stroke patients' rehabilitations, saving heart muscle in heart attack patients, and implementing methods to prevent diseases by early diagnosis.

Cambridge (MA) Health Alliance spent the first-phase grant on projects for local residents with asthma and diabetes. During the next phase, the system will add more clinical and administrative projects, including depression, children's oral health, patient flow, and open access for specialty and ancillary services.

Diabetes care also was a grant target for HealthPartners in Minneapolis. Its second pilot was to create "the perfect doctor / patient encounter." For the latter project, HealthPartners wanted to improve appointment and information access for patients requiring primary care and specialty care. Five additional pilot projects in phase two will focus on depression, emergency room care, breast cancer, pediatric diabetes, and the management of pain and suffering at the end of life.

Targets for the grant at McLeod Regional Medical Center will focus on beating national best-practice rates for treatment of heart disease and eliminating adverse drug events. For the latter, McLeod will capitalize on enhancements in computer technology and provide extensive training to medical and hospital staff.

At Tallahassee (FL) Memorial HealthCare, first-phase projects were to redesign medication systems and address patients with acute coronary syndrome. Six additional projects for phase two of the program include cardiovascular, diabetes, end-of-life care, patient flow, customer service, and quality of work life.

"All 12 organizations have demonstrated a deep commitment and the will to contribute to the never-ending pursuit of perfection," says **Donald M. Berwick**, MD, MPP, president and CEO of the Institute for Healthcare Improvement. "We are confident that all of these outstanding organizations will continue their efforts to pursue perfect care and will become models of care that the world can emulate."

[For more information, contact:

- ***James M. Anderson**, President and Chief Executive Officer, Cincinnati Children's Hospital Medical Center, 3333 Burnet Ave., Cincinnati, OH 45229-3039. Telephone: (513) 636-4200.*
- ***Peter A. Gross**, MD, Chairman, Department of Internal Medicine, Hackensack University Medical Center, 20 Prospect Ave., Hackensack, NJ 07601. Telephone: (201) 996-2000.*
- ***Donald Berwick**, MD, MPP, President and Chief Executive Officer, Institute for Healthcare Improvement, 375 Longwood Ave., 4th Floor, Boston, MA 02215. Telephone: (617) 754-4800.]* ■

Removing patient irritants improves care

Small things add up for customers

A worried patient entering a hospital doesn't want to struggle to find the place where he or she needs to go. Nor should someone who is already under stress have to spend an hour trying to figure out how to work the television, lights, or bed in the room. Yet these small irritations can create a lasting negative impression on patients. That's why Brockton (MA) Hospital targeted such little nuisances and their elimination through its Removal of Patient Irritants Team (RPI). The team — part of an overall effort to reverse a downward trend in patient satisfaction scores — won accolades last year from Press Ganey Associates, which made the hospital one of its finalists in the annual Client Success Stories competition. More importantly, patients are noticing the change, says **Carol Martin**, RN, director of cardiopulmonary rehabilitation at the 290-bed hospital and leader of the RPI team.

The idea immediately was to resolve as many issues that bother patients as possible, while making sure that those that are more complex are quickly brought to the attention of the appropriate person for development of an action plan.

The RPI team is one of five that the hospital implemented four years ago, explains Martin. The others are the measurement team, which keeps track of data and provides weekly updates on patient satisfaction scores; the communication team, which is in charge of all patient communications, including hospital room bulletins; the reward and recognition team, accountable for applauding the efforts of staff members who perform above and beyond the call of duty; and the standards and values team, which makes sure that hospital values are known, understood, and are part of the hospital staffs' performance evaluations.

Initially, the team members were unsure what they should do, so they concentrated on reading every single patient satisfaction survey that was returned. Martin says of particular import was the comment section. "Patients don't usually write any comments," she notes. "If they do, you know it is something that is important to them." Positive comments immediately were e-mailed around the hospital, and negative notations were listed and systematically attacked by team members.

One of the first items they noted was that emergency department (ED) patients complained that they couldn't get pillows. "We asked the staff in the ED why they didn't have pillows, and they said it was because if they had them, the emergency medical technicians would walk out with them, or the patients would take them to the floor with them when they were admitted and the department would never see them again."

The simple solution was to purchase green pillowcases. "Any time you saw a green pillow, you knew it belonged to the emergency department," Martin says. It was a quick and easy benefit to provide to patients. "We still lose a few pillows, but patient comfort is more important."

