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'Storytelling' by staff, patients brings issues to life, aids change

Technique used successfully to support safety, satisfaction, training

It's as old as humankind itself, yet when recast through modern technology, storytelling is becoming one of the newest and most effective techniques for engendering cultural change and facilitating performance improvement in health care.

"It comes down to a question of motivation and change management," explains **James A. Espinosa**, MD, FACEP, FAAFP, medical director of the Overlook Hospital emergency department (ED) in Summit, NJ, and quality advisor and fellow of the Atlantic Quality Institute, for Florham Park, NJ-based Atlantic Health System (AHS), of which Overlook is one of several facilities. "That question always hangs in the air, but conventional elements of QI don't really address the issue."

"It's a great way to train staff," adds **Karen Baldoza**, MSW, project manager for the Boston-based Institute for Healthcare Improvement (IHI). "We have a very fun culture, and this reflected it very well."

The IHI has used video storytelling to create a training video, but its uses are virtually limitless. For example, the National Institutes of Health (NIH) has adapted a CD-ROM "virtual schoolhouse" developed by AHS into a core tool to be used internationally. AHS, which began its pioneering work in storytelling in 1996, has used it to help improve clinical processes, including timely delivery of medications;

Key Points

- Storytelling captures group's interest and personalizes key issues.
- Organizations such as the National Institutes of Health and the Institute for Healthcare Improvement have gotten on the storytelling bandwagon.
- Technique has a virtually unlimited range of potential applications.

to teach principles of quality management (patient satisfaction, teamwork and leadership, cause and effect, patient safety); to support root cause analysis; and to partner with risk management.

Today, storytelling has become a regular feature of its ED microsystem meetings, where stories of what went well and what did not are shared openly.

Why storytelling works

Why has storytelling proven to be such a powerful tool? "Storytelling works because it really brings across more than just facts," notes **Tina Maund,** MS, RN, director of performance improvement, at AHS/Overlook. "On the human level, it really captures people's interest and engenders an emotional investment."

In one application, she recalls, Overlook used it to tell the story of a process. "Our flowchart for medication administration in the OR covered two walls of our conference room," she notes. "So we videotaped to tell the story. Seeing it acted out by real people in a real environment made comprehension much easier."

"It was a way to involve the organization in something different," says Baldoza. "People wanted to work on it because it was different and creative, but it was also a teaching and training opportunity."

"Especially in process redesign, video storytelling can work with a larger group, with everyone having the same perspective since they're all sitting around the table," adds **Linda K. Kosnik,** RN, MSN, CS, chief nursing officer at Overlook and fellow with the Atlantic Quality Institute. "It also validates the importance of the process by using leadership. It allows the staff to really understand what's important to the organization; it becomes more of a personal issue."

Early experiences

What motivated AHS to begin exploring the storytelling technique? "There are a number of elements of health care QI that are imports from industry," Espinosa notes. "And they are excellent at defining problems and addressing the execution of change in terms of where we should head. But to get others to work with you requires *persuasion*. Increasingly, we recognized that what we saw in data persuasion was getting the data to tell a story. We had to get a wide range of people to see a similar vision. In order for it to have meaning, we had to get at what was in our heads, and you can only do that so many times verbally over and over. The theatrical element enables us to *show* what's in our minds."

The first experience with storytelling in video was the "virtual schoolhouse," the core of which were videos of actual patients telling their own stories in their own words. "The virtual world looks like a building, and one room is a gallery of stories, where real people tell real stories about atypical chest pain presentations," Espinosa explains.

"The NIH kept the architecture [AHS sold it to NIH for $1], but upgraded it. They added even more diversity of people to it, and then populated the rest of the world with a lot of 'best-in-class' science, but they kept the core. As we

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understand it, release is imminent, and it will be available to everyone through the NIH web site in time," he explains.

Over the years, AHS has found a wide variety of applications for storytelling. Here are just a few examples:

- **Patient safety education:** "We developed within AHS a core group of scenarios to be used for patient safety education," Maund notes.

"We tried to teach staff in areas where there were errors or the potential for errors through a mini-root cause analysis, using a video." In the evaluation forms, the response was overwhelmingly positive. "We were told that the use of videos was very effective in terms of bringing points across in analyzing safety problems and taking the learning going forward in a way that errors were prevented or situations were made safer," she reports.

