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INSIDE

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Hospitals threaten to pull plug on ORYX, demand more say in JCAHO decisions

Hospital associations, AHA file protest; JCAHO scrambles to respond

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, is scrambling to appease hundreds of hospitals that have effectively called a halt to their participation in ORYX, JCAHO's new electronic reporting system, until the commission addresses their objections and provides an avenue for input from providers.

In early January, 17 state hospital associations sent a letter of complaint — accompanied by a supportive letter from the Chicago-based American Hospital Association (AHA) — to the JCAHO, protesting the Joint Commission's newest effort to electronically collect performance and outcomes data. The hospitals said ORYX doesn't make sense, won't work due to a lack of uniformity in the various reporting software, and is too costly.

Hospitals: Is ORYX even necessary?

They say they are fed up with a regulatory commission in which "the right hand doesn't know what the left hand is doing,"and is seemingly insensitive to the burden and expense its year-old reporting program and new core standards program are heaping on the hospitals.

They are calling for more provider input and frankly questioning the need for ORYX in light of existing reporting programs and requirements. They further complain that the Joint Commission has yet to demonstrate it can hold up its end of the program because it has failed to process data and provide feedback in a timely manner.

JCAHO president **Dennis S. O'Leary**, MD, quickly called for meetings with the hospital associations to discuss the issues raised in the letter. For now, the state associations are diplomatically saying they expect the Joint Commission to respond positively to their concerns. O'Leary was unavailable to be interviewed by *Hospital Peer Review.*

The AHA letter, written by **Don M. Nielsen**, MD, senior vice president for quality leadership, assured O'Leary that the AHA supports

the concerns of the 17 signatories and said that in the past year, "there was immense difficulty in the implementation of the sentinel event policy and the restraint standards policy and the untested implementation of the present ORYX policy."

The concerns in the associations' letter center on the recent efforts by the Joint Commission to fold into ORYX a core set of performance measures that are related to focus areas previously defined by the Advisory Council on Performance Measurement. **(See box on p. 47 for a list of the Advisory Council's 12 focus areas.)**

The letter singled out these six issues, summarized below:

1. Hospitals and health systems around the country have made a good effort to comply with the original ORYX performance measurement policy, even though that policy was developed by the Joint Commission with minimal input from those who were to be affected by its implementation. And those efforts to comply were expensive. "Now, a second measurement effort is to be developed with little to no input from those affected that will incur significant additional expense without any demonstrated effectiveness relative to the first policy."

The initial documents describing the core measurement effort are confusing and use terms referencing "assigned" and "selected" interchangeably. They lack clarity regarding phase-in of new core measures and phase-out of present ORYX data requirements. Effectuation is flawed, causing difficulty with implementation and "generating much animosity toward the JCAHO." Before proceeding with further development, "serious thought should be given to seeking and listening to informed input and involvement from those institutions and systems that are to be affected by this second measurement policy."

Not everyone at JCAHO agreed, either

2. This could be stated as "the left hand doesn't seem to know what the right hand is doing." The proposed core measurement policy appears not to have been fully discussed by the Joint Commission's Board of Commissioners or the Advisory Council of Performance Measurement. Two members of the council are cited who confirmed lack of approval. "Full understanding of the operational issues and support from each of these entities should be present before proceeding with implementation."

3. Transmission of data to approved vendors and from the vendors to the Joint Commission doesn't seem to be occurring effectively. "The JCAHO's capability to collect and evaluate the data from all institutions has yet to be demonstrated." Implementation of a second measurement effort that will superimpose additional data collection and evaluation requirements should not occur until those inadequacies have been corrected.

'The JCAHO's capability to collect and evaluate the data from all institutions has yet to be demonstrated.'

4. The proposed time line creates operational problems for facilities. "If the transition is made from the current ORYX initiative to the core measures program, the proposed one year increase in the number of measures from a minimum of 8-17 results in more than a 100% increase in staff time and resources." Also, the continuation of current ORYX requirements past a minimum of six measures does not result in any benefit for the organization — no time is provided to organizations to develop and implement quality improvement efforts in response to their performance measurement activities. It is recommended that a cap be placed on the current initiative in 1999 when six to 10 indicators are reached so efforts can focus on improving performance.

5. Multiple entities, including states and managed care plans, require measurement efforts. "Any new measurement effort should evaluate existing and proposed future data collection requirements prior to embarking on the development of an additional measurement set" and should represent an effort to prevent duplicative, overly burdensome requirements.

6. How many vendors are going to go to the expense of adding the proposed core measures vs. dropping their participation in the program? Facilities ultimately will have to pay the costs incurred by the vendors when they add measures.

The associations' letter closed with the request that the Joint Commission reconsider its approach. The associations asked that "an active dialogue begin" between accredited institutions and the Council of Performance Measurement

Hospitals will pay a lot if core standards are added

Vendors have no choice but to pass on costs

March 31 is your deadline for submitting third-quarter 1998 ORYX data. Those data have to be submitted through your hospital's chosen Joint Commission-approved performance measurement system vendor. "There are a lot of hospitals, with a lot of measures, using a lot of vendors nationwide," says **Becky Miller**, director of performance measurement and quality at the Missouri Hospital Association. "Without experience under their belt, now the Joint Commission is considering taking off on another initiative."

"It appeared that any vendor who wanted to play the game got to play," says **Patrice Spath**, ART, a health care consultant in Forest Grove, OR, and *Hospital Peer Review*'s consulting editor. Now the Joint Commission has a morass of data coming in, say Miller and Spath, and every hospital is using a different vendor with different data elements and different measures. "The goals of the ORYX project will be difficult to achieve with such a variety of systems and measurements," continues Spath. "By specifying 12 focus areas, I think the commission is trying to put some validity and quality control back into the project. Perhaps the ORYX project should have concentrated on these topics from the very beginning."

