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INSIDE

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Celebration Health: Nothing Mickey Mouse about this new paradigm

Walt Disney town uses best practices to design innovative facility

In the new town of Celebration, FL, Walt Disney's imagination becomes real life. Here, not far from Cinderella's castle, neat homes with white picket fences and large front porches perch along winding narrow streets, and a brick-paved downtown sports lakefront restaurants and shops. It's Disney's vision of the perfect town: the best ideas of the past mingling with the best ideas of the future.

And, taking the same approach, Disney came up with a completely new kind of hospital: Celebration Health, which opened in July. The core of the hospital's mission is to empower individuals, from Celebration residents to Orlando-area tourists, to take charge of their own physical, emotional, and spiritual well-being.

"We knew from the beginning that we were looking at a completely new paradigm," says **Des Cummings**, CEO of the development division of Florida Hospital, which includes Celebration Health in its six-campus system. "In the first half of the 20th century, we faced diseases [such as] polio, over which we had little control, but in the last half of the century, we're facing diseases that we bring on ourselves.

"To gain the best outcomes, we have to engage patients in caring for themselves. The chronic diseases are really the threat of the future. In the old model, we just had to partner with the providers who did everything to the patient. But if you want to change lifestyles, you have to engage people to manage their own conditions."

Determining future health needs

Along with staff from Florida Hospital, the Celebration planners began meeting with the International Health Futures Network, led by Clem Bezold, president of the Alexandria, VA-based Institute for Alternative Futures; Leland Kaiser, president of Brighton, CO-based Kaiser and Associates; Kenneth Pelletier, clinical associate professor of medicine at the Stanford University School of Medicine in Palo Alto, CA; and Kathryn Johnson, president/CEO of The Healthcare Forum in San Francisco. The group worked to define what health would mean in

Everyday Innovations

A new twist on tracheostomy ties

Tracheostomy ties can cause lots of problems for home care patients, says **Margaret Hickey**, RN, MSN, CORLN, clinical director at the Tulane Comprehensive Cancer Center in New Orleans. The standard twill tape ties or Velcro ties are absorbent and easily become wet and soiled. So Hickey came up with a handy, simple tip she says patients love.

"We use IV tubing to secure the mature tracheostomy tube. This tubing can be easily cleaned as well as the skin around the stoma and the neck," she says. "The tubing is not absorbent and does not become wet to irritate the neck. Additionally, the patients and caregivers are fond of the IV tubing tie because it does not need to be changed daily but remains clean and secure for a prolonged period. It is also more aesthetically pleasing vs. the sterile, hospital-like white ties."

The IV tubing is strung through and over the tracheostomy tube faceplate and tied in a square knot securely on the side of the neck. The tubing is trimmed to size after it is knotted.

To read more about tracheostomy tube ties and other everyday innovations, visit the Best Practice Network's Web site at www.best4health.org. The Best Practice Network, a new organization devoted to promoting information sharing in health care by nurses, physicians, and other health care professionals, offers creative solutions to problems large and small.

For more information, send an e-mail to joinus@best4health.org or call (800) 899-2226. ■

the future and how it could be fostered within a community. And they brought the best of the best from other health care facilities into the plan, Cummings explains.

Since Florida Hospital was already sold on the benefits of benchmarking both inside and outside the industry, the search for best practices was a natural part of the development process, Cummings says. "Benchmarking has to be a mindset that you take to everything you do if you want to see real improvement," he says. "Instead of having our people groan when we say we're going to do benchmarking, they naturally integrate it as part of the planning process. You have to develop that culture. The next step for the health care industry is to do some serious benchmarking outside the industry."

To that end, Celebration planners worked closely with the Disney "imagineers" to learn what pieces of the Disney approach would work in health care. From Disney, they got the idea to build their philosophy into a facility through innovative architecture. The campus is designed to look like a 1930s Mediterranean resort, featuring a sunlit atrium, art-lined walls, and oversized windows and balconies for fresh-air access. Perhaps even more noticeable is what the hospital lacks: a maze of corridors and that hospital smell. From Disney came the idea of "front stage" and "back stage," in which the unappealing aspects of the hospital business are relegated to back corridors.

"It doesn't smell like a hospital, and it feels like a hotel," says **David Dore**, MD, an orthopedic surgeon at Celebration Health. "You don't see doctors in white coats, lab techs, or even the mailman walking around on the front stage corridors. If I'm wearing my white coat, I always use the back stairs. Those kinds of things make people nervous, and we're trying to promote an atmosphere of health. Going to the hospital is bad enough."