After piloting the videos in small groups, the program was expanded and used in AHS' "Megaday," which all staff must attend. "We had people who were recognizable in the clips," Maund notes. "Since some of these people held very high positions, it made it clear there was organizational support for this. Also, with these people being recognized, those watching felt very connected."

- **Critical thinking:** New staff often lack much-needed critical thinking skills, and Kosnik sees this as one of the key challenges in safety and process redesign.

"Hardwiring is a challenge, and this is a great retention tool," she asserts. "New staff really see value in being trained to identify problems as they occur, as opposed to identifying the causes *after* they occur."

- **Redesigning medication processes:** Anesthesia usage in the OR was one example, Kosnik reports.

"You tape the process with a small group. Then, larger groups watch. You stop the video at various points so you can evaluate and see redesign opportunities," she explains. "Then, we re-video the new process and see if we can find holes in it."

Maund notes that a similar process was used with blood specimen labeling. "We had to script the tech to limit interruptions. Using video, the group started critiquing the new process, so by the time we finished, we had a much *better* new process."

- **Live stories:** In this technique, actual patients, family members, or staff are brought in to tell their story to a group. "This allows us to get a firsthand perspective," Kosnik explains.

"These can be positive or negative stories. We also try to look at things that went well [positive inquiry] to make sure they go well again," she says.

Benchmarking is spreading

The NIH and IHI programs are just two early examples of organizations that will be learning from and benchmarking AHS's experiences.

"We've used video clips both in regional conversations in our system as well as in major presentations, such as the IHI Forum, for the last several years," Espinosa reports.

"We presented at the Partnerships for Patient Safety program in Washington, DC, under the auspices of the Veterans Health Administration (VHA), the American Hospital Association, and other associations. It's been of interest because it gives senior leaders something actionable they can do the next day in patient safety, patient satisfaction, and clinical areas," he says.

The IHI training video was a prime example. "Linda, Tina, and I went up there, met with them, and presented the process," Espinosa recalls.

"Their interest was to put together vignettes that had to do with their new standard operating procedures and cultural expectations around conferences. They did a treatment in the form of a debrief, where people talk about conferences, what could have been learned or done differently. Suddenly, you're in the speaker's head; you *see* what happened," he says.

"One of our VPs sat in on that meeting," adds Baldoza. "She thought, 'This is what *we* should be doing.'"

The video uses the stop-action technique particularly well, Espinosa notes. "On the screen, it actually says, 'Stop Here.' It encourages a conversation to occur, for opinions to be expressed."

Real-world problems are outlined, such as how to support a speaker who has audio-visual (AV) problems. "It's really about conscious customer service, but also how any new [standard operating procedure] can be frozen and then disseminated," Espinosa says. "But it's not done as you normally think it would be: 'Here it is, do this.' Instead, it addresses the *why*. What is the heart of this? If you give me meaning, I can do it."

Baldoza, who headed the project for IHI, explains that she pulled people from all different

parts of the organization. "We wanted everyone to be involved. All of a sudden, we found these unique talents; we didn't know that one person had worked for MTV, for example." Like the folks at AHS, Baldoza says she also found that involvement of senior leadership was key.

IHI intentionally picked small problems as their focus, Baldoza explains. "We do a lot of meeting planning, and strange things come up — problems with AV, with the hotel. This gives someone new the ability to see what this might look like, and how they might problem solve."

Baldoza still uses the training video. "We always show it to new people," she says.

It is not hard, or necessarily expensive, to benchmark the experiences at AHS or elsewhere. "It was surprisingly low-cost, and we learned a lot; it was much easier than I thought it would be," Baldoza reports.

"We can give people a plan on what steps to take," says Espinosa. "Leaders just need to know what it is they want to address."

"This can be done in a very low-tech manner," Kosnik adds. "We found that you can just get a room, use the same camera you would use to tape a birthday party, and get extraordinary results."

Espinosa cautions that storytelling is not a panacea to solve all an organization's problems. "Storytelling is like the wing of a bird; it has to be linked to process change," he asserts.

"We have anecdotal evidence that it has been indispensable in our journey, but it's very hard to study scientifically. After all, once you do the storytelling, you have an intervention, and everything is different," Espinosa adds.