Hospital Peer Review asked a representative of a leading ORYX vendor how a change in the initiative might affect her company's operations. **Nell Wood** is director of marketing and communication at the Quality Indicator Project, operated by the Maryland Hospital Association in Baltimore, a performance measurement system with 1,800 participants around the country, 1,100 of which are acute care hospitals.

Hospitals collect data according to the project's definition and use tools provided by the project to transmit data to the project. If a hospital wants to use its data for ORYX-related purposes, the project then passes the data on to the Joint Commission. Some hospitals simply collect data for their own performance improvement projects, not to satisfy Joint Commission requirements.

"It's impossible to predict how much of a burden this will represent," says Wood, "and anyway, at this point, I'd be speculating because we don't know what's going to happen with the ORYX initiative. If ORYX were to evolve to a point where there were core measures that everybody had to use, and if the core measures were completely new and different, of course extra resources would be required to embed them into our system. All vendors would incur those costs to upgrade their systems."

Presumably, she says, the core measures will reflect the interests and abilities of the hospitals, in which case, most vendors' programs would likely have at least some of the measures already embedded.

"There's no getting away from the fact that it would place a resource burden on vendors to embed the new measures in their programs," says Wood. "And, as is the nature of any business, any time you're incurring additional cost, you need to recoup those costs, and the way you do that is by having the ultimate price to the user reflect them."

Bottom line: This will cost you money. ■

and the Board of Commissioners. "We firmly support the concept of performance measurement and accountability for improvement," stated the letter.

O'Leary responded immediately to the letter, stating that the Joint Commission is committed to meaningful dialogue with organizations and their associations at multiple stages throughout the process for identifying core measures. He said that intent was articulated at the October Board of Commissioners meeting, and a more specific outreach plan regarding the core measures project would be considered at a meeting of the Executive Committee later in January.

His letter said the letter from the 17 associations raised some significant issues, but also contained some misperceptions. O'Leary wrote that he wanted to correct that situation, so he's arranging to facilitate an open forum between the state hospital associations and the Joint Commission. The forum would include all state hospital associations, not just the 17 signatories.

"I do finally wish to challenge the assertions set forth in item 2," stated O'Leary's letter. "The

awareness of, and support for, the core measures project by the Advisory Council on Performance Measurement and the Board of Commissioners is a matter of record." Both had reviewed and supported the *Framework for Determining Core Measurement Priorities*, the *Attributes and Criteria to Guide the Selection of Core Performance Measures*, and the specific priority areas for core measure identification for hospitals, he wrote. Also, at the October meeting, the Board discussed a plan for shifting to core measures from current ORYX requirements. "It was agreed that appropriate timelines for core measure implementation would be determined when there was a reasonable experiential base for doing so."

O'Leary wrote that the state hospital association's letter provided an opportunity for crystallizing key policy issues surrounding the eventual introduction of core measures into the accreditation process. ■

17 associations dispute new ORYX requirements

The following 17 state hospital associations wrote a letter to **Dennis S. O'Leary**, MD, president of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, in which they expressed concerns about new developments in the ORYX performance measurement policy:

- Alabama Hospital Association
- Connecticut Hospital Association
- Delaware Healthcare Association
- Florida Hospital Association
- GHA: An Association of Hospitals and Health Systems
- Illinois Hospital and HealthSystems Association
- Indiana Hospital and Health Association
- Association of Iowa Hospitals and Health Systems
- MHA: The Association of Maryland Hospitals and Health Systems
- Michigan Health and Hospital Association
- Missouri Hospital Association
- MHA: An Association of Health Care Providers
- New Jersey Hospital Association
- Oregon Association of Hospitals and Health Systems
- The Hospital and Healthsystem Association of Pennsylvania
- South Carolina Health Alliance
- THA: The Association of Texas Hospitals and Health Care Organizations

What to do about ORYX? Improve priority areas

HPR's *expert offers advice on weathering storm*

"Quality management professionals appear to be caught in the middle of a 'he said / she said' debate," comments **Patrice Spath**, ART, a health care consultant in Forest Grove, OR, and *Hospital Peer Review*'s consulting editor. "It's no wonder everyone is confused." **(See articles on pp. 37-42, 47, regarding the Joint Commission's proposed ORYX requirements.)**

The unanswered questions are myriad and monumental, says Spath:

- How many measures must a hospital have chosen for the ORYX initiative, as of this date?
- How many will be required in the future?
- Will specific measures be required, or just any measures that fall into the core focus areas? And are these core measures or focus areas? *[Editor's note: That question still is unanswered at the time this issue of* Hospital Peer Review *went to press.]*
- Will these measures be in addition to, or instead of, the ones currently chosen by the hospitals?
- Will the number of "approved" systems decrease if vendors can't support the proposed new focus areas / measures?
- Will my hospital's approved system become non-approved at some date?

Spath offers this advice: "Continue to measure and improve patient care activities that have been chosen as high-priority areas by your organization's quality council. Remember, the bottom line must be meeting the needs of your facility. Continue to gain experience collecting valid and reliable data and using comparative data — from whatever source — to compare your performance with that of other facilities. Learn how to interpret risk-adjusted measurements, analyze comparative reports, and respond to outlier situations. This experience will be invaluable regardless of what the Joint Commission or state and national regulatory groups may require in the future." ■

Commentary

How did we arrive at this impasse?

Looking back, one could argue that the Joint Commission should have anticipated major problems with ORYX, its electronic outcomes reporting system.

From the onset in late 1997, it was not entirely clear just what JCAHO wanted to accomplish with such a database, other than selling the data back to providers.

When those providers asked hard questions about who benefits, the Joint Commission talked about a national repository of risk-adjusted data for benchmarking, which it would administer.

But how was the Joint Commission going to guarantee the quality of those data when it did not impose any common standards on the vendors' programs that collected and reported the data?

Providers were quick to see the problems that would arise from this massive flaw, and the call for remedial action recently issued by 17 state hospital associations is probably just the tip of the iceberg. Indeed, it was apparently the Joint Commission's belated attempt to address this standardization issue — through a new requirement for 12 core measures — that sent the hospitals over the edge.

