

HOSPITAL PEER REVIEW®

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Special Report: Credentialing

Florida law foreshadows big change in credentialing for hospitals nationwide

Sunshine State mandates standard verification program for all providers

Your credentialing activities may be in for a sea change. Pay attention to what's happening in Florida, because "the eyes of the nation are upon us," in the words of **Lucy Gee** at the Florida Department of Health in Tallahassee. "They're watching to see how we do it. There are a lot of people who wish this had happened a long time ago."

On May 1, Florida's legislature enacted a statute that mandates a standardized credentials verification program for physicians.¹ Credentialing activities have increased significantly in the wake of health care reform, the law points out, and those increases have resulted in a wasteful and cumbersome duplication of credentialing activities among hospitals, medical societies, managed care organizations, and other entities. The statute, effective July 1 this year, is meant to alleviate duplication by providing a system for collection, validation, maintenance, and storage of physicians' core credential data within the State Department of Health.

Physicians are required to designate which private credentials verification entity (CVE) they want to use. Then they must submit their core credentials data — professional education, peer references, licensure, board certification, institutional affiliations, professional liability insurance, Medicare sanctions, and legal violations — to that company. Florida's statute mandates that all CVEs perform primary source verification of all credentialing information submitted to them. The department and designated CVEs will thereafter rely upon the accuracy of the data received from each other.

After submission of the data via a standardized application, physicians are responsible for providing corrections or updates within 30 days after any change occurs. If verified by a private CVE, the data are passed on to the Department of Health. Hospitals that employ or contract with the physicians must obtain credentials data on them from their designated CVEs or from the Department of Health. The new statute forbids a hospital from attempting to collect duplicate core credentials data from a

practitioner or a primary source if the information is already on file with the Department of Health or with any CVE. The statute shields Florida hospitals from liability for reliance on any data obtained from a CVE.

Sounds reasonable, right? But there's a rub, and not everyone is in favor of the new legislation. **Becky Watson**, CMSC, CPCS, president of Florida Association Medical Staff Services (FAMSS) and assistant to the senior vice president and chief medical officer at St. Vincent's Medical Center in Jacksonville, is one who questions the new statute's benefit to hospitals.

"For managed care companies, it's great because it meets their needs," says Watson. "For physicians, it's wonderful because they fill out one application, submit it to the state, and they're done at least until their situation changes. A uniform statewide application is a good idea, but what are hospitals going to get out of this?"

FAMSS has worked toward a central repository of practitioner information for four years. But Watson questions the kind of information hospitals are going to obtain from the repository. "Hospitals, too, want to get out of the duplicate credentialing business," says Watson. This is demonstrated by the fact that most health care systems have created central credentialing offices and come up with their own successful methods to reduce duplication. But, she says, hospitals need different types of information from that required by managed care companies, not only because the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, requires it, but also to avoid big payouts for negligent credentialing or risk-management issues.

"We credential *above* Joint Commission standards," says Watson, "and this legislation will not change that process." Managed care companies, governed by National Committee for Quality Assurance (NCQA) guidelines, only have to verify a physician's highest level of training — if the physician is board-certified, they only verify that. They don't have to go back to medical school, internship, residency, and so on.

"We verify everything about the physician from the time he or she completes medical school to the present — medical school, internship, residency, all the hospitals he's had privileges at, and several peer references," says Watson.

But won't the CVEs be providing all that information when the hospital asks for it? She says the new law does not specify the end result of the verification process. "Until we know what we

will be receiving from the private CVE or the Department of Health, hospitals cannot assess how beneficial this law will be for us."

Here's what could cause a problem for hospitals: Florida's statute requires that CVEs be nationally accredited. The Catch-22 here is that the Joint Commission does not accredit CVEs, but NCQA and the American Accreditation HealthCare Commission (AAHC), formerly known as URAC, do. CVEs are going to follow NCQA or AAHC requirements for gathering information. CVEs can state that they "are recognized by the Joint Commission," as does Professional Credential Verification Service in East Lansing, MI, but that's misleading because the Joint Commission doesn't accredit CVEs, Watson explains.

"If the CVEs are going to follow only NCQA or AAHC credentialing standards," she says, "their data won't meet the needs of hospitals. According to the new statute, we're going to have to purchase the data anyway. What we purchase will just be an unnecessary piece of paper to put in the file. Then we'll still have to credential as we usually do to satisfy Joint Commission standards."

Patrick Reymann, JD, an attorney with Buckingham, Doolittle & Burroughs in Akron, OH, and an expert on credentialing, agrees: "Florida's new statute may just be adding a step to a hospital's credentialing process.

"If that is the case," says Watson, "we'll see our costs for credentialing going up." CVEs charge \$100 to \$400 per report, depending on the amount of information they validate.

Will Florida's law affect other states?

How will this affect your job if you live and work outside Florida? "I think other states are going to follow this trend," says **Daniel Burton**, JD, an attorney with Foley & Lardner, a law firm with offices in Tampa. Florida's new legislation is not a new idea, he explains. Hospital systems have been internally centralizing their credentialing for years. When a physician has privileges at one hospital within a system, he or she can also practice at another hospital within that system.

"The legislation makes a lot of sense and will save time and money as long as it is judiciously applied. A lot of resources are expended by individual institutions duplicating core information from physicians, and that can be more easily done from a centralized location," claims Burton.

Watson says Florida's statute will have an impact upon other states even if they don't follow

suit right away. If the database is kept current, as mandated by the law, managed care companies in other states will realize the same benefit as Florida companies if they purchase the data from the private CVE. Hospitals also will have the benefit of the central repository of information, which will expedite their application completion process. But it remains to be seen whether the new verification process will benefit hospitals in other states, just as it remains to be seen in Florida. Reymann advises hospitals outside Florida to beware: They do not enjoy the same liability shield that Florida hospitals do.

Burton points out another factor connected to the new statute. Any time a state becomes a repository for personal records, he says, some fear that the state will use the information for other purposes not contemplated when the legislation was passed. "It may not be the case here, but it's something that can happen," he says.

Hospital Peer Review asked Watson if any other states have standardized credentialing statutes like Florida's. She says a few states have voluntary programs. Arkansas' program is administered through the state licensing board; Hawaii's is a joint venture between a local insurer and three major hospitals; Alaska's is run through the state's Medical Staff Services and credentials the majority of physicians in Alaska.

Reference

1. Florida 1998 House Bill No. 4515; 455.557. ■

Special Report: Credentialing

Beware of human error in CVE reports

'We must depend on ourselves'

Even though credentials verification entities (CVEs) are committed to using "due diligence" when performing primary source verification of credentialing information submitted to them, both **Linda Nash**, MD, medical director at Ingham Regional Medical Center in Lansing, MI, and **Patrick Reymann**, JD, an attorney with Buckingham, Doolittle & Burroughs in Akron, OH, say they are uncomfortable with the idea of a hospital relying on an agency for verification.

"You can't take anyone else's word that credentials are valid," Nash says. Even when everything else appears to be in order, "you have to go right to the source and verify information yourself." She advises that if you must delegate credential verification, be absolutely sure that your hospital and the entity to which you are delegating primary verification share a common understanding of what "primary verification" means. Look at the firm's policies and procedures spelled out in detail.