Nevertheless, Maund says, "We have found that this is a tool that truly captured people's interest and supports their investment of energy and real commitment to working going forward. Aside from just stating the facts, you really have that humanistic component. People respond in a way that is absolutely absent in the traditional approach." ■

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Risk management: An important partnership

How to present storytelling concept

At first glance, a partnership between staff developing an innovative technique such as storytelling and a department like risk management might seem a bit odd, but it "really isn't off the beaten path," says **James A. Espinosa,** MD, FACEP, FAAFP, medical director of the Overlook Hospital emergency department in Summit, NJ, and quality advisor and fellow with the Atlantic Quality Institute, for Florham Park, NJ-based Atlantic Health System (AHS), of which Overlook is one of several facilities.

"When we talked to large groups such as the Veterans Health Administration or the Department of Defense, they told us one of the big stumbling blocks for them was they couldn't see how they could 'get this past' risk management," he relates. "What they were thinking about was an attempt to map one-to-one their vision of what a story was and show it as if any one individual's take on an event was the same as the event itself, but we know that's not so. Their risk management colleagues have a concern in the discovery process of finding two different versions of reality."

What Espinosa and his colleagues shared with them, and with their own risk management department, was that video storytelling is not an attempt to create a depiction or a memorialization of an event from one point of view, but rather to persuade groups to get a point of view *together* on what the consequences of certain actions might be. "We recognized this was more about partnering with risk management — safety from a system point of view," Espinosa says.

Risk management saw the partnering as an opportunity to share their point of view as well, he notes. "Their input included the recommendation to use amalgams of events rather than individual events, published events in literature, events that are closed claims, or near misses that were not identifiable," he says.

The bottom line, Espinosa continues, is that "we can be helping them. They certainly don't want to see certain events happening again."

The concept now is to go to risk management once a storyboard has been done but before the video has been shot. "This way, they can add a dimension if it has anything to do with safety," he explains. "The potential for trouble arises when the entire video is done *first*." ■

Ventilator education program reduces VAP

Train respiratory care practitioners, ICU nurses

A multimodal education program to teach nursing and respiratory therapy staffs about improved techniques has led to a significant reduction in the incidence of ventilator-associated pneumonia (VAP).

The program was implemented at Barnes-Jewish Hospital, a 1,000-bed university-affiliated primary and tertiary care teaching hospital in St. Louis.

In the 12 months before the intervention, 191 episodes of VAP occurred in 15,094 ventilator days. That rate declined to 81 episodes following implementation, or a decrease of 57.6%. In addition, the estimated cost savings for the 12 months following the intervention were between $425,606 and $4.05 million.[1]

"VAP has such a high mortality rate, and the ICU [intensive care unit] is where a majority of people really get sick, so it is there that you have a greater opportunity to get infections," notes **Jeanne E. Zack**, BSN, of the Washington University School of Medicine, Department of Hospital Epidemiology and Infection Control and co-author of the study.

"Because we monitor certain indicators within our hospital, including VAP caused among people who were intubated, we saw our rate increasing. It was also higher than our national benchmark — the national nosocomial data from the Centers for Disease Control and Prevention [CDC], which they have collected since the 1980s," she explains

This benchmarking was important, she notes, for giving her department an accurate idea of where the hospital stood.

Key Points

- Episodes are slashed 57.6%, more than $400,000 was saved.
- Multidisciplinary task forces draw up new policies, procedures.
- Program is mandatory for respiratory care practitioners.

A quality issue

For Zack, VAP was a clear quality issue from day one. "The thing that really interests me in terms of health care quality is the whole concept of Six Sigma," she explains. "My dad did quality work at Ralston Purina, and I learned about it from him."

Ultimately, she became entrusted with Six Sigma at Barnes-Jewish Hospital. "When I took it on, I told one of our epidemiologists we could get the infection rate to zero," she notes. She recognizes that it's more realistic to take a mechanical device and attempt to achieve an error rate of zero, "but you can strive for it with humans," she insists. "However, one should try to achieve it in a quality way."

Zack says she truly believes that one infection is a negative outcome. "That one person could be my best friend, my brother, my father, or my sister," she says. "That makes it more personal — that person in the bed with a tube in their throat *is* someone's brother, sister, or friend."

Setting up the program

The intervention took place between Oct. 1, 1999, and Sept. 30, 2001, but before it could begin, the groundwork had to be laid. A multidisciplinary task force including two physicians and members of the Barnes-Jewish hospital infection control team was established in February 1999. Its charge: develop a hospital policy. The policy was drawn from existing literature and then compared to the latest CDC recommendations on VAP.