Everyone agrees that a national database for outcomes benchmarking is a laudatory goal, but the commission's standards have long made benchmarking all but a requirement. Many hospitals are involved in benchmarking projects at the local, state, or national levels and are making improvements based on what they find.

So where's the value for them in ORYX, they ask? With a months-long projected lag time before the commission's analysis and feedback occurs, many question the value of ORYX given its lack of timeliness.

Then there's the whole question of ORYX's nebulous costs, which come in an era of downsizing, cutbacks, mergers, and several costly new dictums from the Joint Commission itself, such as the revised sentinel event policy and restraint policy. When resources are so scarce, many providers question the payback of the tens of thousands of dollars spent on ORYX, especially in terms of impact on patient care, and especially when managed care constraints already threaten the quality of that care.

Finally, why create another national repository when there are already dozens of sources, free from government agencies or for a fee from commercial companies, for the same type of information? For example, there is the MEDPAR data available from the Health Care Financing Administration. Every state government collects some type of outcomes and performance data on hospitals, and virtually all of it is free or available at low costs.

Compounding these problems, the Joint Commission has not answered — at least not satisfactorily, many providers say — pertinent questions about how the data will be used. Will facilities be measured against only those facilities that are participating in the same software system? Or will seemingly similar measures, such as medication errors, from various software programs be aggregated and analyzed? With no two vendor software packages having common definitions or methods of measurement, such an approach could have nightmarish consequences for providers.

Unfortunately, the Joint Commission also is fighting its own flawed track record in getting reporting systems up and going. Its IMSystem, an indicator measurement system developed in 1996 and funded by higher survey fees, has had little impact.

Now the Joint Commission is asking the industry to pay for another elaborate database, one that would certainly catapult the JCAHO into the top ranks of commercial data purveyors but would also provide questionable benefit for the providers who build it, according to many in the industry.

How the Joint Commission responds to providers that question its motives and its methods will determine the future of ORYX. If JCAHO can convince the hospitals of ORYX's benefits and allay fears about poor methodology, then ORYX might work. If not, ORYX could become a major black eye for the accreditation body and a political albatross it can ill afford.

Susan Hasty
Executive Editor, ***Hospital Peer Review***

ORYX: 'There has to be a better way to do this'

More people on the front lines speak out

Hospital Peer Review asked **Keith Young**, director of data and information services at the Alabama Hospital Association in Montgomery, how his association came to be included among the 17 signatories to the letter to **Dennis S. O'Leary**, MD, president of the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL.

"The AHA [American Hospital Association in Chicago] coordinates monthly conference calls among the state hospital associations, and some include the Joint Commission," he explains. It was through such a conference call that the Alabama Hospital Association became party to the discussion. "Some state associations are more intimately involved with ORYX than we are because they provide data vendors to their hospitals," he says.

How was it that no more than 17 associations signed the letter? "The Joint Commission issued a news release asking for input on those core areas in late November," he says, "and their deadline was very brief — institutions had until Dec. 15 to reply. There wasn't time for all the associations to find out about it, then to review the coordinating letter and get their names on it."

The Joint Commission's decision-making process could be slower and a bit more deliberate, Young says. "ORYX is just now kicking in, and already changes are being made before there's been time to work out the kinks. I think things are happening a little too fast."

Some hospitals were submitting between five and eight different indicators to get to their 20%, he explains. The first year's reporting requirement was to cover 20% of patient population. "The Joint Commission had only supplied rough areas in which they wanted data collected, not specific measures or categories, so providers were choosing whatever they wanted," says Young. That was good in that it allowed facilities to choose those indicators most appropriate to their institution, which optimized their quality improvement projects. But the ORYX project became unwieldy, he says. The set of performance measures was too broad.

"Whether those 12 focus areas are meant to encompass the indicators a hospital reports on is cloudy at this point," says Young. "Some people have interpreted the requirement to mean that the focus areas are in addition to indicators already reported on. Others say the measures that a facility chooses to report on may not fit into one of those approved focus areas." Things have to get sorted out, he says. "The hospital associations really need to talk with the Joint Commission and figure these things out."

'Discussions have been going on for months'

Becky Miller, director of performance measurement and quality at the Missouri Hospital Association in Jefferson City, also says her state association became involved in the letter through the twice-monthly conference calls. "Many times during those calls, we talk about Joint Commission issues or discuss comments we are hearing from our hospitals," she explains. "Issues relating to the core measurement initiatives have been discussed over the past several months by this group. We knew the initiative was going to get under way, and we had some concerns. This letter is just a culmination of those discussions that have been going on for several months."

The AHA took those issues and put them in letter format for the review of the 17 associations that were involved in the conference calls on an ongoing basis.

"The gist of our letter," says Miller, "gets down to process issues — how the Joint Commission develops new policies and new standards. Our concern is that the commission has not analyzed thoroughly the impact on hospitals of changing this performance measurement requirement. They haven't gotten as much input from the field as they could have." They are going ahead without consulting those whom their decision influences most — hospitals. That's the No.1 issue expressed in the letter, says Miller.

"I don't recollect ever being asked by the Joint Commission for advice on these issues," she says. The state associations all employ staffs that are knowledgeable about Joint Commission regulatory issues, and they hear word from the field about the issues they're dealing with. We're in a position to — and are very willing to — provide input to the Joint Commission to make systems work better for our members, the commission, and health care in general," says Miller.

(Continued on page 47)

PATIENT SATISFACTION PLANNER

From interview to instrument: How to develop a PS survey

A satisfied patient will recommend your facility

Managers at a mid-sized southwestern community hospital decided they were dissatisfied with the patient satisfaction survey they were using. The survey didn't give the information necessary to improve services. So, a core team set about developing a new survey.

