AMERICAN HEALTH CONSULTANTS®

Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

IN THIS ISSUE

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Health care organization shares the wealth with 'benchmarking days'

Site visits from other institutions yield two-way learning process

Being a nationally recognized health care system certainly has its benefits, the most obvious being "front-of-mind" awareness and a favorable perception among potential patients.

But Baptist Health Care Corp. of Pensacola, FL, recipient of numerous awards and honors for excellence both in health care and as an employer, has parlayed its reputation into a new profit center as well as a new source of benchmarking — both for fellow health care organizations across the country and for its own benefit, as well.

The vehicle for these new opportunities is the Baptist Health Care Leadership Institute (www.baptistleadershipinstitute.com), established in late 1999.

"It really came out of requests from health care colleagues across the country," notes **Pam Bilbrey**, MS, MBA, senior vice president of corporate development for Baptist Health Care.

Bilbrey has responsibility for Baptist University, Baptist Health Care's extensive leadership development program, and also holds executive-level responsibility for the Baptist Health Care Leadership Institute, as well as serving on its faculty.

"We had really done some major cultural change, we received a

Key Points

- Institute evolves into new profit center for health care system.
- Services were dictated by demand from institutions across the country.
- Before visit, attendees asked to identify their areas of greatest concern.

lot of recognition nationally, and word got out among our colleagues. They asked if they could come spend time with us or interview our leaders on the phone," she explains.

What drew these other institutions to Baptist? Here is just a sampling of the awards it has received:

- It received the *USA Today* Quality Cup for extraordinary results in employee and patient satisfaction.
- It was recognized by the Herman Group as an "Employer of Choice."
- It ranks in the top 1% in patient satisfaction as measured by Press Ganey Associates.
- As a result of an independent employee satisfaction survey, Sperduto and Associates said that "Baptist Health Care has the highest employee morale we have ever seen, in any industry."
- Baptist recently was ranked #15 by *Fortune Magazine* in its "100 Best Companies to Work for in America" listing, by far the highest-ranking health care employer.

Only way to respond

Baptist's leaders were flattered by all the attention and happy to help their colleagues, "but it became overwhelming," Bilbrey recalls. "People would come here to benchmark, and then they'd say, 'This is great, can we send more people?' The institute was established as a way to manage this demand, and it grew from there."

And grown it has. To date, 1,200 health care groups from 47 states have come to Baptist, sending a total of more than 5,700 professionals. The institute's services include:

- benchmarking sessions;
- seminars and special events;
- consulting services;
- best practice resources;
- speaking engagements;
- audit tools.

The institute has become a new profit center for Baptist, says Bilbrey, noting that it became necessary to charge for the services because of the time its staff had to spend meeting requests from the other institutions.

Benchmarking at the core

Benchmarking, and more specifically the "benchmarking days" that Baptist offered to other hospitals, were the foundation of the institute in its early days and ultimately led to the additional services. "After the success of the benchmarking days, we created the seminars, then after that, people asked us to consult with them," she says.

On a typical benchmarking day, one health care organization will visit, sending a leadership team of anywhere from six to 15 or 16 people.

"Before they arrive, we ask them to fill out an organizational profile on who they are," Bilbrey notes. **(See an excerpt, p. 27.)**

The profile includes basic statistics, such as the size of the facility, number of emergency department visits, services offered, and so on. Other information requested includes patient, employee,

(Continued on page 28)

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Organizational Profile — Excerpt

Employee Satisfaction Information

Number of employees: _____ Annual turnover rate: _____

Are you experiencing a nursing shortage? ☐ Yes ☐ No

If yes, is it moderate or severe? ☐ Moderate ☐ Severe

Are you currently measuring employee satisfaction? ☐ Yes ☐ No

If yes, what measurement tool are you using? _____

How often do you measure? _____

What would you say is the knowledge of employee satisfaction scores in your organization?
☐ High ☐ Average ☐ Low

What are your various employee communication methods/venues?