The task force included respiratory therapy, the critical care pulmonary director, infection control specialists, and nursing. "We ended up having

VAP Fact Sheets

A series of fact sheets distributed and posted prominently reinforced staff awareness of proper procedures for minimizing ventilator-associated pneumonia (VAP) at Barnes-Jewish Hospital in St. Louis. The sheets covered five major topics:

1. Risk factors
2. Causes of VAP
3. Decreasing the risk to patients
4. Proper procedure for draining ventilator circuit condensate
5. Collecting a suctioned sputum specimen

Here, for example, are facts contained in sheet #5:

- Wash hands or use waterless antiseptic agent.
- Put on clean gloves.
- Connect suction tube adapter to sputum trap.
- Put on sterile gloves.
- Connect sterile suction catheter to rubber tubing on sputum trap.
- If secretions are thick and tenacious, install small amount of normal saline into endotracheal tube.
- Insert the tip of the catheter into the endotracheal tube or tracheostomy. Do not apply suction. Advance catheter until patent coughs.
- As patient coughs, apply intermittent suction for collection of 2 mL to 10 mL of sputum.
- Remove gloves and wash hands or use waterless hand antiseptic agent.
- Transport specimen within two hours when kept at room temperature or within 24 hours when refrigerated.

Source: Barnes-Jewish Hospital, St. Louis.

task forces at the consortium level," Zack notes, explaining that BJC HealthCare, of which Barnes-Jewish is one facility, is a multisystem organization with 13 different hospitals under one umbrella. "All policies and procedures come out of there," she says. "They come down from the vice president as a prime directive."

The VAP education program, drawn from the new policies, was to target the ICU nursing staff, in addition to the respiratory care practitioners. "We targeted them because they are the primary caregivers to those on ventilators — as such, they have an impact on VAP," Zack explains. "They perform inline suctioning, they may drain the ventilator circuit of condensate, and so on." The program was mandatory for the respiratory care practitioners, and optional — but strongly encouraged — for the nurses.

The program included several different components, including a 10-page self-study module on risk factors and practice modifications; training at staff meetings; and formal lectures. Fact sheets and posters reinforcing the information were posted throughout the ICU and the department of respiratory care services. **(See fact sheet examples, at left.)**

The inservices were provided by one of the infection control staff. For the respiratory care practitioners, two one-hour lectures were taught on the pathogenesis and prevention of VAP.

"The key was to educate people," says Zack. "When I was a staff nurse in the ICU, we knew how take care of patients, but no one talked to us about VAP."

One of the key methods for measuring the effectiveness of the education program was a 20-question exam testing staff's VAP prevention knowledge. The same test was given following the intervention, and test scores were compared. Anyone scoring less than 80% on the post-intervention test (in the case of the respiratory care practitioners, it was given six months after completing the self-study module) was required to repeat the self-study module. The average pre-intervention test score was 79.6; the average post-intervention score was 90.9.

Excitement a key to success

Generating excitement among staff was one of the keys to the program's success, Zack notes. "You can have this great initiative, but it won't be that effective if you don't go out and get people excited. We posted fact sheets in bathrooms and lunchrooms to increase awareness; we didn't just give the test and leave. We also hammered the message home with posters on VAP."

Then, when results started coming in, the excitement level was further reinforced. "After staff did the pre-test, the education, and the post-test, as rates started to drop — the first changes being in the surgical ICU — I mentioned it to my colleagues. They got so excited; they complained when we first gave them the test, but this was a good way of letting them know they had an impact."

The team continued to show personnel their dropping rates at QI meetings. "We told them

Need More Information?

For more information, contact:

- **The Association for Professionals in Infection Control and Epidemiology** (APIC), Washington, DC. Telephone: (888) 235-2074. Copies of the Barnes-Jewish program are available on CD-ROM from APIC ($75 for members and $95 for nonmembers). Call and ask for *BJC Healthcare Presents: Educational Modules for the Prevention of Nosocomial Infections.*
- **Jeanne E. Zack**, BSN, Washington University School of Medicine, Department of Hospital Epidemiology and Infection Control, St. Louis. E-mail: jez3285@bjc.org.

they did a great job and talked about positive things," she notes. "To improve quality, lower lengths of stay, reduce mortality, and save the hospital [more than] $5000,000 is pretty exciting."

It was no less important, she notes, to have a leader who told the respiratory therapy staff that the program was mandatory. "Plus, the other exciting thing is that respiratory therapists receive CEU credits in the state of Missouri for programs like this," Zack adds.