The team — the nursing administrator, the head of the quality management department, and the head of nutrition services — first wanted to find out what patients liked and disliked about the institution. The team knew that, from any patient's perspective, quality is doing the right things right. The team ran a set of interviews to find out:

- **Is there a difference between quality and customer satisfaction?**
- **What do patients consider to be the "right things" in hospital care?**
- **How do patients' quality judgments affect their overall satisfaction?**

The team was determined to learn from recent inpatients their impressions of their hospital stay. Were patients satisfied enough to be willing to utilize the provider's services in the future, and to recommend its services to family and friends? The interviews, they hoped, would provide information on what patients remembered about their stay, both good and bad. The data would be used to construct a new survey instrument to be administered to patients within 72 hours of discharge.

Four interviewers — all management-level hospital employees — participated in data collection. They conducted 21 interviews, and 93 critical incidents emerged in the following five dimensions of service quality:

- accommodations;
- quality of physician;
- quality of staff care;
- food;
- discharge process.

The critical incidents that emerged from the interview process contradicted any notion that patients are naive, such as the following comments:

- My doctor decided on the type of anesthesia to be used without informing me.
- How can the physician wait until the last minute to decide the treatment plan?
- When my pain recurred, I was unable to contact my doctor.
- When I went to the bathroom, they didn't measure my urine. I had to ask them each time to bring the container.
- My husband was going through alcohol withdrawal — he should have been watched.

Those incidents suggest that, in many instances, patients are capable of evaluating some aspects of the quality of their care. The incidents also challenge the concept that patient satisfaction is less a function of the doctor's competence than of the peripheral service, such as ease of the admissions process and the food service. Of 82 valid critical incidents reported, 11 referred to core processes. The team concluded that while good core service might not increase the likelihood of a positive evaluation, poor core service would increase the likelihood of a negative evaluation.

Many meetings were called for

Development of the survey items involved an average of three meetings per item, with each meeting lasting approximately two hours. The resulting instrument contained 50 items on a five-point Likert scale and three open-ended questions. **(See survey excerpt, p. 44.)**

The preliminary survey was pilot-tested on 100 discharged patients, and each test was accompanied by a cover letter. Follow-up mailings were done at one, three, and seven weeks after the initial mailing. The three- and seven-week follow-up mailings were made up of another survey and another cover letter. No bulk processing was allowed, such as the use of computer-generated letters or mailing labels. A $1 incentive was included with half the mailings. Of the 100 surveys mailed, 92 were delivered and 45 were returned.

The resulting tested survey, titled "How Did *We* Do?" is reliable, valid, and has a significant

(Continued on page 45)

Patient Satisfaction Survey Excerpt

For each of the following statements, please check the appropriate box.

Mark the NA box if you had no opportunity to judge that aspect of care during your stay at xxxx Community Hospital.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	NA
I received my medication on time	☐	☐	☐	☐	☐	☐
The menu offered foods I liked	☐	☐	☐	☐	☐	☐
My doctor kept me informed	☐	☐	☐	☐	☐	☐
My room was clean	☐	☐	☐	☐	☐	☐
The discharge process was smooth	☐	☐	☐	☐	☐	☐
My doctor was available	☐	☐	☐	☐	☐	☐
The hospital was well supplied	☐	☐	☐	☐	☐	☐
I received the foods I selected from the menu	☐	☐	☐	☐	☐	☐
The staff answered my call light quickly	☐	☐	☐	☐	☐	☐
The food looked good	☐	☐	☐	☐	☐	☐
I was well informed of what I should do after discharge	☐	☐	☐	☐	☐	☐
My bed was comfortable	☐	☐	☐	☐	☐	☐
The hospital staff took good care of me	☐	☐	☐	☐	☐	☐
I knew my doctor's name	☐	☐	☐	☐	☐	☐
The staff treated one another with respect	☐	☐	☐	☐	☐	☐
The hospital was well maintained	☐	☐	☐	☐	☐	☐
The food tasted good	☐	☐	☐	☐	☐	☐
My medications were ready when I was ready to go	☐	☐	☐	☐	☐	☐
The billing procedures were explained to me	☐	☐	☐	☐	☐	☐
I was served the right amount of food	☐	☐	☐	☐	☐	☐
The nurse checked on me frequently	☐	☐	☐	☐	☐	☐
I had assistance making plans to leave the hospital	☐	☐	☐	☐	☐	☐
My doctor told me when I was going home	☐	☐	☐	☐	☐	☐
The food servers were pleasant	☐	☐	☐	☐	☐	☐

Source: Pyzdek Management, Tucson, AZ.

impact on intent to return. The service process managers report the results have been useful to them in planning process improvements.

Source: Thomas Pyzdek, MS, FASQ, a quality consultant with Pyzdek Management in Tucson, AZ. Pyzdek is the author of *The End of Management* (Tucson, AZ: Quality Publishing; 1998). Telephone: (800) 628-0432. Web site: http: / / personal.riverusers. com / ~pyzdek. E-mail: pyzdek@ asqnet.org. ■

Do 'consumers' trust health care providers?

Hoosiers are about to tell the powers that be

Indiana's health care leaders are launching a statewide initiative to make sure their state's 5 million citizens are full partners in decisions affecting their care. The project, dubbed "Indiana's Eye on Patients," is designed to identify what specific health information consumers believe is most useful, to improve consumers' access to information, and to improve the care process in general through better communication. The project begins with research and then applies it, says **Bob Morr**, vice president of the Indiana Hospital and Health Association (IHHA) in Indianapolis.

"Everyone is a potential patient, and one of the most important things we've been hearing from residents in this state is their distrust of a system that they had trusted for years," says Morr. "They've been expressing frustration about the role the insurer or the health plan now plays in decision-making."

Morr says Hoosiers feel they are losing personal power in the health care transaction. "When asked in focus groups, 'Who do you think has the most effect over health care decisions for you: the health plan, the doctor, the hospital, the insurance company, or yourself,' [Indiana residents] say they want to see themselves put first in that order. Last would be an outside third-party payer." They also have concerns over what they perceive as a decline in quality of health care.