The other idea from Disney is the emphasis on customer service. A concierge in the main lobby greets patients — called "guests," also in the Disney mode — taking basic information such as insurance from them if it's a first visit, alerting the appropriate office of their arrival, and giving directions. Patients are given pagers if a wait is required, as are family members awaiting the outcome of a surgery.

"People who are fairly healthy and are just coming to see the doctor don't feel like they're in the hospital, and those who are inpatients have privacy by keeping things separated," Cummings

COMING IN FUTURE MONTHS

- What can hospitals learn from retailers?
- Best practices for using the Internet
- MIS benchmarks: A black hole of ignorance
- Benchmarking outside the industry
- Disease management: Are best practices

says. "We learned from Disney that the first thing you create is an internal expectation of what the experience is going to be like through the architecture. In most hospitals, you think 'I must be pretty sick if I'm here.' All the messages tell you you're sick, and many times those are architectural messages."

But even if the patient is sick enough to be admitted, the positive atmosphere continues. Each of the hospital's 60 beds is in a private, universal care delivery room. That means the patient stays in the same room the whole time, even if he or she requires intensive care. All the nurses are intensive care unit-trained, and the staff rotate according to the patient's needs. The rooms accommodate any type of equipment needed, all behind a panel that can be closed for a more pleasing atmosphere. There is no overhead paging to disturb patients, and rooms feature a family area with a sleeper sofa.

"Besides being much easier on the patients, the universal care model is easier on the staff as well," says **Kathleen Mitchell**, director of acute care and lifestyle enhancement. "The same staff serve the patients the whole time, and physician rounding is more efficient because the patients don't move. There's less room for error, less potential for nosocomial infections, and less work for environmental services since they're not doing as many terminal cleanings."

Best Practices from Celebration Health

- **Universal rooms.**
  All of Celebration's rooms are private and equipped for any type of patient from medical/surgical to intensive care. Patients stay in the same room during their entire stay. All nurses are intensive care unit-trained so the staff can rotate around the patient, and equipment is hidden behind a panel to create a more comforting atmosphere.
- **Patient education.**
  Interactive computer stations are located throughout the campus so patients can access health education materials, research knowledge bases, and obtain printed materials. Visitors can also schedule doctor's appointments and obtain information about fitness and nutrition classes or other events. Patients have access to the hospital's 2,200-square-foot library.
- **Concept pharmacy.**
  Prescriptions are transmitted electronically and filled by a robot so pharmacists have more time for patient consultation. Discharge prescriptions can be filled and delivered to the patient's room before they leave the hospital.
- **Fitness.**
  The hospital's fitness center has more than 60,000 square feet of exercise space and activities for all ages and fitness levels, including a spa, swimming pool, and a room for Cycle Reebok, a group bicycle workout. Child care and personal training services are available. An electronic notebook attached to each piece of equipment keeps track of workout activities, and the system flags your name for a motivational call from the staff if you start to slack off.
- **Pediatric services.**
  Celebration takes the fear out of hospitals through ideas like a children's play room in the emergency department (ED), children's programming in the fitness center, and videos available to patients getting magnetic resonance imaging (MRI). A separate area in the ED is set aside for minor emergencies to shield children from major trauma and reduce waiting times.
- **Customer service.**
  Patients are given a beeper if a visit requires a wait, leaving them free to visit the resource library or the atrium. There are no overhead paging systems to disturb patients and few traditional hospital waiting rooms. Patients can schedule appointments throughout the Florida Hospital system with just one phone call. The hospital's restaurant is designed as a café with international cuisine, vegetarian specialties, and a mesquite-fired brick oven.
- **Technology.**
  Celebration Health is designed as a paperless records system with immediate transfer of health information and simultaneous access to computerized charts by multiple providers. The imaging center is fully digitized, eliminating the need for retakes and allowing radiologists to manipulate images for better diagnostic outcomes. Celebration is the second facility in the world to offer functional MRI, a test pinpointing areas of the brain affected by specific sensory stimulation.
- **Architecture.**
  The building is designed to look like a 1930s Mediterranean resort, including an atrium with flowers and greenery. The hospital is divided into a "front stage" or healthy corridor that includes physician offices and other services needed by mostly healthy people, and a "back stage" or healing corridor for more extensive, acute care.

Source: Celebration (FL) Health.

The setup also helps with staffing requirements, since nurses are rotated based on patient needs. Since all the nurses can handle any type of patient, there's not much downtime. Also, a priority admissions nurse handles all admissions, doing paperwork, orienting patients and families to the unit, and dispensing initial medications. That takes some of the burden off the patient care nurses, Mitchell says.

Cummings says the hospital's innovations should be good for patient outcomes as well as the bottom line. It's too early for much hard data, but he says the hospital is already ahead of the targeted four-year plan to break even.