Reference

1. Zack JE, Garrison T, Trovillion E, et al. Effect of an education program aimed at reducing the occurrence of ventilator-associated pneumonia. *Crit Care Med* 2002; 30:2,407-2,412. ■

QIOs go beyond typical quality initiative

Expand target areas for critical care improvement

The national network of Medicare quality improvement organizations (QIOs) has done more than merely support a new initiative by several national organizations to improve critical care; it is in the process of going beyond the basic scope outlined in the initiative.

A QIO is an organization funded by Medicare, Medicaid, and private payers to evaluate and improve the quality of health care services.

The initiative recently was announced by the American Hospital Association (AHA), the Federation of American Hospitals, and the Association of American Medical Colleges, with support from the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the National Quality Forum.

Its intention is to put leaders in the medical community on the same path to improving critical areas of care through voluntary public reporting of hospital performance data.

Over the next three years, under contract to CMS at the U.S. Department of Health and Human Services, QIOs nationwide will:

- Help hospitals develop the capacity to collect and report quality performance data.
- Assist hospitals and physicians in using performance data to identify opportunities for improvement, and then improving systems of care, so every patient reliably gets top-quality service.

To lay the groundwork, CMS has asked QIOs in Arizona, Maryland, and New York to launch a two-year pilot project to work with hospitals to test a broader set of standardized performance measures and develop a consumer-friendly, web-based display of performance data.

"We were awarded this contract in November 2002, and have been working with the CMS folks and with the other two QIOs that have pilot projects — the Health Services Advisory Group Inc. in Arizona, and the Del Marva Foundation for Medical Care in Maryland," reports **Tom Hartman**, project director for the Hospital Public Reporting Pilot for IPRO, the QIO for New York State, based in Lake Success.

Working concurrently

The three QIOs will be working on 10 clinical areas:

- Acute myocardial infarction (AMI)
- AMI/coronary artery bypass graph depression
- Asthma
- Breast cancer
- Congestive heart failure

Key Points

- An opportunity for improving performance and systems of care is to be identified.
- Three quality improvement organizations are to address a total of 10 different clinical areas.
- A eries of quality indicators will be used to inform decision making.

- Diabetes
- Immunization
- Nursing homes
- Pneumonia
- Surgical infection prevention

IPRO will focus specifically on three areas: congestive heart failure, AMI, and pneumonia. "The 10 measures we are talking about are recommended by the AHA," says Hartman. "The pilot projects will be evaluating the use of other measures that go beyond these 10."

This phase currently is in process. "We will test new measures, and the ones that look promising in terms of being useful, valid measures of hospital quality will be added," he says.

Candidate measures will include those currently being used at the local, regional, or statewide level — especially those included in the list of measures endorsed by the National Quality Forum. "We will determine what looks useful to us and what might appeal to purchasers and consumers, as well as those that are regarded as valid by hospitals and physicians," Hartman says.

Ultimately, CMS and the QIOs will make the final determinations. "The intent is to be fairly well uniform," he explains.

Hospitals being recruited

All three QIOs are now recruiting hospitals in their states to volunteer for the pilot project.

"We expect a very high level of participation because we have the support of the Health Care Association of New York State, the statewide hospital trade association, as well as the Greater New York Hospital Association," says Hartman, who notes there are about 230 general acute care hospitals in the state.

"The hospitals will feed us data, and we, in turn, will feed back the results on all these measures both statewide and to all the other states," he says. The data will include performance norms according to size of hospital, as well as region.

"Teaching hospital status will probably be another strata," Hartman notes. Ultimately, these results will be posted on a publicly available Internet site.

Another component of the pilot will be a patient satisfaction survey, which will be provided by AHRQ. "AHRQ and CMS have been working for a number of months to develop a standardized patient experience survey," he reports. "So, the hospitals will not only collect clinical data, but they will test patient satisfaction."

The instrument will be sent to recently discharged patients of each hospital, he explains, and ultimately will be part of the report card that will be posted on the web site.

"This will help consumers make informed choices, and ultimately spur improvement in hospitals," Hartman posits. ■

Need More Information?

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- **IPRO**, 1979 Marcus Ave., Lake Success, NY 11042-1002. Telephone: (516) 326-7767. Fax: (516) 328-2310. Web site: www.ipro.org. E-mail: info@ipro.org.