The Indiana State Medical Association and the Indiana University School of Medicine are cosponsoring the initiative with the IHHA. They will lead a consortium that will publicly disseminate the data at a symposium in September.

"Many Hoosiers tell us they feel powerless when it comes to health care. They believe insurance plans, doctors, or hospitals control their medical destinies. They want to be in charge," says **Roger J. Allman**, president of King's Daughters' Hospital in Madison, IN. Once the launchers of the initiative learn precisely what consumers want, Allman says, they will work to provide it.

Eye on Patients includes five projects, each of which is designed to gather information that will help patients determine what care is right for them:

• **Examining causes of variation.**

Consumers had been asking why practice patterns vary not only across the country, but even within Indiana. Wide geographic variation in use rates, surgical procedures, and Medicare dollars spent is documented in the *Dartmouth Atlas of Health Care*. In addition, the IHHA databases show differences in admission and procedure rates among counties.

For example, a group of cardiologists, employers, and hospital leaders from Muncie identified other sites demographically similar to their area, such as South Bend, that had much lower angioplasty rates. According to the *Atlas* database, Muncie performed 8.1 angioplasties per 1,000 Medicare enrollees in 1995 — 26% higher than the national average (six procedures per 1,000 patients) and 43% higher than the rate in South Bend. The Muncie group has had great success in getting across-the-board support. "Changing behavior of physicians and health care leaders is one of the biggest hurdles to improving health care," stated **John E. Wennberg**, MD, principal investigator of the *Atlas* at Dartmouth (NJ) Medical School.

$150,000 has been committed to conduct a variation analysis at the School of Medicine.

• **Researching public opinion.**

About 20 focus groups will explore how hospitals and physicians can improve care and restore confidence in the system. Consumers will be asked to identify specific problems they have encountered and to discuss types of information they need to manage their own and their families' care. The results gathered will be widely circulated among hospitals and doctors and used as a framework for quality improvement projects within their organizations.

• **Sharing decision-making.**

Research has shown that the more information a patient has access to, the better his or her treatment

choice, care, and outcome will be. Inappropriate utilization has been shown to decline when patients have more information, and cost savings are demonstrable. A task force will examine current products available for consumer education, including videotapes, Internet services, and manuals, to see which are most useful, most clinically sound, and most cost-effective. The group will discuss ways to encourage physician advocacy of sharing decision-making with consumers.

• **Expanding patient perception databases.**

Two years ago, a Patient Perception Profile initiative collaborated with the Picker Institute, a Boston-based firm specializing in patient survey research, to provide 36 hospitals and medical staffs with a database on patient feedback. The resulting comparative database now will be enhanced and expanded to include more hospitals, to increase the sample size, and to incorporate additional questions on how well the patient functions after discharge.

• **Learning "what is right."**

While Eye on Patients is a collective undertaking, the group understands that much can be learned from the individual efforts of providers, researchers, and others working to improve patient care. A special committee will issue a call for studies and will look at case studies on existing Indiana projects aimed at improving quality of care or patient-provider relations in such areas as end-of-life care, patient-focused billing, and shared decision-making protocols. ■

33% of patients would prefer to pay with plastic

Mayo and other big players accept credit cards

One-third of health care consumers would use credit cards to pay medical bills if they could, according to a recent consumer opinion survey by American Express Co. in New York City.

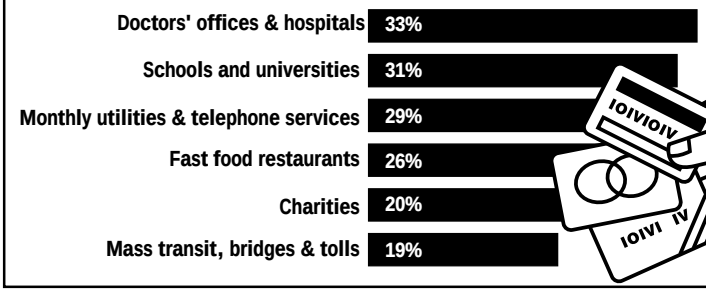
Of those preferring to use credit, 14% had to ask providers if cards were accepted. The survey indicates that 46% of the time, patients think of using their credit cards for payment only when they see a sign indicating the provider takes credit cards.

Taking a cue from these results, you might want to post a sign in the reception area telling patients your organization cheerfully accepts credit cards for those co-pays.

There has been a 39% increase year over year in the number of hospitals and hospital-related providers that accept credit cards, including the Mayo Foundation, Columbia-HCA Healthcare Corp., and Memorial-Sloan Kettering Cancer Center. Patients who pay with plastic pay at the time of service. That's important, because only 1.3% of respondents to the survey reported they put health care-related expenses at the top when they prioritize their household bills. Health care costs rank next to last, only ahead of telephone bills. ■

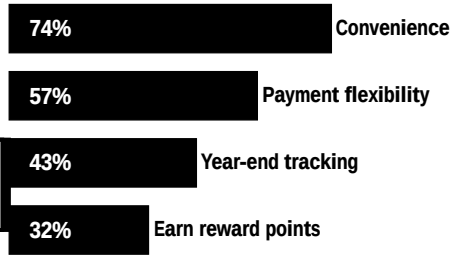
Where Consumers Want to Use Plastic

According to the American Express 'Everyday Spending' Index, consumers will continue to seek new places to use plastic. **In the future, consumers would like the option of using plastic to pay for the following expenses:**



Why Cardmembers Use Plastic for Medical Expenses

According to the American Express Healthcare Index, there are several reasons why American Express **Cardmembers want to use plastic to pay for health care-related services**. Here are their reasons:



Source: American Express, New York City.

(Continued from page 42)

Susan White, vice president of quality management at the Florida Hospital Association in Orlando, agrees: "We'd like to be more involved in that process. The decision-making process would benefit if the state hospital associations played a more active role."