The team did some mystery shopping at the facility and noticed that it often was difficult to find someone who could provide a patient with directions. "So we started a greeter program where every manager has to pick an hour and work as a greeter at our main entrances," she says. "I got a lot of grief for it, but the program is still working."

The impact of the greeter program goes beyond patients, too, adds Martin. "It makes it clear to the staff that managers are interested in patient satisfaction. In addition, the visible presence of managers means that some problems can be addressed much more quickly than they might have been otherwise."

Everybody cares for patients

Another program involves patient rounding, in which patient advocates, nonclinical managers, and maintenance personnel make rounds to all new patients. During the week, patient advocates make the visits. On the weekend, clinical and nonclinical managers volunteer for the shifts. Maintenance associates visit every new patient within 24 hours of admission to ask about their accommodations and provide basic instructions for the television, lights, call button, and bed.

To ensure that there is wide participation in and knowledge of the RPI team activities, Martin holds meetings on different units every week. "It was hard to get staff nurse involvement, because their shifts aren't predictable," she says. "But by having a meeting on different units each week, we can get nurses to come in for a few minutes, even if it's just to grab a bagel. It's often long enough for them to provide good ideas or hear what we are doing."

In one instance, a nurse said there weren't

enough intrevenous pumps available. "If you tell a nurse manager that, they might say you are using them on too many patients. But we stepped back and looked more in depth. We called other hospitals to see what their use was and found we used them 50% less than other hospitals. We ordered more pumps right away."

If a problem is brought up — either by patients or by staff — it is addressed. If it can't be fixed immediately, staff is apprised of the situation so they know where it stands.

When a complaint comes in, it is brought to the attention of the person in charge of that area. For instance, if a patient complains that a room is too warm, the complaint goes to maintenance. Since rooms don't have individual heating systems, the maintenance staff might recommend using fans. The manager who can best deal with the problem is in charge of making rounds to patients who have made such a complaint and is given two weeks to work on the problem. "Then they come to a weekly meeting and report on what they have done and what they couldn't do." Only once has the manager in charge failed to come up with an action plan in the two-week time frame, says Martin.

The overall goal, she says, was to improve patient satisfaction scores from the 38th percentile to the 98th percentile. It's a high goal, and Martin says that since there are 650 hospitals in the Press Ganey database, she'd be happy with any score in the 90s. Initially, she succeeded. "We had a full year where we were over the 90th percentile," she notes. Then a nursing strike hit the hospital last fall. Upon the return to work, the scores were once again very low. "But we went right back to work, addressing patient and staff issues and the scores started going up again." By the start of May, the scores had been in the 90s for about a month.

With good support from the CEO and other senior management, Martin says no one doubts the importance of patient satisfaction. "It is the No. 1 item on the senior staff agenda every single week," she says. "I have my own budget, and every week the CEO asks what I need to make this all work."

Not that money is the only answer. "It's not even about the big things, but about the small ones," says Martin. "It's acknowledging a problem, asking how you can fix it. It's often a lot less than you think."

The staff takes great pride in the achievements, which even were noted on paychecks, with a banner that said the hospital was in the top 10% for patient satisfaction in the country. But Martin does have a word of warning. "Don't waste your time on the 1% of people who you can never make happy," she says. "Put your efforts on exceeding the expectations of the others and on swaying the feelings of those fence sitters."

[For more information, contact:
*• **Carol A. Martin**, RN, Director of Cardiopulmonary Rehabilitation Services, Brockton Hospital, 680 Centre St., Brockton, MA 02402. Telephone: (508) 941-7231.]* ■

Academic practice faculty, management doing well

The annual Medical Group Management Association (MGMA) Academic Practice Compensation and Production Survey Report should bring welcome news to faculty and management in academic practices.

According to the 2002 report based on 2001 data, the median compensation for primary-care faculty was $127,004 in 2001, up 1.7% from 2000. Family practice experienced the largest increase in the primary-care specialties for the second year in a row, with 3%.

The median compensation for specialist faculty was $170,899 in 2001, up 3.8% from 2000. The top specialties experiencing compensation increases from 2000 are rheumatology at 9.4%, diagnostic radiology at 8%, neurology at 6.6%, and orthopedic surgery at 4.3%.

Pulmonary medicine and anatomic pathology experienced 1.8% and 3.2% decreases, respectively.