"Our philosophy is to become a health resource for all of a person's life," Cummings says. "The difference between this hospital and any other hospital is when you drive by another hospital you look at it and say 'I hope I never have to go there.' When you drive by Celebration you say, 'I'm glad it's there, and why don't we go there tonight. We can eat dinner there and work out in the club.' It suddenly becomes a health resource instead of just a place for sick people."

Editor's note: Celebration Health has had so many benchmarking requests that they've developed a two-day seminar that will be offered four to six times a year. For more information, call (407) 303-4461. ■

Planning Celebration was a chance to build the best

Benchmarking showed what to include at all levels

At Celebration (FL) Health, benchmarking is more than just a concept; it's a way of life. When planners began the process of developing the hospital five years ago, they incorporated the search for the best of the best into every step.

One example is the hospital's women's center. A task force spent two years envisioning the center and made a dozen benchmarking site visits in the process. Hospitals that had components Celebration wanted — women's health as a top priority, physician offices on-site, a healing environment, openness — were studied, resulting in a women's center like none other.

"The woman never has to leave the facility to have all of her physician and diagnostic care," says **Des Cummings**, CEO of the development division for Florida Hospital. "We have a team concept as opposed to three or four different sets of nurses and physicians working in different locations and not necessarily communicating. If a woman has osteoporosis and needs nutritional counseling, an orthopedic consult, and some hormone therapy, we can do that in one place. This idea is usually applied to areas like cancer and not to women's medicine where the conditions aren't necessarily life-threatening."

A multidisciplinary team of physicians — OB/GYN, family practice, perinatology, GYN/oncology, infertility, and urogynecology — has offices in the center, and the diagnostic imaging center and a special women's resource library are also on-site. There is one main number to call for scheduling or information.

Putting patients in control

"We learned so much from our site visits, including what the other hospitals wish they could do differently," says coordinator **Mary Lou Cummings**, RN, BSN. "We're getting excellent feedback from our patients. They have a much different attitude about their health. They feel more in control, and they know they have options."

Celebration Health's orthopedics department is another example of the value of best practices. An interdisciplinary committee that includes not only physicians, nurses, and physical therapists but also the office manager and representatives from marketing and accounting is working to set up a joint institute.

"We're looking at how we can best care for our patients and minimize their hospital stay," says **David Dore**, MD, an orthopedic surgeon specializing in hip and knee replacement who is the director of joint reconstruction. "We have all the data from national and state averages to numbers from the best of the best, and we think we can get our numbers within those best practice parameters."

The best practice standard for length of stay after knee replacement, for example, is 3.3 days, Dore says, and four days for hip replacement. Dore's goals are the same for his unit, with an extra challenge: Those numbers will have to reflect 75% of patients being discharged to home instead of rehabilitation. "The information just isn't there in the literature about whether those numbers reflect patients going home. But if you're

getting them out of the hospital just to send them to rehab, all you're doing is cost-shifting."

Best practices incorporated in orthopedics include intensive preoperative education, where patients are brought in the night before their surgery to get instruction on postoperative physical therapy and other care. The physical therapists work with patients in groups of four before and after surgery to provide peer support and motivation.

Also, the physicians work with other specialists throughout the hospital on issues relating to their patients. Dore, for example, recently attended a seminar on cholesterol. "I never worry about the joint replacement itself," he says. "I worry about the possibility that something else could go wrong with the patient, like a heart attack or stroke."

Dore says the positive atmosphere at Celebration has a direct impact on patients. "From an orthopedic standpoint, these are well patients who have this one problem. I don't want to get them in a sick mode just because they have to come to the hospital." ■

Humana CHF program cuts costs, admissions

Regular telephone contact improves quality of life

A two-year study of nearly 5,000 congestive heart failure (CHF) patients enrolled in a disease management program found a 57.5% drop in hospital admissions for all diagnoses and a 61.1% reduction in inpatient health care costs. **(See graph, p. 174.)**

The patients, all members of the Louisville, KY-based Humana Inc. health plan, also saw a 58% drop in hospital days, and a 48.9% decrease in emergency department visits as a result of participating in the program from Cardiac Solutions of Buffalo Grove, IL.

Other results included a 34% drop in sodium intake for patients on the program a year or more and an 8% increase in functional status in the first year of the program as measured by the Duke Activity Status Index.

"There is no question that we are taking better care of our congestive heart failure patients," says **Richard Vance**, MD, Humana's vice president for population health improvement. "We believe the results of this program provide the blueprint for care of CHF patients nationwide in the future."