Hospital receives achievement award

Quality projects recognized

Award recognition programs are another strategy being used locally to spur quality improvement among health care facilities that contract with Medicare.

For example, the Peer Review Organization of New Jersey (PRONJ) recently awarded Columbus (NJ) Hospital, an affiliate of the Cathedral Healthcare System, with an achievement award for its work in Medicare's Sixth Scope of Work quality improvement projects.

The projects included acute myocardial infarction, atrial fibrillation, heart failure, pneumonia, and stroke / transient ischemic attack.

"PRONJ has a contract for the state of New Jersey through Medicare, and Medicare has on a national basis mandated these QI projects," says **Michele Kearney**, RHIA, senior director of information services for Columbus.

The state of New Jersey abstracted 1998 records to come up with baseline figures for participating hospitals, Kearney explains.

"Based on those results, they told each hospital what their baseline was, as well as the target for improvement. In all of our projects, we submitted a QI plan indicating who would do what, updated our forms as we implemented the projects, and we surpassed all targets," she adds.

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The hospital was provided with software to abstract the records for all quality indicators, and then submitted the data back to PRONJ.

Work started on the projects in early 2000, Kearney recalls. "Basically, I outlined the plans and took them to our quality assessment committee and they approved it," she says, noting that Columbus is a small (210 beds) community hospital. The quality assessment committed was comprised primarily of medical staff, with representatives from nursing and health care utilization resources as well.

PRONJ assisted all participating hospitals along the way, providing free publications, posters, and pocket cards to physicians. "At each departmental meeting, doctors presented their data, and reminders were put in our newsletter as well," notes Kearney. "It was mainly a matter of keeping awareness high."

Results were monitored at monthly quality assessment committee meetings. "Whatever we found, it was reported to the physicians present at the meetings," Kearney observes. "In some cases, we found that if an area was not meeting its target, it was a documentation omission rather than a failure of performance, so we revised the discharge instruction forms to make reporting simpler." ■

Benchmarking could save hospitals billions

Mortality, complications could be reduced

If overall performance in all acute-care U.S. hospitals were the same as the nation's top hospitals, close to 57,000 more patients could survive each year and nearly $9.5 billion in annual expenses could be saved, according to a study by Evanston, IL-based Solucient.

The study, *Solucient's 100 Top Hospitals National Benchmarks for Success*, recognizes 100 hospitals for setting national performance benchmarks across four critical areas: quality of care, operational efficiency, financial performance, and adaptation to the environment.

Among the study's key findings:

The number of medical complications could decrease by more than 18% for patients in nonwinning or "peer" hospitals, affecting more than 150,000 patients annually, if those hospitals improved to the winning or "benchmark" performance level.

If all hospitals operated at the benchmark level, a patient's average length of stay could show a marked decrease.

"Winners of the 100 Top award have demonstrated superior performance across their hospital as a whole by successfully balancing quality of care with operational and financial performance to better meet community needs and assure improvement of outcomes for patients, while adapting to external constraints and pressures," says **Jean Chenoweth**, executive director of Solucient's 100 Top Hospitals program.

"In short, these hospitals are able to bring increasingly better services to their patients and provide great value to their communities, despite the growing pressures of an aging population and tighter reimbursements," she says.

Among the study's other findings:

Winning hospitals treat more — and sicker — patients than nonwinning hospitals, admitting an average of almost 16% more patients and maintaining a higher patient-case mix than peer hospitals.

The 100 Top Hospitals provided more successful outcomes, helping patients survive life-threatening illness 10% more often than their peers.

Winning hospitals employ fewer staff but offer nearly $2,000 more per employee in annual salary and benefits than do peer hospitals. A recent related Solucient study indicated that benchmark hospitals tend to maintain higher ratios of registered nurses to inpatient days.

Total profit margins for winning hospitals are twice that of their peers. However, benchmark hospital revenue tied to outpatient services is

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lower than at peer hospitals.

The Southern region of the United States represents the highest number of benchmark hospitals (31), followed by the North Central region (29), the Northeast (26), and the West (15).

"Our results indicate that winning hospitals are achieving success through routine measurement of key performance indicators and collection of accurate internal and comparative information," Chenoweth says. "These hospitals appear to understand that a focus on daily organizational and clinical processes in combination with sound strategic decision making assures better patient outcomes and greater organizational efficiency."