Fraud was caught by primary verification

Nash's meticulous work led to the apprehension of a fake doctor this past summer — a man who practiced medicine for more than 10 years despite the fact that he never went to medical school. The man faces charges of fraud, has been fined, and may have to serve time in prison for his actions. If it weren't for Nash's strict policy of not relying on others for credential verification, the man might have gone on treating and performing surgery on unsuspecting patients and exposing her facility to malpractice liability. Ingham Regional conducts annual audits of its credentialing process when staff review files to ensure thoroughness.

Hospital Peer Review asked Nash if she thought Florida's new statute mandating a standardized credentials verification program will be good or bad for states that adopt it. (See related story, p. 1.) "Knowing what I know now, if such a statute were in force in my state, I would insist on spot checking and running periodic random audits of the agency holding the information," she replies.

Reymann offers this warning: "The fact that the [Florida] statute mandates that CVEs do primary source checking doesn't mean every one does or will. You have to allow for human error." When a physician moves from hospital A to hospital B, the information supplied by hospital A should be accurate. "But if I were the lawyer for hospital B," Reymann says, "I'd say to my client, 'I'm nervous about your relying on that information. If they've done their job, great. But if not, what's your liability?'" The Florida statute shields hospitals from liability for reliance on any data obtained from a CVE, but how narrow is the information coming in, and how good is it?

"What about the information that's *not* in there?" asks Reymann. "The hospital gets immunity if it relies upon information it gets, but is the

JCAHO insists on primary verification

Choose your CVE with care

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, determined late in 1995 that the American Medical Association's (AMA) Physician Masterfile adequately addresses the "Principles for Users of External Agencies for Primary Source Verification of Credentials," and therefore that its use meets Joint Commission primary source verification requirements set forth in the Medical Staff standards of the *Accreditation Manual for Hospitals*.

The *Manual* now states that "at the time of appointment and initial granting of clinical privileges, the hospital obtains verification of relevant training or experience from the primary source, whenever feasible. . . . Information from credentials verification organizations (CVEs) such as the Physician Masterfile may also be used."

Then, in MS 5.4.3.2, it states, "The hospital

is also encouraged to consider additional information . . . from other sources [that] may provide . . . information that is new or that may flag an inconsistency when compared with the individual's application."

Under Intent, the document states that "hospitals may use an external agency . . . to collect information from primary sources provided that the agency also furnishes the hospital with any additional information from the primary sources." Under Example, the document lists eight principles for evaluating CVEs.

The AMA's Physician Masterfile contains credentials on all American physicians (more than 805,000 physicians), not just members of the AMA, and DOs are included. The listing contains primary source-verified biographic and demographic information, including medical education and residency training, licensure status, federal Drug Enforcement Administration registration, American Board of Medical Specialties' board certification, and other core data. The file also provides an alert of all final licensure disciplinary actions and sanctions by the Department of Health and Human Services. The AMA charges \$15 per physician for the information. ■

information complete? Can I feel comfortable that the first hospital knows about all the doctor's malpractice cases? How broad is the immunity?"

Reymann says the same goes for reliance upon the National Practitioner Data Bank (NPDB). He strongly advises against any hospital relying fully on information found there. "Hospitals don't report everything, and things do get fudged," he says. "Hospitals should do their own independent review, because the NPDB doesn't give them any statutory immunity. The data bank is no more than a source of information."

Reymann says he's skeptical about any single-source verification system. "I don't have a problem with eliminating redundancy — that's what the AMA is trying to do with its program too — but I would rather the system were dealing with general qualifications for medical staff membership, such as where the physician went to school, whether he or she is licensed in the state, whether he or she has DEA [federal Drug Enforcement Administration] registration, even whether he or

she has had disciplinary actions by the state. Those are points of information that it would be great to have in one place — the basic 101 of credentialing." But when you get into other people's opinions of a doctor's clinical ability and judgment, no bank can tell you that, he says. "A data bank cannot be wholly comprehensive for the entire credentialing process. All it can do is give objective outside data."

In Reymann's opinion, the further there is a movement away from general qualifications in the credentialing process, the less relevant the databank is. "I'm not comfortable with a hospital relying on anyone but itself for information. Reliance upon the centralization of information makes me back-check to ask where it comes from and how broad a net was cast."

Hospital Peer Review asked the attorney if hospitals outside Florida enjoy the same liability shield as do Florida hospitals. "Florida cannot give another state immunity," he says. "Outside entities can access information, but they can't get immunity." ■

Special Report: Credentialing

Tougher standards are coming your way

16,000 incompetent doctors slipped through cracks

New competency requirements might be in the wind for your organization. A recently issued report by the Pew Health Professions Commission at the University of California in San Francisco recommends stronger regulations and more frequent skill tests for doctors to protect the public from incompetent doctors and health care workers.

The commission would like to see doctors prove their competence throughout their careers, not just when they get their license to practice. It wants boards to be more accountable in certifying specialists, and states to implement nationally uniform scopes of practice for all the professions. Minimal standards, states the report, have served only to make certain that the most egregiously incompetent professionals are prohibited from practicing.

“The report has been released,” says **Elizabeth Lynch**, spokeswoman for the Center for the Health Professions at the University of California, San Francisco. “We’re doing our best to promote it within the regulatory and policy-maker communities that would be interested. Beyond making recommendations, there’s not a specific time line for them to be implemented. We hope they will be implemented, but that’s not something we can ensure.”

The Pew report cites a recent Rand Corporation document that found “large gaps between the care that people should receive and the care they do receive.” It also cited a Public Citizen annual survey of doctors who have been disciplined for incompetence, crimes, negligence, and over- or underprescribing drugs. This year the survey named more than 16,000 doctors and said this was only a small percentage of the true number of incompetent doctors.

The Commission’s recommendations are a mix of policies demanding changes at the state, federal, and private-sector level. Other recommendations include:

- requiring individual professional boards to be more accountable to the public by significantly increasing their public members (the Commission recommends that public members make up at least one-third of each board’s membership);

- requiring states to regulate practitioners to demonstrate their competence in the knowledge, judgment, technical skills, and interpersonal skills relevant to their jobs throughout their careers;

- having states require policy oversight and coordination of professional regulation through consumer-dominated boards or central agencies;

- having Congress establish a national policy advisory body that would research, develop, and publish national scopes of practice and continuing competency standards (the body would be required to develop uniform standards of practice authority, including model legislation for use by individual states);

- having states require boards to provide relevant information about health care practice licenses to the public in a comprehensible manner;

- having states develop alternative mechanisms for existing professions to resolve their scope-of-practice disputes until national models can be developed and adopted;

- having Congress enact legislation that facilitates professional mobility and practice across state boundaries;

- having states enact and implement scopes of practice that are nationally uniform for each profession and based on the standards and models developed by the national policy advisory body;

- requiring states to provide the resources necessary to adequately staff and equip all health professions’ boards to meet their responsibilities. ■

Special Report: Credentialing

Federal databases are increasing in number

NPDB, HIPDB collect different data

The concept of a centralized database is attractive to many credentialing experts, and a state repository may be a step toward a comprehensive national system. The goal of Florida’s legislation centralizing credentialing, says **Lucy Gee** at the Florida Department of Health in Tallahassee, “is to get practitioners out from under their redundant paperwork. The state is the repository of the credentialing data, and anyone requiring the information need not go to the practitioner, but to the state.” (See related story, p. 1.)

Comparison of the NPDB and HIPDB

National Practitioner Data Bank

Who reports?

- Medical malpractice payers
- Boards of medical examiners
- Other state licensing boards
- Professional societies with formal peer review
- Hospitals and health care entities

What information?