The key to the success of Cardiac Solutions' program, which was developed under the name MULTIFIT by researchers at Stanford University, is managing the patient, not just the CHF, says **Cornelia Tilney**, vice president of marketing for Cardiac Solutions' parent company, Ralin Medical Inc. Claims data show that when you look at patients who have had a prior hospitalization with a primary diagnosis of CHF, 50% to 60% of the inpatient costs are for non-CHF conditions, she says. Cardiac Solutions can bring the costs down 70% for CHF, and 40% to 50% for other costs.

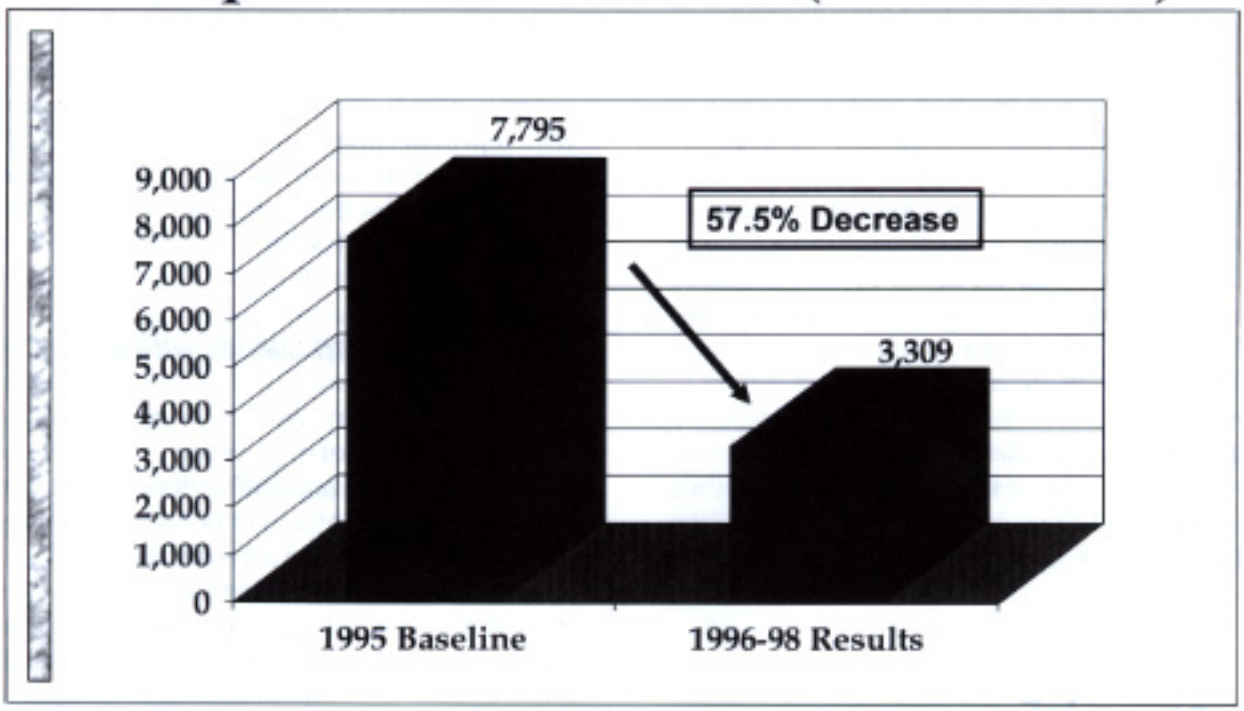
Establishing relationships with patients

Cardiac Solutions employs cardiac nurses with at least five years of experience — the average is 10 years — in five regional offices to help patients manage their symptoms at home through regular telephone contact. The program begins with a home visit from one of Cardiac Solutions' contracted home health agencies that assesses the patient's physical and psychosocial status, diet, and medication compliance. Patients receive a workbook with a simple format that teaches them how to manage their disease. Nurses go over the information chapter by chapter with them on the telephone. The nurses follow a scripted format for the calls, asking a series of questions and entering the responses into a database as they go.

Key points

- The Buffalo Grove, IL-based Cardiac Solutions congestive heart failure program reduced admissions by 57.5%, inpatient costs by 61.1%, hospital days by 58%, and emergency department visits by 48.9% in a two-year study of nearly 5,000 Humana patients.
- The program relies heavily on frequent nursing contact in person and by telephone with patients to make sure they comply with doctors' orders and know how to identify early warning signs.
- Nurse disease managers provide the sometimes missing link between established treatment guidelines and implementation on the patient level.

CHF Patient Utilization Data
Hospital Admissions (All Codes)



Source: Ralin Medical, San Francisco.

Patients may also call the nursing center themselves if they need immediate help.