Hospital Peer Review asked Miller where she thinks this is headed. "I know where the Joint Commission wants to go with the ORYX initiative, and no one can deny we need a consistent method to measure quality before we can compare providers," she says. "We all agree on that. What we don't agree on is how to do that without placing an undue burden on providers."

The Joint Commission, she says, has to look at its time line and make sure it is reasonable. "They are adding another level to their original time line with the core measure initiative," Miller says. "If they expect both initiatives to go forward, hospitals are going to be submitting an increasing number of non-core measures in addition to an increasing number of core measures."

The commission also should look at its current requirement on the number of measures hospitals should submit, she says.

"We already have confusion over the current ORYX initiative, and now we have something in addition to that before we have experience with the first initiative," says Miller. The initial ORYX initiative already is under way; hospitals started collecting data in July for the current initiative. "Before we're off and running with that," she emphasizes, "now additional requirements are being thrust upon us."

JCAHO wants to add core measures to ORYX

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, issued a statement in November saying the Board of Commissioners had approved 12 acute care focus areas for the identification of core performance measures.

The priority measurement areas were recommended by the Advisory Council on Performance Measurement. The document stated the next stage of ORYX will be built on these initial core measurement priority focus areas:

- Adverse drug reactions
- Acute myocardial infarction
- Antibiotic use
- Breast cancer
- Congestive heart failure
- Depression
- Diabetes
- Equipment failure
- Maternal/newborn
- Medication errors
- Pain management
- Pneumonia

Ten focus areas for long-term care were approved as well:

- Activities of daily living
- Cognitive impairment
- Decubitus ulcers
- Depression
- Diabetes
- Falls
- Incontinence
- Indwelling catheters
- Medication errors
- Restraint and seclusion

The Joint Commission issued a national call for performance measures in those areas with a deadline of about three weeks from the original notice. **Julia Roberts**, Joint Commission media relations manager, says 43 organizations submitted a total of 539 potential hospital core performance measures. Twenty-seven organizations submitted a total of 160 potential long-term care core performance measures. Core measures will be selected from among the submitted measures and from the thousands of measures catalogued in the Joint Commission's ORYX database.

[Editor's note: For more information on matters pertaining to ORYX, call the ORYX information line at (630) 792-5085. There you can access a list of the requirements by accreditation program, a list of performance measurement systems, or help with selecting measures, including 20% calculations. You also can speak with a staff member. Documents will be faxed to you if you press "4," or e-mailed if you send e-mail requests to ORYX@JCAHO.org. Include your name, organization, and phone number. The Joint Commission's Web site also contains ORYX information. Go to http://www.jcaho.org/perfmeas/oryx/2nextev.htm for "The Next Evolution in Joint Commission Accreditation."] ■

Miller says she hopes the Joint Commission takes the state associations' letter seriously and realizes there are many field resources from which to get input. "We need to all come together and figure out a better way to do this," she says.

Don M. Nielsen, MD, senior vice president for quality leadership at the AHA, told *Hospital Peer Review* he thought the responsiveness of the Joint Commission is a very positive sign. "I know we'll be able to work together in coming to a successful resolution of these problems," he says. The state hospital associations and the Joint Commission both expect to be able to get to a core measurement data set, he says. "That's everyone's ultimate goal — a core standardized set of measures that can be used for quality improvement purposes as well as for purposes of accountability."

Nielsen agrees that there has to be more clarity around this issue. He says that just how the 12 focus areas are constituted in relation to the core data set was part of the issue raised by the associations' letter and that he's confident the question will be cleared up during the proposed forum.

The Joint Commission's call for common core measures caused a great deal of concern, because issues were not clearly stated and because of a lack of involvement from state hospital associations, says Nielsen. "There is concern about the fact that there has been little input from the field in regard to this policy and its development," he continues. "I'm optimistic that the establishment of the forum is a positive step toward fixing this situation."

The associations expressed their concerns collectively, because, says Nielsen, "it was the combined feeling of these hospital associations that it would be more effective to write one collective letter than individual letters." The AHA facilitated the development of the letter and coordinated the different hospital associations. ■

Hospitals are keeping costs low, says survey

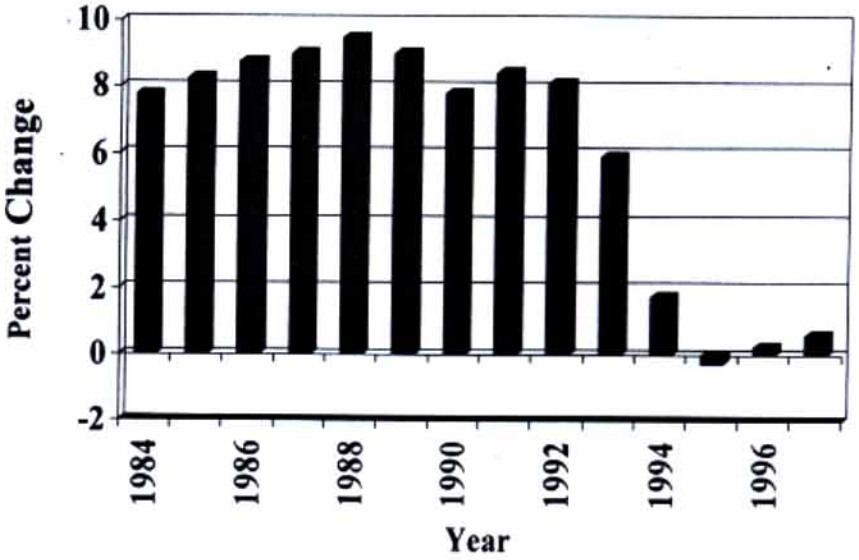
Virtual halt in Medicare growth may not last

According to the latest annual survey by the American Hospital Association (AHA) in Chicago, hospitals and health systems still are keeping costs low. The survey shows that for the third year in a row, there has been little or no growth in hospital costs. In 1997, growth in both inpatient and outpatient hospital costs (total adjusted expense per admission) was 0.6%; five years ago, growth was about 8%. **(See chart at right.)**

Medicare spending rose in 1998 by just 1.5%, the smallest increase since the beginning of the program in 1965. In the last decade, Medicare spending rose by an average of $12.8 billion annually, or 10% a year. But in 1998, it grew just $3.1 billion, to a total of $213.6 billion.