- Medical malpractice payments
- Adverse licensure actions
- Revocation
- Suspension
- Reprimand
- Censure
- Probation
- Surrender
- Adverse clinical privilege action
- Adverse professional society membership actions

Who can query?

- Hospitals
- Other health care entities
- Plaintiff's attorney
- Practitioner (self query)
- Researcher
- Boards of Medical Examiners
- State licensing boards

Healthcare Integrity and Protection Data Bank

Who reports?

- Government agency
- Department of Justice
- Department of Health & Human Services
- Any other agency that administers or provides payment of health care
- State law enforcement agencies
- State Medicaid fraud control units
- Federal/state agencies responsible for licensure/certification of health care providers, suppliers, and practitioners
- Health plans

What information?

- Licensure and certification actions taken against providers, suppliers, and practitioners, including
 - Revocation
 - Reprimand
 - Censure
 - Probation
 - Suspension
- Any other loss of license
- Any other negative action or finding that is publicly available information
- Civil judgments
- Criminal convictions
- Exclusion from federal/state health care program
- Other adjudicated action or decision

Who can query?

- Federal/state government agencies
- Health plans
- Health care provider (self query)
- Health care supplier (self query)
- Health care practitioner (self query)

Because the federal government employs many health care providers, its personnel spend much time and effort on credentialing. All facilities use standards of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, in their processes, and primary source verification is repeated each time a provider applies for membership and privileges at another institution. Duplicated staff time and fees are a waste of resources and tax dollars, and the current system is notoriously slow. Procedures are being

developed to permit reciprocal sharing of a credentialing process via access to a centralized database. Demonstration projects are in place in New Mexico, Alaska, and the District of Columbia. It is hoped that linkage of information will:

- promote interagency sharing and national readiness;
- assist in current efforts to establish networks of health care facilities;
- facilitate the establishment of telemedicine initiatives that cross agency or state boundaries.

Already in place is the National Practitioner Data Bank (NPDB), which only contains records on physicians who have had adverse actions taken against them by state medical boards, professional societies, and health care entities, or have had professional liability judgments, settlements, or awards since September 1991. The Health Care Quality Improvement Act originally required eligible entities to report to the bank information regarding medical malpractice payments and adverse actions against physicians.

Two years ago, Medicare and Medicaid sanction information was incorporated into the database. The information collected in the NPDB is considered confidential and is released only to eligible querying entities (for a fee) and to practitioners who wish to see what information is there on themselves. Practitioners may not change the information that has been reported. However, if they believe a report contains inaccurate information, they may dispute the report, add a statement to the report, or both. The NPDB is managed by the Federal Government's Division of Quality Assurance in the Department of Health and Human Services.

HIPDB info not available to general public

What may not be so familiar to you is the new Healthcare Integrity and Protection Data Bank (HIPDB). The Health Insurance Portability and Accountability Act of 1996 led to its creation. Still in its infancy, HIPDB will be a national health care fraud and abuse data collection program for reporting and disclosure of final adverse actions taken against providers, suppliers, or practitioners. Primarily a flagging system, information from the HIPDB will be available for a fee to federal and state government agencies, health plans, and — via self-query — to providers, suppliers, and practitioners. HIPDB information will be not available to the general public and will be considered confidential. (See **table listing who reports what information to the NPDB and HIPDB and who can query the data bank, p. 6.**)

Vivian Chen, ScD, MSW, associate director of policy at the Division of Quality Assurance, says hospitals are ineligible for HIPDB as *Hospital Peer Review* goes to press simply because of an oversight in the legislation. The regulation was open for public comment until late December, so that situation may have been changed by the time you read this article.

“What sets HIPDB apart from the NPDB,” Chen says, “is that HIPDB will contain more than peer review actions. It will include criminal convictions and judgments, as well.” Data will include state and federal licensure actions not limited to quality issues. “That data is given now in the NPDB as a service, but it's not officially a part of that legislation,” she says.

The Federation of State Medical Boards' Action Data Bank provides information only on those physicians who have been disciplined by state medical boards.

(Editor's note: See www.hrsa.dhhs.gov/bhpr/dqa/fedcred.htm and www.hrsa.dhhs.gov/bhpr/dqa/hipmain.htm on the Internet for more information on federal credentialing initiatives. The AMA's Web site, www.ama-assn.org, contains information on the organization's credentialing products.) ■

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P_{ra} Plus screens for risk of repeat admissions

Consider this tool for your elderly patients

A survey tool developed recently at the University of Minnesota School of Public Health in Minneapolis may prove useful to you. The P_{ra} Plus determines older patients' risk of repeat hospitalization and comprises a screening questionnaire and a formula for deriving a risk score. It identifies older patients who may benefit from interventions designed to avert health crises and the need for expensive care.

Organizations determine the thresholds for risk categories according to the level of risk they wish to identify. For example, it is known that people with P_{ra} Plus scores of 0.5 or greater have twice the hospital days and costs of those with scores below 0.5. Accordingly, an organization using P_{ra} Plus could select 0.5 as its threshold for high risk. Different populations are stratified into different percentages of high-, moderate-, and low-risk people. About 7% of general elderly populations and 18% of Medicaid elderly populations have P_{ra} Plus risk scores of 0.5 or higher.

Thresholds for risk categories can be established using either of two methods:

- **risk-driven** — preselecting a risk score as the cutoff for further intervention;

- **resource-driven** — selecting cutoffs based on the number of enrollees that can be served in light of the resources the institution is prepared to devote to a given intervention. This is more pragmatic and helpful in allocating limited resources.

For example, consider this scenario for a resource-driven threshold method: An organization wishes to provide a high-intensity case management program to its highest-risk senior patients, and its budget allows for 10% of its members to receive the benefit. In addition, the budget would allow a lower-risk additional 25% of its members to take part in targeted prevention and health promotion programs. To establish thresholds for the high-, moderate-, and low-risk categories using the resource-driven method, the organization would first administer the screening questionnaire to its entire elderly population. The 10% of members with the highest risk scores would be classified as high risk and would enter the high-intensity case management program. Those scoring in the 65th to 90th percentile would constitute the moderate-risk group and qualify for the less intensive interventions.

Questions in the instrument deal with age, gender, state of health, state of mind, living conditions, ability to take care of oneself, and financial status. Answers to questions 1-6 and 16-17 in the questionnaire are used to calculate the P_{ra} Plus risk score. Answers to questions 7-15 are optional and provide a bridge to the assessment process as well as information useful for the medical record. They also may result in a patient being classified into Medicaid and institutional rate cells, leading to higher Medicare reimbursement.

The tool can be understood by respondents with an eighth-grade education and can be administered in person, by telephone, or by mail. It takes about seven minutes to fill out. Licensing fee for P_{ra} Plus is \$500 per year. For more information, contact **Lynette Sylvain** at the Center on Aging at the University of Minnesota at (612) 625-8954.

Related Reading

Pacala JT, Boulton C, Reed RL, et al. Predictive validity of the P_{ra} instrument among older recipients of managed care. *J Am Geriatr Soc* 1997; 45:614-617.

Boulton C, Pacala JT, Boulton LB. Targeting elders for geriatric evaluation and management: Reliability, validity, and practicality of a questionnaire. *Aging Clin Exp Res* 1995; 7:159-164. ■

Health care spending slows; up 4.8% in 1997

Both public and private spending decrease

Health care spending in the United States rose only 4.8% in 1997, the slowest increase in almost 40 years, according to a new report released by the Health Care Financing Administration (HCFA) in Baltimore. Spending totaled \$1.1 trillion, with average per person spending at just under \$4,000. HCFA's longer-term estimates, however, project spending to grow more rapidly in the coming years.