"The nurses work to develop a relationship with the patient," Tilney says. "The same nurse will call the patient each time, and they send short biographies and photos of themselves to help the patients feel comfortable. They also send postcards with congratulations when the patients reach certain milestones. They are not only a highly competent clinical resource, but also a motivator, coach, and cheerleader."

Protocols based on AHCPR guidelines

The protocols of the program are based on national guidelines from the Agency for Health Care Policy and Research in Rockville, MD, and the American Heart Association in Dallas. These guidelines often fail in clinical practice, MULTIFIT's developers say, because no one has the specific responsibility of making sure they're implemented and because of logistical problems, including little time for individual patient-physician contact.

In this program, the nurses follow protocols on lab management, medication management, lifestyle management, and symptoms. If the patient has a cough, for example, the protocol helps the nurse determine whether it's from the medication or perhaps a respiratory infection and what action to take. If the situation appears urgent, the nurse will send the patient to the physician immediately.

If guidelines and treatments don't match, the nurse will point out the differences and ask the physician whether any changes should be made. Besides providing a check-and-balance system, this approach also takes some pressure off the physician's time, Tilney says. For example, one area the nurses focus on is the use of angiotensin-converting enzyme (ACE) inhibitors, which sometimes are not prescribed at optimal doses suggested by national guidelines. In a 1997 study on MULTIFIT published in the *American Journal of Cardiology*, the number of patients who received target doses of the ACE inhibitor lisinopril increased by 82%.

The results of the phone conversations are reported to both the physician and the patient,

along with results of written questionnaires the patients complete periodically. Seeing their progress on paper is a good motivator for patients, Tilney says. If patients know someone is keeping track of their sodium intake, for example, they're much more likely to watch their diet.

When Cardiac Solutions began the CHF program, all contact was face to face. But when the company got the national Humana contract, the frequent home visits became logistically impossible. So they tried the telephone method and found that the results were just as successful. "We found that when we have patients on the phone, we have their undivided attention," Tilney says. "When you're in the home, the patient may be distracted by the TV or the cat or the phone ringing."

Vance says the program combines the efficiency of telephone contact with the personal touch of as-needed home visits. "It's more practical than having every contact be a visit from a home-health nurse. With those nurses, their car time is downtime unless you have sophisticated technology in place. This way, we're using their time more efficiently."

Cardiac Solutions' ability to reconfigure the program to meet Humana's needs is one of the keys to its success. "The changes were done in collaboration with us, and that allowed us to get buy-in from our physicians," Vance says. "Their disease managers have earned the trust of our physicians as well as our patients. Both the patients and the physicians feel comfortable calling the nurses. This model is showing the way that disease management can restructure health care."

For more information on the Cardiac Solutions program, contact the company at 4371A Abbott Ct., Buffalo Grove, IL 60089. Telephone: (800) 343-6311. ■

BEST PRACTICES

Nutrition intervention in ICU improves outcomes

Research dissemination changes nursing practice

If you knew of a way to reduce length of time on a ventilator, cut costs, and improve outcomes for critically ill patients, wouldn't you do it? Especially if the best practice was something that makes as much intuitive sense as feeding your patients?

But a critical care nurse and a dietitian at Sequoia Health Services in Redwood City, CA, found that the standard of care in their intensive care unit (ICU) did not include across-the-board early nutrition intervention. **Colleen O'Leary-Kelley**, RN, MS, CCRN, CNSN, a critical care nurse, and **Stacey Dunn-Emke**, MS, RD, CNSD, clinical nutrition manager, say they suspected nutrition was playing a big part in keeping patients on ventilators longer than necessary, so they teamed up to study the issue.

They found that 26% of patients at the hospital were at moderate to severe risk for malnutrition. Medical records of ventilator-dependent patients were analyzed for a two-year period. The mean length of stay for patients with early nutrition intervention within 24 to 48 hours was 16.9 days, and the median length of ventilation was seven days. For patients with delayed intervention, the mean length of stay was 25.9 days, and the median length of ventilation was 11 days.

"Some physicians are just not tuned in to nutrition," Dunn-Emke says. "It doesn't give you that quick reaction. If you give a patient IV lasix, you'll get an immediate outcome, but with nutrition, it's not that obvious."

Dunn-Emke says physicians are sometimes nervous about tube feedings, and most assume the intubation will not be long-term. If the patient will come off the ventilator tomorrow, why initiate tube feeding? "I can understand why they're hesitant,

Key points

- Enteral feedings within three days can reduce length of time on a ventilator and improve outcomes for critically ill patients.
- Such feedings, which cost only about $80 per day, could save Medicare as much as $1.08 billion from 1996 to 2002, according to a study by Washington, DC-based KPMG Peat Marwick.
- A concerted effort to disseminate these findings led 66% of nurses at a California hospital to change their practice regarding early nutrition support.

but that mindset causes problems," she says. "Those patients are getting no protein and no calories to boost their immune response. Without the nutrition, it's also harder for the body to metabolize drugs so those drugs are not going to be as effective. The patients end up staying on the ventilator and in the hospital longer."