_____

_____

_____

Leadership Development

Do you currently have a leadership training program in place? ☐ Yes ☐ No

If yes, please describe (number of leaders involved, frequency of meetings, etc.):

_____

_____

_____

Is there any other information about your organization that would be helpful to us as we prepare a proposal to assist you in pursuing a culture that supports service and operational excellence?

_____

_____

_____

What are three specific expectations you have of a consulting engagement on service and operational excellence?

1. _____

2. _____

3. _____

Source: Baptist Health Care, Pensacola, FL.

Need More Information?

For more information, contact:

- **Baptist Health Care**, 1000 W. Moreno Pensacola, FL 32501. Web site: www.ebaptisthealthcare.org. For more on benchmarking, contact Becky Siegel at (850) 469-7084. E-mail: bsiegel@bhcpns.org.

and physician satisfaction scores, turnover rate, and nursing shortages. "Then they share with us their top three or four challenges," she says.

With the information in hand, the institute staff seek to create a day that addresses the concerns noted by the participating institution. "For example, if their concerns lie primarily in the area of patient satisfaction, we would be more heavily weighted in that area, or if they have specific clinical areas on which they want more information, we'll focus on that, but we always include a more rounded agenda," she explains.

The morning begins with a welcome and introduction to Baptist Health Care's organization and culture by the president of Baptist Hospital. "Then, typically, we'll move into the area of employee satisfaction, making the case that you need a high level of employee satisfaction before you can reach a high level of patient satisfaction," Bilbrey says. "Then we move into patient satisfaction."

These two areas are always covered, regardless of the specific needs expressed in the profile. Afterward, the more specific areas are covered.

"One of the techniques we use is scripting," she notes. "So, if they are interested in the business office, we will go into detail on how to develop scripts, what they are, and how they work."

Developing leadership, accountability

Other areas covered include leadership development and accountability. "We discuss why you need to develop leadership accountability, why it is so critical, and how you hold leaders accountable to drive results," Bilbrey says.

All benchmark days also include a tour of the facility, which again reflects the visiting institution's areas of interest. The day starts to wind down at about 3 p.m. The fee for the day generally runs around $5,000, she says. "That's because of the massive number of people and staff we have to take off-line," she explains. "In addition, we provide lunch and lots of materials." The fee also covers follow-up calls and questions.

One of the neatest things about these benchmarking days, Bilbrey says, is that each visiting organization is asked to bring a 30-minute discussion of one of its best practices.

"Depending on what it is, we invite the appropriate people from our staff to listen to the presentation," she says, which results in two-way benchmarking. "Everybody loves to tell about their successes."

After a recent presentation in Las Vegas, Bilbrey was approached by an institute graduate — in another example of the student becoming the teacher.

"She had brought home information about our 'daily huddle' [through which staff are updated about system events on a daily basis], which she thought was a great idea and which her facility implemented. However, they took it a step further; they also found a way to use the tool with their physicians. Each day, they post the 'daily' up on a wall in front of the sink in the OR, so whenever a doc scrubs, he sees it. I brought this back to our teams, and I think we will use it here," she explains.

What's ahead for the Baptist Health Care Leadership Institute? For one thing, garnering participants from the three states that have not yet had any facilities attend benchmarking days.

"It's kind of a contest," Bilbrey explains. "For example, we haven't gotten Rhode Island yet, but we may have someone from there soon. We're trying to get all 50 states; it's a fun thing to track. ■

Benchmarking beneficial for fiscal management

Productivity opportunities can be identified

When considering opportunities to improve financial performance, benchmarking may not immediately come to mind; but health care managers who have used benchmarking techniques to enhance the fiscal well-being of their institutions have found it to be invaluable.

"We use benchmarking to compare ourselves [to other institutions] in terms of productivity, fiscal performance, volume, quality of care, and patient satisfaction," says **Kevin Hammeran**, chief administrative officer of James Whitcombe Riley Children's Hospital in Indianapolis.