Median compensation for chief department administrators with additional responsibilities was $94,500 in 2001, up $10,000 from 2000. Chief department administrators without additional responsibilities had a median compensation of $83,200, up $12,995 from the previous year.

According to the new survey report, the size of a department is what makes the difference when it comes to what academic practice managers

earn. Managers in departments that have greater numbers of physicians and that pull in more revenue tend to command higher compensation.

Clinical practice managers earned a median compensation of $59,800 in 2001, while directors of billing/coding and medical directors had a median compensation of $43,884 and $132,000, respectively.

For more information on the survey, or to inquire about purchase, visit the MGMA web site at www.mgma.com. ▼

Solucient delays 100 top hospitals report

Citing a holdup in data from the Center for Medicare & Medicaid Services (CMS), Solucient has announced that the 2001 edition of the *100 Top Hospitals: Benchmarks for Success*, won't be published until this fall.

CMS granted an extension of the deadline until the middle of June for hospitals to submit Year 2000 cost reports. Until those data are in, Solucient can't produce its reports.

Two other specialty reports — one on cardiovascular hospitals and another on the best intensive care units, also will be delayed until 2003. Solucient also remains unsure of the timetable for its next report for orthopedics. ▼

NCQA, AMGA looking for grant applications

The National Committee for Quality Assurance (NCQA), the American Medical Group Association (AMGA), and Pharmacia are calling on physician-directed organizations with at least three providers to apply for a safety grant as part of the Safety Collaborative for the Outpatient Environment (SCOPE) initiative.

Ten grants of up to $50,000 will be awarded to applicants. Proposals are due by the end of June, and projects should start by September.

Organizations with patient safety projects that already are under way are eligible to apply, provided the project has not been completed.

Applications will be blinded and reviewed by a panel of nationally recognized experts who are not employed by AMGA, NCQA, or Pharmacia. Applications will be evaluated with respect to the number of people who could be impacted if the project was implemented widely and the health and fiscal impact if successful; innovation and creativity in the approach; soundness and feasibility of the proposed intervention(s); strength and appropriateness of the evaluation plan and measures; applicability of the project to other practices; and clarity and readability of the application.

More information is available at www.amga.org/AMGA2000/QMR/OMC/scope_omc.htm. ▼

Healthcare Benchmarks™ (ISSN# 1091-6768) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Healthcare Benchmarks**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30-6 Monday-Thursday; 8:30-4:30 Friday.

Subscription rates: U.S.A., one year (12 issues), $527. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $422 per year; 10 to 20 additional copies, $316 per year. For more than 20 copies, call customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $88 each. (GST registration number R128870672.)

Editor: **Lisa Hubbell**, (425) 739-4625.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Chris Delporte**, (404) 262-5545, (christopher.delporte@ahcpub.com).
Production Editor: **Emily Palmer**.

THOMSON
AMERICAN HEALTH CONSULTANTS

Editorial Questions

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

Leapfrog announces 12 new regions

Consumers, employers, and others interested in quality health care in a dozen new regions now can check out how their favorite hospitals compare by going to the Leapfrog Group's web site (www.leapfroggroup.org). The 12 regions are: Colorado; Central Florida; Dallas-Fort Worth; Kansas City, MO.; Massachusetts; Memphis, TN; Metro New York City; New Jersey; Rochester, NY; Savannah, GA; Wichita, KS; and south central Wisconsin. They join the regions rolled out last year — Atlanta, California, Michigan, Minnesota, East Tennessee, Seattle, and St. Louis.

Leapfrog looks at whether hospitals have adopted use of computerized physician order-entry systems, how well they perform selected high-risk conditions, and whether their intensive care units are staffed with specialists trained in critical care.

According to the group, the initiative has the potential to reach about 40% of the consumers in the country. Hospitals voluntarily fill out an on-line survey on their adoption of the three criteria, or their plans to do so. The results are reported in a survey that anyone can access and are updated every month.

"These regions are helping set the pace for the nation," explains **Suzanne Delbanco**, PhD, executive director of The Leapfrog Group. "By prompting patients to consider three proven safety practices when choosing a hospital, and encouraging local health care providers to adopt them, purchasers can help protect thousands of Americans from disability and death."

Delbanco says that each month's results include data from more hospitals that are choosing to fill out the survey, and new regions will be added in the near future. ■