The report shows that the gap between spending paid for by public and private sources inched closer in 1997, continuing a trend that began in 1990. Private funding paid for a little more than half of health care — \$585.3 billion — down from nearly 60% in 1990, while public programs, including Medicare and Medicaid, paid for 46.4% in 1997, up from 40.5% in 1990. (See pie charts showing where funding came from and where it went, p. 13.)

The overall slowdown in spending has been driven largely by rapidly falling growth in private spending, which reached an all-time low of 2.3% in 1994. In addition, the rate of spending from public funding sources (Medicare and Medicaid) has slowed since 1994, contributing to lower overall spending growth.

Total Medicaid spending increased only about 4% in 1996, to \$160 billion, the slowest growth since Medicaid's inception nearly 30 years ago. Preliminary data suggest the slowdown also can be attributed to decreases in enrollment in the past three years.

In 1997, Medicare financed \$215 billion in health care spending for its 38.4 million aged and disabled enrollees. However, annual Medicare spending growth slowed from 12% in 1994 to 7% in 1997. This reduction reflects four influencing factors:

- a slowdown in medical price increases;
- the impact of legislation intended to reduce the growth in Medicare provider payments;
- changes in provider practices due to fraud and abuse enforcement activities;
- a small but steady decline in the growth of the overall Medicare population.

(Continued on page 13)

Discharge Planning Advisor

— the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

'Perfect' case management setting found in county's 'closed' system

Program stresses education, wellness, primary care

An innovative case management program at the University of Texas (UT) Health Science Center in San Antonio might never have gotten under way if **Raje Wolf**, RN, BSN, CCM, hadn't been involved in building a house.

Hired by UT to help with its managed care contracts, Wolf became interested in looking at how the entire care delivery system of Bexar County might be changed for the better. Inspired by what she was going through in her own life at that point — a house-building project — she drew a model of the integrated delivery system she envisioned.

"I had drawn a house with pillars, with education as the foundation, and I made it look nice, with lots of colors," says Wolf, director of integrated clinical services for the UT Health Science Center, which is UT's medical school. "I'm in my office with this picture on the wall, and a doctor comes by and asks, 'What is that?' He got excited over the house I had built."

That University of Texas physician, who happened to be senior vice president of medical management, became the champion of Wolf's brainchild. Wolf says she is now involved in "building a road map for case management."

The Bexar County setting, she explains, is perfect for designing a case management program because it is a closed system. Members of the University Physicians Group, a division of the University Health System, are the only

physicians that serve Bexar County Hospital, she adds. "We don't have full-continuum case management, but you couldn't ask for a better place to have it."

The county is feeling the financial crunch of providing health care to an aging population with a high incidence of chronic illness, Wolf says. Complicating the situation is an influx of patients from medically underserved areas in south Texas and Mexico, she notes.

"[Health care] is not globally managed, and it's very difficult to afford spells of illness, very expensive," Wolf adds. (See related story on how the case management program will be financed, p. 10.) It's also not the best approach for the patient, she points out. "The new program will look at the patient as a whole, put the patient in the center and have things focused on them. In the past, the payers or the physicians were seen as the main event. This is a patient-centered case management model."

The case management "house" that Wolf designed has three "pillars": primary care case management, disease state management, and a wellness program. She explains the pillars as follows:

- **Primary care case management.**

The primary care case managers are nurses who are attached to physicians at various ambulatory sites. The physicians in turn are attached to patient populations who are part of that physician's roster no matter where they go.

These primary care case managers will follow

Financial burden eases for taxpayers, indigents

When the University of Texas Health System and Bexar County designed a case management program for the county's 200,000 residents, the idea was to provide the best possible health care at the lowest possible cost, says **Raje Wolf**, RN, BSN, CCM, director of integrated clinical services for UT's medical school.

"Financially, there was no way not to do this," says Wolf, who designed the program after being hired by UT to help with its managed care contracts. "The goal is to make sure people get preventive health care, quality health care that will impact chronic illness trends."

Since less than 10% of the population uses 55% to 60% of health care resources, managing catastrophic patients serves not only the indigent county residents who receive preventive care, but taxpayers and the medical school as well, she notes.

The new integrated delivery system is supported financially by a managed care model called Carelink, Wolf explains. Federal funding is based on money spent previously caring for

the county's uninsured population. "There is a capped amount of money, so the issue is how to effectively manage with X dollars. Historically, they've treated whoever comes into the ED."

If patient stays and chronic illness costs are reduced, there is money available to care for more people, she notes. "If we optimize the ambulatory care setting, hopefully we'll get people in a healthier state. It's a re-education of the population."

To participate in Carelink, an individual must be a resident of Bexar County and must sign up. Members pay a monthly fee on a sliding scale based on income. The program is not limited to the indigent, she notes. "Some attorneys with two-person staffs are on this plan, but their monthly rate is much higher than someone who works at Burger Barn. "An employee of, say, a mom-and-pop carpet company might participate if he or she can't afford the insurance the company offers, Wolf adds.

The county hospital will only provide health care to non-members in emergency cases, she notes. "Resources are scarce and we can't continue to do that. If so, we end up with just emergent care. We have to optimize the ambulatory setting or we end up with severe losses on the inpatient side." ■

patients wherever they go, not just for inpatient and ambulatory care. They will serve young patients who live in "medical homes" with around-the-clock nursing supervision because their parents can't manage their care at home. They will be available if a school is having trouble giving medications to a student in situations where the home and school are not in communication about a member's needs or if a member has on-the-job needs.

"These nurses are ambulatory-based, but when patients are admitted, they will follow them," Wolf explains. "They will go into the hospital, see the patient, look at the chart, see that appropriate supplies such as durable medical equipment and ancillary services like physical therapy are available. They will be responsible for utilization review, discharge planning, and case management."

Each nurse will have a caseload of between 7,000 and 7,500 members, distributed among five categories: well, well with risks, acutely ill,

chronically ill, and terminally ill.

A skeleton staff of utilization management nurses will be posted at the hospital to communicate with payers. They will also be on call to fill in for the ambulatory-based nurses and vice versa.

Under the UT plan, some subspecialists, such as pediatricians, internists, and family practitioners, will serve as primary care physicians (PCPs). The physicians who staff the system's HIV clinic will function as PCPs for their patients.

- **Disease state management.**

The first step of this aspect of the program will be to look at the Bexar County patient population to determine what the disease systems are and where the county is spending its money. Once the county decides where to put disease state management, handling of the various disease states will be aligned with the corresponding departments at the UT medical school.

Some obvious choices are asthma, cardiovascular disease, and diabetes, Wolf says. "Diabetes is

really No. 1 here because of the Hispanic population, and pollution is causing an increase in asthma. The emergency department [ED] is loaded with folks not taking their medications properly.”

When primary care case managers identify patients who need extra attention, they will refer those cases to the disease state managers. These managers will be aligned not only with disease processes, but with subspecialties as well.

“If the primary care case managers identify a patient who needs a transplant, they will pass that patient to the transplant case manager,” she notes. This category is needed because San Antonio is one of three transplant centers in Texas, Wolf adds.

- **Wellness program.**

One of the advantages of having the county hospital as the medical school’s delivery system is that the approximately 500 physicians in the University Physicians Group have the same patients all the time, she points out. “We have the grandparents, the parents, and the children, unlike other insurers and managed care companies who don’t have the luxury of a captive audience,” Wolf notes.