"It's unclear how long this trend can continue," stated **Dick Davidson**, AHA president. "With the resources needed to meet the Year 2000 technology challenges and skyrocketing drug prices, keeping costs low will become more difficult." Hospitals, facing pressures from increased competition and managed care, have just begun to feel the impact of Congress' five-year $44 billion payment reduction, which started last year. The Medicare Payment Advisory Commission says Medicare payments to hospitals will drop from 90 cents per dollar of outpatient care before enactment of the Balanced Budget Act to 78 cents after it.

Annual Change in Total Expense per Adjusted Admission 1984-1997



Source: American Hospital Association, Chicago.

The AHA survey also suggests:

• A major focus of almost all hospitals is community wellness.

• The average length of stay for patients continues to drop, declining last year to an all-time low of 6.1 days.

• Outpatient visits continue to climb. Over the past five years, they increased about 29%. During the same period, overall inpatient days dropped 13%.

• The number of full-time equivalent personnel employed by community hospitals increased to 3.79 million.

• About 23% of hospitals were involved in developing an HMO product during the year, up from 19% three years earlier.

[Editor's note: To obtain a copy of "Hospital Statistics," the AHA survey report, call the AHA at (800) 821-2039. ■

New impregnated catheter inhibits superbugs

Device is active against drug-resistant bacteria

The Release NF catheter soon may become an important weapon in the hands of your hospital's infection control specialists. Impregnated with nitrofurazone, an agent long recognized as antibacterial that kills bacteria by a different mechanism from that of true antibiotics, the new catheter has been shown to reduce both the incidence of hospital-acquired infections and the spread and opportunity for mutation of antibiotic-resistant bacteria. The catheter permits sustained release of a controlled dosage directly into the urinary tract to prevent the onset of infection.

Recent tests of the new catheter, manufactured by Rochester Medical in Stewartville, MN, show it to be broadly active against many of the types of multidrug-resistant bacteria that are associated with hospital-acquired urinary tract infections (UTIs) caused by Foley catheterization. A total of 80 clinical isolates, derived primarily from the urine of infected patients, were tested in vitro against Release NF catheter sections and control catheter sections. The tests included both antibiotic-susceptible and antibiotic-resistant strains of the same species. **The following table shows the species of resistant bacteria against which the catheter was active and their associated antibiotic resistance patterns.**

Bacteria	Resistant to:
E. coli	advanced penicillins, ciprofloxacin, aminoglycosides, third-generation cephalosporins, piperacillin/tazobactam
Citrobacter freundii	third-generation cephalosporins, advanced penicillins, piperacillin/tazobactam, aztreonam
Klebsiella pneumoniae	piperacillin/tazobactam, advanced penicillins, trimethoprim/sulfamethoxazole
Staphyloccus aureus	oxacillin, clindamycin, ciprofloxacin
Coagulase-negative *Staphyloccus*	oxacillin, ciprofloxacin, clindamycin, trimethoprim/sulfamethoxazole

The catheter segments also were active against susceptible *Enterococcus faecium*, but did not inhibit the tested strain of vancomycin-resistant *E. faecium*. Previous clinical tests of the catheter showed a sixfold reduction in bacterial UTIs during the first five days of catheterization; the great majority of hospital patients are catheterized no longer than five days. Now, the new tests show the catheter's effect on the antibiotic-resistant strains of these bacteria.

Commenting on the test results, the investigators said, "We were impressed to see that the medicated catheter was every bit as active against multi-drug resistant strains of five of six bacterial species we tested as it was against their antibiotic-susceptible counterparts, whereas the control catheter had no activity whatsoever. . . . our results suggest that the medicated catheter should be as clinically effective against many of the new multidrug resistant bacteria as it is against traditional antibiotic-susceptible strains." ■

THE QUALITY - CO$T CONNECTION

Medical staff competency: How much is enough? Part I

Departments develop numbers-based requirements

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

New applicants for medical staff membership, as well as physicians being reappointed to the medical staff, must show evidence of current competence in performing the requested privileges. Joint Commission standards require that each clinical department develop its own criteria for determining how a physician's competence will be measured. The standards do not, however, specify what those criteria must be.

Some medical staff departments rely solely on the recommendations of peer physicians or on the results of ongoing monitoring and evaluation. However, an increasing number of departments are also developing competency requirements based on the number of patients treated by the individual physician. These types of competency-based criteria usually are applied to procedure privileges. The clinical departments define the annual number of procedures that must be performed by a physician to maintain competency. For example, in one hospital, physicians who request bronchoscopy privileges must have performed 10 therapeutic and 12 diagnostic bronchoscopies each year to retain privileges for these procedures. In the case of bronchoscopy with transbronchial biopsy without fluoroscopy, a physician must perform 25 or more of these procedures each year to retain privileges.

The development of proficiency criteria for the varied types of procedures performed by the medical staff may seem an overwhelming task. To reduce the work involved, the clinical departments can implement the process in steps by continually defining and adding new competency criteria. Medical staff ad hoc committees, with membership representatives of the physicians performing different categories of procedures, can be formed to develop the criteria. There are eight major considerations to be addressed by the group in the design of volume criteria. This month we will address the first four:

- What category(ies) of medical staff membership may be granted privileges for specific types of procedures?

The medical staff may recommend that only MDs or DOs be allowed procedure privileges in certain categories. Otherwise, the medical staff may choose to allow open procedure privileging as long as criteria are met.