Besides the drug metabolism issue, malnutrition also can lead to ineffective breathing patterns due to the effects on respiratory muscle structure and function, ventilatory drive, and lung defenses. Adverse effects also include diminished diaphragmatic muscle mass, decreased minute ventilation and vital capacity, decreased inspiration and expiratory muscle strength, and diminished cell-mediated immunity. On the other hand, overfeeding can also cause problems, such as fluid overload, glucose intolerance, and increased carbon dioxide production.

Evaluate patient's caloric needs

To avoid these complications that can impact weaning outcomes, Dunn-Emke suggests that the caloric requirements of critically ill patients be evaluated by a dietitian within 48 hours of admission and that feedings should start within those first three days, provided patients are hemodynamically stable. Feedings should be started at a fraction of the final volume and advanced over hours or days until the goal volume is met. By day five of intubation, 100% of the patient's assessed requirements should be met.

Since enteral feeding costs only about $80 per day, the cost savings can be tremendous. In fact, a study from KPMG Peat Marwick LLP of Washington, DC, found appropriate use of inpatient enteral feeding in the care of critically ill or injured patients could save the Medicare program as much as $1.08 billion from 1996 to 2002. The study analyzed Medicare patient records for 13 specific diagnosis-related groups throughout 1994. Another study[1] found that malnourished surgical patients experienced a 48% rate of complication, compared to a 23% rate of complication among well-nourished patients.

O'Leary-Kelley didn't want to just complete the nutrition study; she wanted to make sure the nurses and physicians who work with these patients were well-informed of the results. A critical care nurse and a doctoral student at the University of California, San Francisco, O'Leary-Kelley knew that while research provides a great deal of useful information that could improve outcomes, bedside nurses just don't have time to read it. So she devised another study to find out if a concerted effort to disseminate research findings would impact nursing practice.

O'Leary-Kelley and Dunn-Emke presented the information from the nutrition study face to face with ICU nurses during shift report four times over a six-week period.

They posted the findings in the unit and also gave nurses a written report. Then each ICU nurse was surveyed. The result: 66% of the nurses said their practice was enhanced by increased awareness of nutritional needs of ventilator-dependent patients and that the information increased the likelihood that they would seek physician orders for early nutrition support.

"Before the nurses had this information, they would most likely just wait until the physician decided what to do about feedings," O'Leary-Kelley says. "Arming them with the findings gave them a basis to stand on when talking to the physicians. Our patients are getting fed earlier and weaning more quickly from the ventilator."

Education sessions were also done with physicians on the critical care committee, and she says the fact that the research was done with their patients made a big difference. "I think the physicians are paying more attention to what the dietitian puts in the notes."

The hospital has also started a new nutrition screening process in which nurses evaluate every patient's nutritional needs upon admission. If the patient has significant weight loss or a high-risk diagnosis, for example, dietitians are notified. Dunn-Emke is also providing regular inservices with nurses, physicians, physician assistants, and physician and respiratory therapists throughout the hospital. She periodically sets up a nutrition information booth outside the hospital's cafeteria to give information to both staff and patients.

For more information on the nutrition studies, contact Colleen O'Leary-Kelley, University of California, San Francisco, N611Y — Box 0610, San Francisco, CA 94143-0610. Telephone: (408) 738-4348. E-mail: colear@itsa.ucsf.edu.

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Hospitals are hot for collaborative strategies

Few expect to remain freestanding

In our continuing effort to help readers stay on top of emerging trends in health care, *Healthcare Benchmarks* spoke to **Rufus Harris**, principal in the Westmont, IL-based health care consulting firm TriBrook / AM&G L.L.C., about collaborative strategies hospitals are pursuing.