The study scored facilities according to key measures: risk-adjusted mortality and risk adjusted complications, average length of stay, expenses, profitability, percent of outpatient revenue, total asset turnover, and data quality. ■

Are patients' DNR orders overinterpreted?

They may be marker for less-aggressive care

A new study conducted by researchers at the Johns Hopkins University School of Medicine in Baltimore indicates that some physicians may be overinterpreting the do-not-resuscitate (DNR) orders that some patients opt for near the end of their lives. Aside from withholding cardiopulmonary resuscitation in the event of a cardiac arrest under DNRs, the study finds that some physicians also are refraining from using other kinds of life-saving procedures for patients who have DNRs.

"DNRs are supposed to be intended to allow patients to forego CPR after arresting," explains **Mary Catherine Beach**, MD, MPH, assistant professor at Johns Hopkins School of Medicine, and the study's co-author. "Generally, patients who choose a DNR may also choose to forgo other life-savings measures, but the DNR was not intended for this purpose. During my medical training, I noticed that docs with DNRs on their patient would question doing other life-prolonging procedures as well."

Key Points

- Physicians sometimes refrain from other life-saving procedures.
- Physicians should openly discuss goals of therapy with patients.
- Educators must provide physicians with skills needed for such situations.

Because patients can reasonably choose to forego CPR yet still wish to receive other life-sustaining or life-prolonging treatments, Beach became concerned that DNRs were being used as a surrogate marker for less-aggressive care, rather than as a specific instruction. This, in turn, led to the study, which appeared in the December issue of the *Journal of the American Geriatrics Society*. (The effect of do not resuscitate orders on physician decision-making. *2002;* 50:12.)

The findings of the study appear to confirm Beach's suspicions. The study reported responses from 241 physicians (352 attendings and 111 residents were surveyed, with a 52% response rate), describing three cases dealing with patients who had life-threatening illnesses. Some physicians were told the patients had DNRs, while some physicians were told the patients did not have DNRs.

"We designed a survey for all attending and resident physicians at a large urban academic facility," says Beach. "We presented three clinical vignettes in which otherwise identical patients did or did not have a DNR. This was followed by a series of 10 treatment options; the doctors were asked to rate whether they would agree the patients should have those treatments." In each of the three scenarios when a DNR order was present, the physicians were less likely to provide life-sustaining treatment for the hypothetical patient. "Some of these

COMING IN FUTURE MONTHS

■ What resources do leading institutions use for knowledge sharing and tool development?

■ How to use benchmarking to enhance productivity, financial performance

■ Multisystem umbrella yields uniform policies and procedures

■ Intensive care specialists reduce hospital death rates

■ How to put the pizzazz back into your benchmarking efforts

treatments actually have nothing to do with CPR," she notes.

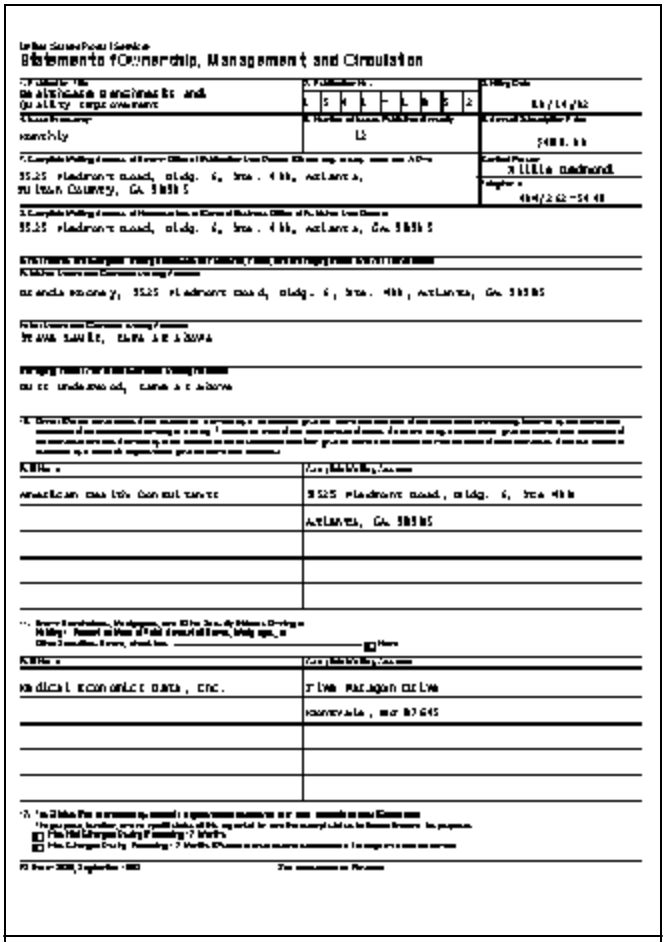
Why would physicians react in this manner? "I think when someone sees a DNR, he thinks the patient is dying," Beach explains. "So when they ask themselves, 'Why should I do this colonoscopy?' they're really saying, 'Why subject someone who is dying to unnecessary pain and suffering?'" Of course, the patient may, in fact, want that colonoscopy. There are several ways to avoid such possible misunderstandings, she says:

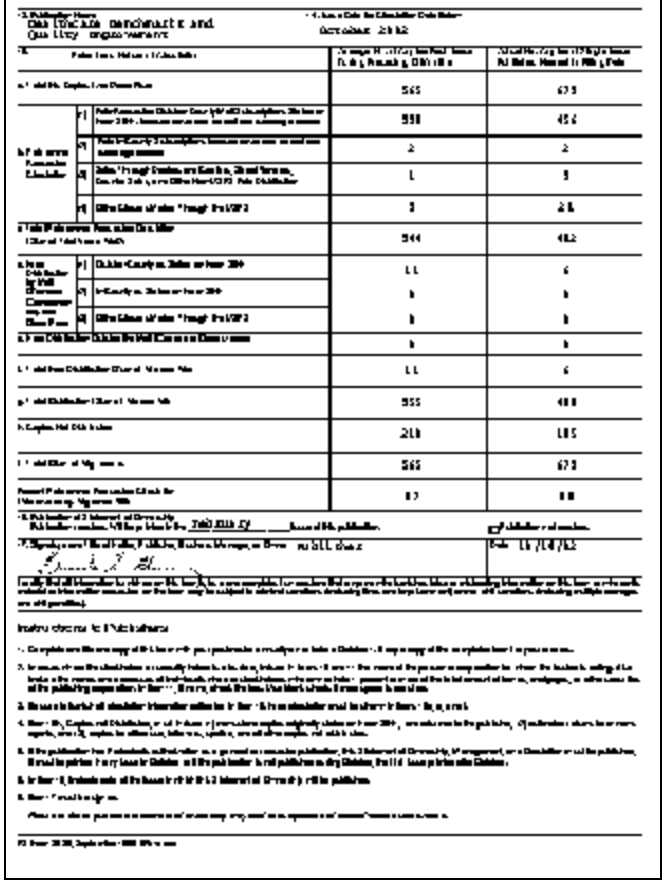
- **Physicians should openly discuss the goals of patient therapy with their patients.**

"Go in and have a discussion of what the patient hopes to achieve," she advises. "You can then negotiate more specific treatment options, [and] have them noted in the chart and communicated to all involved in the patient's care."

- **Hospital policy should distinguish DNR from palliative care.**

"Some hospital policies simply mention 'routine terminal care,'" notes Beach. "Some routine procedures are certainly not equated with DNR."


Statement of Ownership, Management and Circulation



Need More Information?

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- **Medical educators have to educate physicians in the skills needed to take on these discussions.**

"Palliative care should be devoted to achieving a higher quality of life, as well as making these decisions," Beach asserts.

"Quality managers should review such cases with physicians and remind them that DNR orders do not mean 'don't treat the patient,'" she says. ■

Cardiologist care critical

Many Americans survive a heart attack only to die from a second heart attack or other medical problem soon after leaving the hospital. But a new study sponsored by the federal Agency for Healthcare Research and Quality suggests that heart attack patients fare better if they are treated by a cardiologist, and better still if they are treated by cardiologist and a family physician or internist rather than by a primary care physician alone after they go home from the hospital. The study was published in the November 21, 2002, *New England Journal of Medicine.* ▼

Is simple approach better for heart rhythm problems?

Findings in a study published in the December 5, 2002, *New England Journal of Medicine* say the preferred way of treating common heart rhythm problems is actually no better, and perhaps even worse, than a simpler approach using cheaper drugs.

The study shows that the method of restoring and maintaining heart rhythm prevents no more deaths than the alternative approach that merely controls the rate at which the heart beats.

The "rhythm" approach does not reduce risk of stroke or improve quality of life — all of which had been presumed to be benefits over the "heart rate" strategy. ■