- Have relevant medical professional societies recommended annual numbers of procedures required to maintain proficiency? Have any research studies been published on the relationship between volumes and outcomes?

Some professional societies have addressed procedure competency through the development of guidelines for credentialing and privileging of physicians in specific procedures. The American Society of Gastrointestinal Endoscopy (ASGE) was one of the first groups to formally recommend proficiency numbers for residency or fellowship training in gastroenterology or surgery.

Current medical literature also may be a source for performance requirements. Many studies in the past 10 years have evaluated the effect of surgical volume on patient outcome, with many studies showing that higher-volume providers tend to have better results. The medical staff ad hoc committees should evaluate the findings of these studies in setting their competency-based performance criteria. **(Examples of relevant articles are listed in the resource section at the end of this article.)**

COMING IN FUTURE MONTHS

- Keep an eye on those medical errors: New sources of help
- Patient-controlled analgesia well-tolerated and effective
- Medicare conditions of participation: An update
- How much do patients understand about clinical trials?
- Disabilities hamper patients' ability to communicate

• What are the number of procedures that should be performed prior to granting privileges to new medical staff applicants? How will the new applicant document performance of these procedures? If the desired number of procedures cannot be substantiated by a new medical staff applicant, will the privilege be allowed only after observation of the physician's technique? How many procedures should be reviewed to ensure competency?

Identify the annual number of procedures that must be performed in order for the new applicant to be considered for privileges. If the new applicant has not performed the desired number of procedures, specify the number of procedures that must be observed by a physician with privileges during the new applicant's provisional status. Get the new applicant's permission to obtain records from his or her training program or previous hospital affiliations that document the applicant's performance of specific types of procedures.

• What is the definition of a "formal training program"? Is this limited to a residency / fellowship training program, or do posteducation training programs qualify? What educational attributes should be present in a formal training program?

The physician requesting privileges to perform the procedure should be able to provide documentation that he or she received supervised training and hands-on experience. Residency and fellowship programs should be able to confirm in writing the number of cases for each procedure for which privileges are requested and the actual observed level of competency for the applicant.

Privilege decision predicaments arise when an established physician requests new procedure privileges after attending a "short course" training program outside of residency / fellowship education. Such short courses can be defined as an organized teaching program lasting less than several weeks and often only a few days. The clinical departments must determine what types of educational programs provide sufficient training and experience to qualify the applicant for full procedure privileges. Similar criteria can be designed for all posteducational training experiences. The decision regarding the adequacy of the training program rests with the medical staff credentials committee. The ad hoc committees should provide general evaluation guidelines.

Next month's *Quality-Co$t Connection* will discuss how much time can elapse between a training program and the privilege, plus another set of considerations to be addressed by the group in the design of volume criteria.

Resources

Ellis SG, Weintraub W, Holmes D, et al. Relation of operator volume and experience to procedural outcome of percutaneous coronary revascularization at hospitals with high interventional volumes. *Circulation* 1997; 95:2,479-2,484.

Rogers DA, Regehr G, Yeh KA, et al. Computer-assisted learning vs. a lecture and feedback seminar for teaching a basic surgical technical skill. *Am J Surg* 1998; 175:508-510.

Cundiff GW. Analysis of the effectiveness of an endoscopy education program in improving residents' laparoscopic skills. *Obstet Gynecol* 1997; 90:854-859.

Regan JJ, Guyer RD. Endoscopy techniques in spinal surgery. *Clin Orthop* 1997; 335:122-139.

Shwayder JM. The learning curve for laparoscopically assisted vaginal hysterectomy / laparoscopic hysterectomy. *J Am Assoc Gynecol Laparosc* 1994; 1:S33. ■

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Editor: **Dorothy Pennachio**, (201) 760-8700, (dorothy.pennachio@medec.com).
Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Paula Stephens**, (404) 262-5521, (paula.stephens@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.
Editor, *Discharge Planning Advisor*: **Lila Margaret Moore**.

Editorial Questions

For questions or comments, call **Dorothy Pennachio** at (201) 760-8700.

SourceKit

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

Dennis S. O'Leary, MD, president, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL. Telephone: (630) 792-5000; Web site: www.jcaho.org.

Don M. Nielsen, MD, senior vice president for quality leadership, American Hospital Association, Washington, DC, office. Telephone: (202) 638-1100; Web site: www.aha.org.

Becky Miller, director, performance measurement and quality, Missouri Hospital Association, Jefferson City. Telephone: (573) 893-3700; Web site: www.mhanet.com.

Nell Wood, director, marketing and communication, Quality Indicator Project, Maryland Hospital Association, Baltimore. Telephone: (410) 512-4670; e-mail: nwood@mhaonline.org; Web site: http://www.qiproject.org/ContactMHA.asp.

Keith Young, director, data and information services, Alabama Hospital Association, Montgomery. Telephone: (334) 272-8781; Web site: www.alaha.org.

Susan White, vice president, quality management, Florida Hospital Association, Orlando. Telephone: (407) 841-6230; Web site: www.fha.org.

Julia Roberts, media relations manager, Joint Commission on Accreditation of Healthcare Organizations, Oakbrook Terrace, IL. Telephone: (630) 792-5914; Web site: www.jcaho.org.

Thomas Pyzdek, MS, FASQ, quality consultant, Pyzdek Management, Tucson, AZ. Telephone: (800) 628-0432; e-mail: pyzdek@asqnet.org; Web site: http://personal.riverusers.com/~pyzdek.

Bob Morr, vice president, Indiana Hospital and Health Association, Indianapolis. Telephone: (317) 633-4870; Web site: bmorr@inhha.org. ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review*, CE participants should be able to meet the following objectives after reading the March 1999 issue:

- Explain the basis of the concerns of the 17 state hospital associations regarding the ORYX initiative.
- Describe why the downward trend in Medicare spending growth may turn around.
- Explain the upswing, then downswing, in the numbers of sentinel events self-reported to the Joint Commission.

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