Following are Harris' insights as well as a chart **(see chart on Collaboration Alternatives, below)** from the firm's 1997 National Hospital Merger and Acquisition Survey, based on a random sample of 106 U.S. short-term, non-federal hospitals. **(For more information on integrated health systems, see *Healthcare Benchmarks*, October 1998, pp. 145-151.)**

- Affiliations are the most frequently pursued collaborative strategy, but they aren't necessarily the most effective. "No one really wants to merge, so they're choosing non-asset based affiliations that are less threatening," Harris says. "The problem is that hospitals don't have much incentive to change. It's unlikely that one hospital in an affiliation would close a redundant program, for example."
- Mergers and acquisitions will also be pursued. The primary driving reasons include increasing managed care contracts, reducing operating expenses and capital expenditures, and improving community health. Employer pressure is an emerging factor, Harris says. Only 11% of survey respondents expect to remain freestanding. "Those who expect to be independent tend to be the sole provider in the community," he says. "If there's not a lot of competition, collaborative strategies are less critical. But if there is, it may be something you want to consider."
- Mergers and acquisitions, shared services, and service trades are the most successful strategies.
- Although economics are the primary reasons for collaboration, attitudinal factors such as autonomy, trust, and vision are equally important.
- Vision, image, and ethics are the most important factors in selecting partners. The top reasons for failed collaborations include loss of local autonomy, lack of trust, lack of shared commitment and vision, and lack of flexibility.

COLLABORATION ALTERNATIVES

	Cooperative Planning	Shared Services[1]	Service Trades And Partnerships	Affiliations	Mergers And Acquisitions
Organizational Structure	• Committee • Corporation	• Contract • Corporation	• Contract • Partnership	• Alliance • Network • Hybrid	• Combined Boards • Consolidation • Merger • Sale/Lease • Holding Company • Joint Ownership/ Operating Agreement
Functions	• Community Health Need Assessment • Joint Planning	• Support Services • Management Expertise	• Diagnostic And Therapeutic Services • Clinical Services	• Management • Managed Care • Purchasing	• Governance • Management • Planning • Capital Finance

Source: TriBrook/AM&G L.L.C., Westmont, IL.

To get a copy of TriBrook/AM&G's 1997 National Hospital Merger and Acquisition Survey, call (630) 990-8070. Or write 999 Oakmont Plaza Drive, Suite 600, Westmont, IL 60559-5504. On the Web: www.amgnet.com. ■

Do you use benchmarks without benchmarking?

Clinical Value Compass can organize your work

Pop quiz: What's the difference between benchmarking and benchmarks?

Answer: Benchmarking is the systematic process for finding the best of the best. Benchmarks are statistical measures.

Do your homework with **Julie Mohr**, MSPH, research associate in Dartmouth Medical School's Center for the Evaluative Clinical Sciences in Hanover, NH, and you'll find out that you really do need to understand the difference. Not only that, but you need to make sure you aren't using either benchmarking or benchmarks in isolation. If you don't have the benchmarks, you can't evaluate the merits of different practices. If you don't do the benchmarking process, you won't have any idea how those numbers happened.

"It seems obvious that you can't do benchmarking without the benchmarks," Mohr says. "But you'd be surprised how many people do a simple comparison of data without understanding the underlying reasons for the numbers. You have to use benchmarking and benchmarks together to get the insights you need to implement change."

If you define and systematically follow a benchmarking process, you can expect the following results, Mohr says:

❒ **tension for change;**

❒ **awareness of current capability vs. best-known capability;**

❒ **movement from a position of inertia to positive action.**

So how do you get started? Mohr and her colleagues at Dartmouth have the answer for that one too: the Clinical Value Compass model, developed to help groups organize their quality improvement work. "We had people coming to us for help with benchmarking, but nobody knew exactly what to ask for," Mohr says. "The Clinical Value Compass gives straightforward answers. It's a set of simple tools that anyone can implement, and there are no tricks involved."

The idea is to break down the process into manageable components that will yield answers about only the most critical indicators of success for whatever process you want to improve. Find out more about those few areas that are of greatest interest to your group, and you can focus attention toward real change.

If you try to measure everything or try to do it without a systematic approach, you'll miss the value of successful benchmarking, Mohr says. The basic steps in the Dartmouth approach are to identify the outcomes, analyze the process, generate change ideas, and then do a pilot test of a change. "Benchmarking is the best way to generate those change ideas," Mohr says. "If you don't have the information to back up your ideas, you won't be able to encourage the culture of change you need to make real improvement."

Tips For Successful Benchmarking

Here are some of the lessons learned through improvement work at the Center for Evaluative Clinical Sciences at Dartmouth Medical School in Hanover, NH, according to Julie Mohr:

- ✔ Remember that learning about best practices is the aim.
- ✔ Understand your own processes.
- ✔ Data aren't perfect, and you can't collect them just once. You must redo them as processes change.
- ✔ Benchmarking is an ongoing process.
- ✔ You must be specific in your selection of benchmarks.
- ✔ You need strong planning and top management support to generate change.

For more information on the Clinical Value Compass model, contact Julie Mohr, Center for the Evaluative Clinical Sciences, Department of Community and Family Medicine, Dartmouth Medical School, 7251 Strasenburgh Hall, Room 304, Hanover, NH 03755-3863. E-mail: Julie.J Mohr@Dartmouth.edu.