As part of the new program, she says, case managers will identify wellness states for this captive population of more than 200,000 members. The focus will be on ensuring patients with, for example, new-onset diabetes get referred for education, and members are reminded it’s time for an immunization or a mammogram, Wolf adds. (See related story on outcomes management, at right.)

Education is the foundation

As the “foundation” of her case management house, education — of patients *and* caregivers — is a huge piece of the program, she says. “It’s important that bedside nurses or other caregivers be able to refer patients to case management,” Wolf stresses. “For example, if a licensed practical nurse realizes that a patient has been in the ED five times in the past few months, this should be a red flag that something is going on.”

It is important, she says, that caregivers have the mechanism to make these referrals, and enough autonomy to be a real help to physicians. “They must look at the patient from a total perspective — psychosocial factors, environment, the whole gamut.”

Educating health system members is equally

Patient outcomes will determine effectiveness

To determine whether the interventions of its new case management program are making a difference, the integrated delivery system of Bexar County, TX, will use integrated outcomes management, says **Raje Wolf**, RN, BSN, CCM, director of integrated clinical services for the University of Texas medical school, which helps oversee the program.

“Documents will be realigned so that everyone is consistently tracking the same things,” Wolf says. “We will put data in to determine if we altered disease states at all. We’ll look at whether people are getting their immunizations. What are the immunization rates for children between [ages] X and Y? Maybe we can bump up the immunization rate for Bexar County.”

This effort may include putting up notices in Spanish and having clinic staff remind parents that a child is due for an immunization, she notes. “Mail-outs are not effective here because many people don’t read or don’t have a regular address. This situation requires a certain level of creativity.

“A lot of times it will involve financials,” Wolf adds. “How much are we able to save by getting somebody involved in chemotherapy before he’s in total dire straits? And if we’re able to identify [the disease] in an earlier state through routine screens and physicals, there’s a better quality of life.” ■

challenging, Wolf says. “We have to have educators everywhere, not only for specific disease states,” she adds. “We’ll have a person in the ED for member service. If someone is waiting six hours with a sore throat, this person will say, ‘I would really like to help you with this. Can I get the physician on the phone for you to make an appointment?’”

One of the toughest parts of setting up the program has been getting staff buy-in, Wolf notes. “When you look at the big picture, it seems so clearly the thing to do, but when you talk to people, they go through these phases,” she adds. “There’s a perceived loss of power, and then, ‘Why should we change? We’ve been doing it this

way for so long.”

Some of the resistance, Wolf notes, has been from people directly involved in utilization management at the hospital and from the social work department. Talk of redesigning those departments, moving the emphasis from the inpatient to the ambulatory side, made people unsure about the security of their jobs, she says.

Thinking about the system as a whole

“Promoting an ambience of open dialogue and communication was essential,” Wolf says. “People have to be able to express their feelings and concerns, and we have to effectively answer their questions. We let them know we were not talking about losing jobs, but about doing something different. It helps to encourage them to think about the system as a whole — the cause-and-effect of what we do.”

To facilitate the program’s continuum-of-care design, patient care committees will meet regularly, Wolf says. “We’ll have physicians dialoguing about who is in the hospital and what’s going on with critically ill patients or with those who have special issues. They may need education, they may be having problems at home, they may need a referral to a psychologist.”

Physicians and primary care case managers will attend the meetings, which will be held at least weekly and maybe daily, she says. “We’ll need to make sure faculty, not just residents, are present at the meetings, but we’ll need residents to participate as well.

“Disease state managers will have similar meetings, but they will be called interdisciplinary team conferences,” Wolf adds.

While the new program will focus on realignment of current staff more than adding personnel, the program still is looking for about 35 new primary care case managers to get things going. Some of those positions will be filled by existing staff, but other UT nurses may elect to continue working on specific research projects for certain physicians, Wolf adds.

Those who do participate in what she calls patient-focused case management will find it a fulfilling experience, she predicts. “This type of case management is very satisfying. You’re looking at the whole patient — not just at finances — and it’s an opportunity to use your talents, to look at patients more globally. People who are certified in case management have a lot of things we can do.” ■

70% of octogenarians suffer dual chronic illness

Health insurance doesn’t guarantee access to care

Roughly 70% of Americans over 80 have at least two coexisting chronic conditions, such as arthritis and diabetes, according to **John Wasson, MD**, of Dartmouth (NJ) Medical School. And all too often, the needs of these patients are not adequately being met.

The 80+ Project, which Wasson heads, gathers information on this growing segment of the population to give providers and case managers the information necessary to improve quality of care for the elderly.

In one recent article, researchers with the 80+ Project examined the extent to which health system encounters addressed patient’s needs.¹ They conducted a telephone survey of 834 randomly selected members of a New England health system. Respondents reported frequent contact with the health care system. Researchers found:

- 93% had seen a doctor in the last six months.
- Roughly 20% had been hospitalized in the preceding six months.
- Roughly 20% had used home health services in the preceding six months.
- 97% of respondents had a primary care physician who was a generalist.
- 10% reported trouble getting care or delays in care due to cost barriers.
- 22% reported structural barriers to care, such as getting an appointment.
- Of the 25% of respondents who reported having at least one of nine common geriatric problems, such as diabetes, 23% reported they had not received treatment for those problems.
- 24% reported financial difficulties.
- 25% reported problems with activities of daily living.

The researchers found that having health insurance, a regular source of health care, and a generalist physician as a primary care provider were not enough to ensure elderly people received access to effective health care.

Reference

1. Bierman A, Magari ES, Jette AM, et al. Assessing access as a first step towards improving the quality of care for the very old. *Journal of Ambulatory Care Management* 1998; 21:17-26. ■

In 1997, personal health care expenditures reached nearly \$970 billion, 89% of overall health spending. While spending on hospitals and physicians usually accounts for the majority of personal health care expenditures, the percentage being spent on these services has been declining and is offset by increased spending for home health and other health care services. The largest increase has been in the costs of prescription

drugs, which have risen at double-digit rates during the past few years.

Expenditures for hospital care accounted for nearly 40% of personal health care spending and were the slowest-growing service, increasing only 3% to \$371 billion in 1997. Spending for physician services increased 4.4% in 1997, continuing a trend of single-digit growth started in 1992.

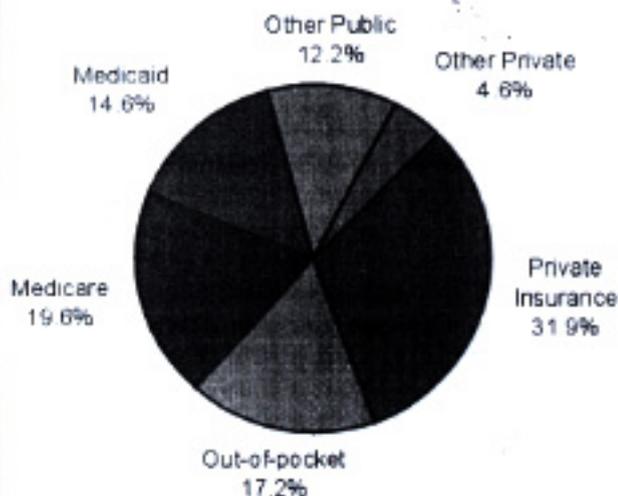
Of the \$585 billion spent by private sources for health care in 1997, about 60% (\$348 billion) was paid by private health insurance premiums. The slowdown in premium growth in the 1990s can be attributed in part to the move from more expensive fee-for-service health plans into managed care. In 1997, 85% of the insured work force was in some type of managed care plan.

Medicare spending grew 4% faster than private health insurance (7% compared with 3%) in 1997. When examined on a per enrollee basis, Medicare and private health insurance benefits have actually grown at comparable average annual rates from 1969 through 1997 — 10.4% and 11.4% respectively. The average growth in private health insurance per enrollee spending slowed between 1994 and 1996, while growth in Medicare per enrollee spending continued. In 1997, Medicare per enrollee spending grew 6%, compared with 4% for private health insurance.

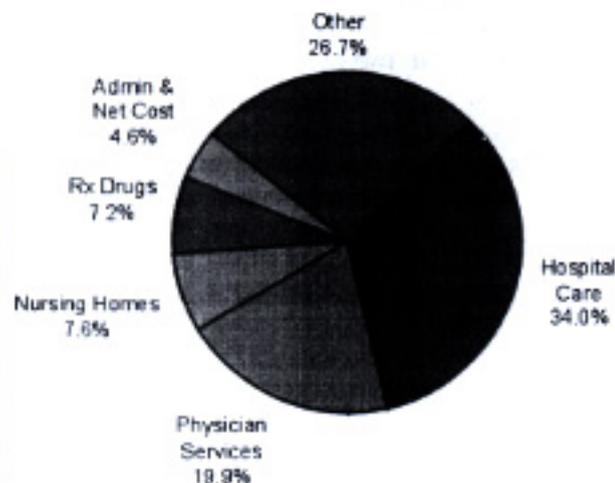
While growth in health care expenditures over the last few years has remained slow, HCFA projected last fall that growth in public health spending over the next 10 years will nearly double, reaching \$2 trillion in 2007. ■

The Nation's Health Dollar: 1997

Where It Came From



Where It Went



Note: Other includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction.

Source: Health Care Financing Administration, Baltimore.

Decision support systems may improve quality

Studies show beneficial effect on docs' performance

Computerized clinical decision support systems, which match patient-specific characteristics to clinical information databases, can reduce hospital errors and cut costs, according to three recent studies. **Dereck L. Hunt, MD**, and colleagues at McMaster University in Hamilton, Ontario, Canada, reviewed 68 trials that evaluated various systems between 1974 and 1998. About two-thirds of the trials showed that the

systems had a beneficial effect on physician performance.¹ The trials included studies on drug dosing, diagnostic aids, and preventive care.

David W. Bates, MD, of Brigham and Women's Hospital in Boston, and colleagues evaluated a system designed to monitor the ordering, administration, and dispensing stages of drug administration at a large community hospital.² The researchers compared the number of nonintercepted serious medication errors made during the six months before the system was introduced with those made during the nine months following its introduction. The number of medication errors dropped 55% after the system was introduced. By preventing drug administration mistakes, the system could save between \$5 million and \$10 million annually, the investigators estimate. The decision support system there cost \$1.9 million to install and costs \$500,000 per year to operate.

System projected to save \$3 million annually

Robert A. Raschke, MD, of Good Samaritan Regional Medical Center in Phoenix, evaluated a smaller, less sophisticated program that alerts physicians to clinical situations with increased risk for adverse drug event-related injury and concluded the program can prevent hospital errors and save money.³ During a six-month trial period at a 650-bed teaching hospital, the system alerted physicians to nearly 600 potential errors, according to the researchers. Because the average preventable adverse drug event adds nearly \$6,000 to the cost of hospitalization, as much as \$3 million might be saved annually, write the investigators.

The investigators caution that, given variations in the quality of decision support systems and the rapid pace of technological improvement, hospitals should evaluate different systems carefully before adopting them.

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2. Raschke RA, Gollihare B, Wunderlich TA. A computer alert system to prevent injury from adverse drug events: Development and evaluation in a community teaching hospital. *JAMA* 1998; 280:1,339-1,345.
3. Hunt DL, Haynes RB, Hanna SE. Effects of computer-based clinical decision support systems on physician performance and patient outcomes. *JAMA* 1998; 280:1,360-1,361. ■



Look at comparative data with an eye toward quality

Distinguish between expected, unexpected variation

By **Patrice Spath, ART**
Brown-Spath Associates
Forest Grove, OR

Most health care organizations are involved in local, regional, or nationwide comparative performance measurement initiatives. Gathering data for these projects can be time-consuming. Nonetheless, significant quality improvement benefits can be achieved if the data are used wisely.

Quality management professionals play an important supportive role in helping caregivers interpret comparative results and initiate improvement projects. The data-gathering exercise will be futile if the recipients of the information don't know how to apply the new knowledge that can be gained from the comparative results that periodically arrive in the mail.

The data provided by a measurement project illustrate your facility's performance measure rate for each indicator and compares your rate to that of other project participants. **A typical comparative report is shown in the chart on p. 15.** In this report, the primary cesarean rate at fictitious Memorial Hospital is being compared to a peer group of facilities. The actual rate for Memorial Hospital is represented by the line that appears to the right of the bar. The average rate for all hospitals is represented by the line that appears to the left of the bar. The bar represents the spread of cesarean rates that fall within two standard deviations from the mean each quarter. Many measurement project administrators provide standard deviations for the data set either graphically or numerically. This allows providers to see how their rate of performance compares to the peer group.

To understand how to react to comparative data like this and see how these data can assist in your performance improvement efforts, it is important to first discuss the concept of process variation. A process is a series of interconnected

and interdependent performance steps. These are the steps taken by health care professionals as they perform their daily patient care activities. In most instances, the processes performed by individual providers are interrelated with those performed by another provider — where one process ends, another begins. Thus we have health care systems, which merely are a network of interconnected and interdependent processes designed to achieve a specific goal.

The numbers presented in any comparative performance measurement project represent the output from a system of interrelated processes in your hospital. For example, if a patient develops bacteremia during her hospital stay, a series of patient care activities occurred, and the end result was an infection. A measure of your nosocomial infection rate tells you the number of infections that result from the “way you do things” at your hospital. This includes the processes performed by nurses, physicians, operating room technicians, housekeeping, and so on. All processes have some sort of variation inherent in them. For example, the manner in which nurses prep patients for surgery will vary slightly from one day to the

next. Process variation is also related to the unique types of patients treated in your facility each day. Because variation is inherent in all processes and systems, you should expect to see fluctuations in your indicator data.

Health care providers must learn to distinguish between an *expected* level of variation and an *unexpected* level of variation. An expected level of variation would be judged due to *common causes*, and unexpected variation would be due to *special causes*. At a minimum, the presence of special-cause variation requires investigation and resolution. However, the organization also may choose to reduce common-cause variation through initiation of a performance improvement project.