A series of articles on the model appeared in *The Joint Commission Journal on Quality Improvement* beginning in April 1996. You can download the articles from the Best Practice Network Web site at www.best4health.org.

Start with the compass, which has at its four points: functional health status, costs, satisfaction, and clinical outcomes. The compass provides a guide to help you determine what results to look for in the benchmarking process. The first step is to clearly define the target population and select a related set of outcomes and cost measures based on the four compass points. If you're looking at total costs, for example, you might start with total charges paid by purchasers, but you should also look at areas such as indirect social costs, time lost from work, and workers' compensation to find ways to minimize the total costs of illness.

The Dartmouth group makes it easy with a benchmarking worksheet that takes you through the process. The five basic steps are:

1. **Identify measures.** Using the Clinical Value Compass as a guide, get your improvement team to reach consensus on two or three measures for each compass point. Make sure these benchmarks are important across your team and that valid data on them are likely to be available.

2. **Determine resources needed to find the best of the best.** The key here is to make sure you can find both internal and external data that are reliable. You'll need to identify in-house experts who can provide information and also direct you to external experts. Also, create a short bibliography of the best articles on the topic in the literature. The Internet can be your best friend during this step, Mohr says.

3. **Design data collection method and gather data.** Make a time line for collecting and analyzing the data and reviewing the literature, and identify who is responsible for completing these tasks.

4. **Measure best against own performance to determine gap.** Look at your internal results, national average results, and data from "the best of the best." Identify the "tension for change" by discovering how big your gap in performance is, Mohr says.

5. **Identify the best practices that produce best-in-class results.** Identify potential benchmarking partners and establish a collaborative learning relationship with them. Have some good information about your own processes before you get on the phone, Mohr says.

"The basic idea behind benchmarking is simple," Mohr says. "You want to ask yourself what you need to benchmark, how you do the process, how other people do the process, and who's doing it best?" ■

Managed care decreases demand for some services

Providers who assume outpatient services increase across the board as managed care increases should reconsider that assumption before using it as the basis for any business decisions, according to the Evanston, IL-based Sachs

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Group. The recently released sixth edition of *Outpatient Estimates,* which forecasts ambulatory utilization through 2002, shows that while the need for many outpatient services increases as a result of managed care, demand actually decreases for others.

Less use of EDs, more cardiac services

For example, Sachs estimates the national demand for emergency department visits could decrease 55% by 2002, while cardiac rehabilitation services could increase 38%. Forecasted increases in outpatient procedures reflect managed care's emphasis on preventive care as well as the initiative to provide services in the most cost-effective site. Other areas of increase include mammography and sigmoidoscopies.

The data take into account local market variations including demographics and insurance coverage. For example, bone density scans are forecasted to decrease 2% nationally, but increase 6% in the Chicago market.

For a copy of the report, which is built from more than 136 million claims and comprises 342 different procedure groups, contact: Sachs Group, 1800 Sherman Ave., Evanston, IL 60201. Telephone: (847) 475-7526. ▼

AHCPR releases new data file

The Agency for Health Care Policy and Research has updated it Medical Expenditure Panel Survey Web site (www.meps.ahcpr.gov) with a new public use MEPS data file. Now available for downloading is the full-year, person-level population characteristics and utilization data for 1996. Variables in this release include demographics, employment, health status, health insurance, and health care utilization.

The MEPS Web site also has several other recent releases that can be downloaded, including Health Insurance Coverage In America — 1996, Job-Based Health Insurance 1987 and 1996, Nursing Homes — Structure and Selected Characteristics, 1996, and Children's Health, 1996: Health Insurance, Access to Care, and Health Status. ▼

Data profile the uninsured in large metro areas

The Washington, DC-based Employee Benefit Research Institute (EBRI) recently released a data resource that profiles uninsured Americans in 22 metropolitan areas with populations of two million or more. EBRI used merged data from the Census Bureau's March 1995, March 1996, and March 1997 *Current Population Surveys* for the tabulations.

Findings include:

❒ **Midwestern and Northeastern metropolitan areas** tend to have lower uninsured rates than Western and Southern areas. The Detroit area had the lowest uninsured rate — 9.3% of its non-elderly population — and Houston had the highest — 30.1%.

❒ **Midwestern and Northeastern metropolitan areas** tended to have higher rates of private health insurance coverage compared with Western and Southern metropolitan areas. The Cincinnati area had the highest rate of private health insurance — 83.5% — and San Diego had the lowest — 58.7%.

Fact sheets on each geographic area as well as a state-by-state basis are available on the EBRI Web site at www.ebri.org. ■