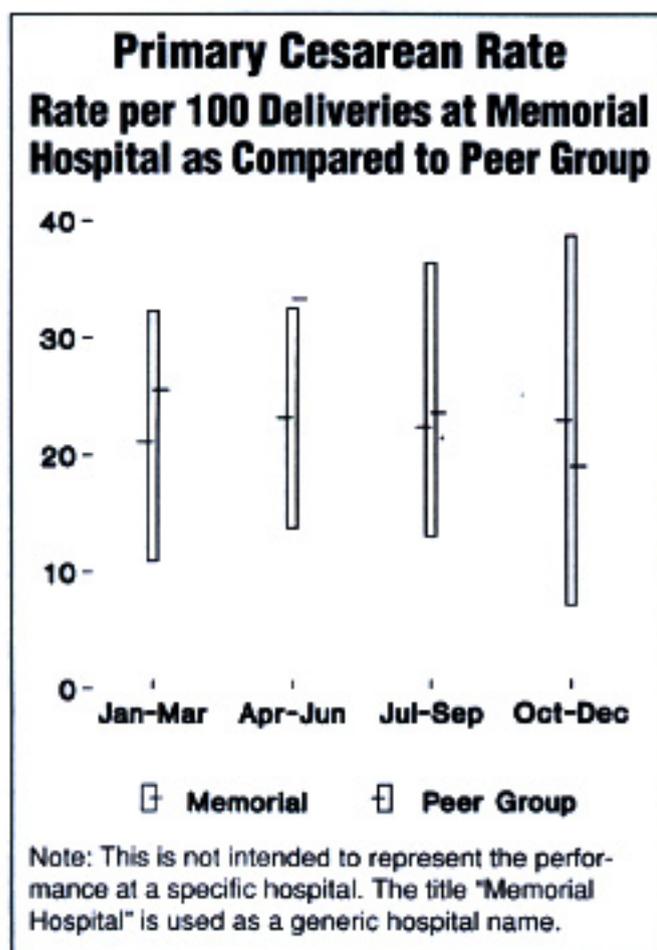
What is the extent of process variation?

For each performance measure, your rate is compared to the rate reported by other hospitals. A standard deviation is usually calculated for each indicator, and you are shown where your performance falls in relation to the standard deviation. Many organizations begin an analysis of the cause of variation when the data show them to be 2+ standard deviations (above or below) from the mean rate. By definition, if you are two standard deviations from the mean there is only a 5% chance that the result is due to common-cause or *random* variation. Conversely, there is a 95% chance the result is statistically significant. If your rate varies more than two standard deviations from the mean, this would be considered an unexpected or special-cause variation that requires further investigation. Such an investigation should have taken place at Memorial Hospital when they discovered that their cesarean rate for the months of April through June was more than two standard deviations from the mean for all facilities.

Because most providers will rarely fall two standard deviations away from the mean for any indicator, some hospitals consider using 1.5 standard deviations from the mean as a starting point for further investigation. At 1.5 standard deviations from the mean, there is only one chance in 10 that the result is due to chance or random variation. Conversely, there are nine chances in 10 that the result is statistically significant.

When a hospital identifies itself as varying 1.5 or 2 standard deviations from the mean for any performance measure, the following common set of actions should be taken:

- **Confirm the accuracy of the data submitted to the project coordinator.**



— Verify the numbers in your internal database.

— Verify the numbers from your abstract sheets or other input documents against the values on the comparative report.

- **Review the data definitions for the indicator.**

— Verify that the data you collected complied with the approved data definitions found in the project's data dictionary.

— Discuss your data definitions with other hospitals in your peer grouping, call the project coordinator to verify your definitions, and discuss the definition with the people coding or abstracting the data in your hospital.

If you find data quality problems to be the cause of the variation, stop your analysis at this point and resubmit corrected data to the project headquarters (or proceed as advised by the measurement project coordinator).

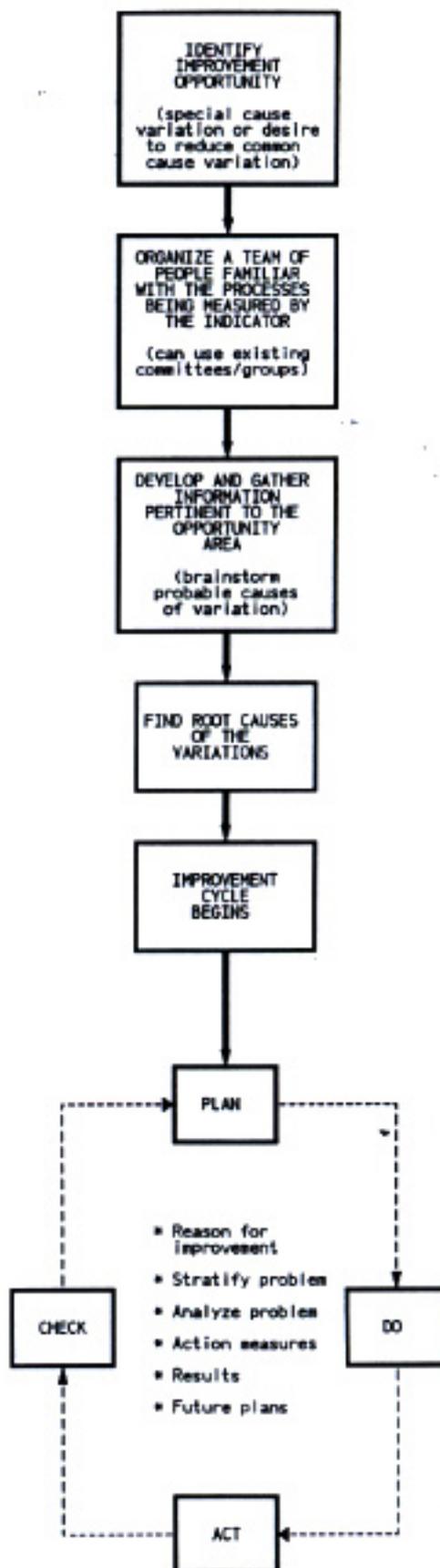
Analyze the variation

If you are satisfied that the variation is *not* caused by data collection and/or definitional problems, your next step is to initiate a more detailed analysis of the variation. The precise steps of the internal analysis of rate variations will vary from hospital to hospital and will be different for each performance measure. **Generally, the analysis and performance improvement actions follow the steps detailed in the chart at right.** Note that a team is organized to evaluate the cause of variation. Team members should include representatives from all disciplines thought to be involved in the processes affecting the performance rate.

It is important the team understands their charge. They should be constantly reminded that the data are not intended to discriminate between "good" and "bad" practices. The data merely show that something is different at your hospital, and it is the team's responsibility to discover what those differences might be. To guard against people's natural tendency to "rationalize away" variations, have the team brainstorm all possible causes.

One issue to be considered is whether or not your patient population is sicker than patients treated at other facilities. Many performance measures include a severity-of-illness or risk-adjustment factor. For example, the Quality Indicator Project of the Maryland Hospital Association uses the risk index derived from the Centers for Disease Control and Prevention's National Nosocomial Infection Surveillance

Steps for Analyzing Comparative Data and Improving Performance



System when calculating and reporting surgical site infection rates. Patient risk adjustments such as this can help clinicians evaluate whether observed outcomes should be attributed to provider variation or to other causes, such as the mix of patients treated. If the performance measurement data are considered to be risk-adjusted, the team should determine whether all dimensions of risk have been adequately accounted for. The dimensions of risk that are commonly considered important patient characteristics are listed below:

- age, sex, race, and ethnicity (demographics);
- acute clinical stability;
- principal diagnosis and its severity;
- comorbid illnesses, chronic diseases;
- physical functional status;
- cognitive and psychosocial functioning;
- cultural and socioeconomic attributes;
- patient attitudes and preferences for outcomes.

Do your best to account for risk

If the comparison data are derived solely from claims data, all of these dimensions will not be accounted for. That's why it is important to further investigate the impact of relevant dimensions on your performance results. Likewise, not all indicators are risk-adjusted. For example, intrinsic patient risk and other factors are not likely to be reflected in primary cesarean rates. For this reason, relevant risk issues may need to be explored further by the investigation team. It is impossible to control for all risk factors, but your organization can better interpret comparisons of outcomes across hospitals with knowledge of what risk factors have been accounted for in the data comparisons. For example, an organization would have to exert caution in comparing outcomes between public hospitals that see many poor patients and suburban hospitals that treat a relatively affluent clientele unless the data have been risk-adjusted for socioeconomic status.

Remember, however, that risk adjustment is necessary only for factors that should actually affect the process. Although many organizations try to risk-adjust for everything, adjustment is not needed for factors that should have no influence on the process. For instance, there is no need to adjust for socioeconomic characteristics when measuring patient satisfaction with the courtesy of service. Providers should strive to be courteous to all patients regardless of socioeconomic status.

Involvement in a comparative performance measurement project does not stop once the data have been gathered and submitted to the project headquarters. The most important task is to analyze the results. It is far too easy to shrug off performance differences by blaming them on patient severity or unique circumstances. Gather data to validate the team's assumptions about what might be causing the variation. When process improvement opportunities are identified, take the appropriate actions and then continue to monitor performance. Rather than viewing analysis of comparative data as a "fault/no-fault" exercise, use the information as the first step toward making the best even better.

Related Reading

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'Release 2 puffs' — but then say more

Sometimes health care providers assume that patients understand their instructions when that couldn't be further from the truth. They assume that what is obvious to them is obvious to the patient, so they omit discussing routine details of proper medication use. Unfortunately, patients often misunderstand the instructions. The following anecdote related by the Institute for Safe Medication Practices (ISMP) may convince you to remind nurses under your aegis to be extra careful when giving patients medication instructions.¹

The Institute recently heard about an asthmatic patient who was not responding to therapy. The patient said he'd been instructed to use his inhaler by his doctor, who picked up an inhaler, held it in the air, and released two puffs to demonstrate its use. The doctor had given no additional instructions.

During follow-up, the patient described how he was using his inhaler. He would get into his car, roll up the windows, release two puffs of medication into the air, and breathe deeply for 15 minutes! At first, he had been puffing into the air and breathing deeply in his house, but he thought it might be more effective to use the inhaler in the confined space of the car.

The message from ISMP is that instructions need to be clear and complete because patients may take them literally, or may erroneously fill in the gaps when information is omitted. Assume nothing regarding a patient's knowledge base, and leave no room for erroneous assumptions. Be thorough, and always include the obvious.

Reference

1. Safety Briefs. *ISMP Medication Safety Alert!* 1998; 16:2. ▼

Routine predelivery blood typing not cost-effective

Routine blood type and screen evaluations upon admission should be eliminated for women admitted for a normal vaginal delivery who do not have previously identified risk factors, according to a recent report. Such a move could save \$120 million each year. Investigators conducted a retrospective review of women who required blood transfusion during admission for an anticipated vaginal delivery at Hutzel Hospital in Detroit. Over three years, more than 16,000 patients were admitted for vaginal delivery. Of those, 76 required a blood transfusion.

The investigators examined the medical records of the 76 for admission risk factors, as well as indications for and urgency of the blood transfusion. Most of the blood transfusions were related to previously identified risk factors, the investigators write. Only four patients were

urgently transfused without at least one of the following identified risk factors: admission anemia, previous cesarean delivery, abruptio placentae, and previous blood transfusion.

The group calculated that urgent blood transfusion was required for 2.5 per 10,000 vaginal deliveries where there were no admission risk factors. They suggest that routine testing on admission does not seem to enhance patient care and should be eliminated for patients without substantial risk factors. "In the rare event that a patient without a previously identified risk factor required an urgent blood transfusion, O negative blood could be given . . . pending formal type and cross match." According to the investigators, the cost of a routine type and screen determination is \$57. For the more than 3.1 million vaginal deliveries performed in 1996, this equates to a \$177,100,000 annual cost for universal testing.

"If admission evaluation of type and screen were only completed on patients with an identified risk factor, . . . the annual cost savings would be approximately \$120,000,000," states the report. ▼

Do patients know what they're signing?

A group of investigators recently analyzed informed consent forms being used by hospitals around the country and concluded that they are unnecessarily complex and make little sense to most patients. In addition, they leave out important information about risks.

Over 600 forms were examined by computer and rated for intelligibility. On average, the documents required at least a high school education to understand. Because 72 million Americans are marginally or functionally illiterate, only between 3% and 20% of adults can understand what the forms say. Reviewing the forms by hand, the

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■ EMTALA and patient dumping a close-up look

investigators gauged the information contained in the forms. While most included blanks for the name and description of procedure, only 5% to 6% included a space for information about benefits, risks, or alternatives.

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1. Hopper KD, TenHave TR, Tully DA, et al. The readability of currently used surgical/procedure consent forms in the United States. *Surgery* 1998; 123:496-503. ▼

Antibiotics reduce infection in chemo patients

Infections are a serious problem for patients undergoing chemotherapy for cancer. A recent study suggests that treatment with quinolone antibiotics dramatically reduces the occurrence of some types of infections common to chemotherapy patients.

Patients receiving oral quinolone antibiotics had roughly 50% fewer infections overall than chemotherapy patients not receiving antibiotics. However, many patients on quinolone antibiotic treatment still developed fevers and had to receive intravenous antibiotics. Furthermore, oral antibiotics had no effect on mortality.

Researchers performed meta-analysis of 18 clinical trials involving 1,408 cancer patients who were undergoing chemotherapy.¹ Compared to patients who received no oral antibiotics, patients who received quinolones experienced 79% fewer gram-negative infections and 77% fewer gram-positive infections. The reduction in gram-negative infections translated to 46% fewer total infections in patients taking antibiotics than in patients not taking quinolone antibiotics. Researchers found similar results in clinical trials that used trimethoprim/sulfamethoxazole as the control regimen.

Oncologists have been concerned that quinolones could predispose cancer patients to infections with other bacteria because they eliminate some of the normal bacterial flora. However, researchers found that the incidence of quinolone-resistant infections was no higher in the quinolone group than in the control group.

Reference

1. Engels EA, Lau J, Barza M. Efficacy of quinolone prophylaxis in neutropenic cancer patients: A meta-analysis. *J Clin Oncol* 1998; 16:1,179-1,187. ▼

Check this Web site for your report card score

Your hospital's cardiac surgery scores may very well appear on the Internet now thanks to a new service that rates cardiac surgery and cardiology programs in hospitals around the United States. Statistics on coronary bypasses, valve replacement surgery, and interventional procedures including angioplasty, stent placement, and atherectomy as well as diagnostic procedures are all out there. The site, www.HealthCareReportCards.com, will update ratings twice a year and will soon also include ratings in other fields, such as:

- orthopedic procedures and diagnoses — total hip replacement, first and repeat surgery; total knee replacement, first and repeat surgery;

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- respiratory illness;
- oncology;
- neurosurgery.

It is expected that new areas will be added approximately once a month. The mortality data used to produce the ratings are purchased from the Health Care Financing Administration — Medicare Provider Analysis and Review (MED-PAR). Mortality in the hospital, 30 days after discharge, and six months after discharge are registered for Medicare patients treated between 1995 and 1997. The ratings are “apples to apples” — they are adjusted for the fact that some hospitals attract sicker patients and thus have a higher mortality rate. About 15% of hospitals are ranked four stars (very good) or five (best), and 70% get a three-star rating, meaning they were average or had an expected mortality rate. The site does not include information on physician performance. ■



Following are names and telephone numbers of sources quoted in this issue:

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