Key Points

- For many, fiscal responsibility is a key component of quality.
- Cost, quality, speed of service comprise "three-legged stool" of performance.
- Benchmarking helpful in pointing out institutional differences as well as similarities.

"Benchmarking is like a signpost to me; it indicates the areas I need to go look at in more detail or depth to determine if opportunities for improvement exist if I'm outside the benchmark," adds **Teresa A. Stroud**, RN, MN, vice president for patient care services at Kosair Children's Hospital in Louisville, KY.

"I start by looking at all benchmarks from both a quality and a financial framework," she continues. "Our mission as a pediatric hospital is to provide the best quality of care. That can be defined as clinical quality, but it is also entails a fiscally responsible level of care; we have to remain fiscally sound so we can continue to fulfill our mission."

"Financial benchmarking should be used as part of the performance improvement process, just like we use outcomes measures," asserts **Sharon Lau**, a consultant with Medical Management Planning (MMP) in Los Angeles.

Lau is quick to add that such benchmarking should not be viewed in a vacuum, noting that she pictures health care as a three-legged stool, comprised of cost, quality, and speed of service.

"Take the laboratory as an example," she says. "Your productivity/financial indicators may include cost per billed test. Those numbers could be very low, leading you to conclude you are very productive. But what if it takes six hours to get a [complete blood count] with differential results, and 50% of them have to be redone? That's why you have to balance all three of those aspects."

You certainly can use your financial data to set targets for productivity or supply costs, she notes. "That's what we recommend, but you need to look at all three legs, making sure you are well-balanced, and try to raise the bar in all three areas."

A wide range of applications

Both Stroud and Hammeran have employed benchmarking in a wide variety of applications. "When we first started working with MMP about eight years ago, we were really bad on supply costs per adjusted discharge," recalls Stroud.

"Since that time, we've worked really hard on managing supply costs. We've been able to use benchmarks to give us direction, and since we've benchmarked a group of hospitals, they've given us ideas as well," she adds.

"In the process, we've been able to make improvements; we're now below the median [in costs]. We're not the best, but we were the worst out of 19 to 20 hospitals, and we've improved to within the top five."

Stroud has utilized measures such as total expense per adjusted patient day to assess performance at her 255-bed tertiary teaching pediatric acute care facility, which is affiliated with the University of Louisville.

"We're part of a multihospital system, so there are expectations about our performance," she explains.

"Because we're a pediatric hospital, there's not that much benchmarking data out there. The common practice would be to compare us to adult hospitals, so MMP [and its databank of children's hospitals] helps me justify my staffing," Stroud says.

Competing for resources

Hammeran faces a similar challenge. "We're an institution within Clarian Health Partners, a collection of facilities that includes the state's only university teaching hospital, its premier private care hospital, community hospitals, and us," he explains.

"Like any other institution that is part of the system, we have to compete for resources. What we usually find is that kids are more expensive [to treat] than their adult counterparts, and children's hospitals have higher staffing ratios [eight full-time equivalents (FTEs) per adjusted occupied bed vs. five on average for an adult hospital]," Hammeran points out.

When it comes time for the system to cut costs, the natural tendency is to treat all facilities the same. Benchmarking, however, enables Hammeran to demonstrate the distinct nature of his hospital.

"It allows us to demonstrate that an FTE cut to us has a more profound effect than it would on an adult hospital," he observes. "We have consistently seen situations where if you look at systemwide benchmarks, we're in good shape, but compared to other children's hospitals we need to add staff."

Stroud has had a number of other occasions to use benchmarking to address financial issues. "We put together a performance improvement team for our emergency department [ED] and redesigned the patient-flow process and developed an admission express unit. This reduced wait times for beds and offloaded workloads for the ED," she recalls.

"We saw patients in a more efficient manner, but with the redesigned staffing, we actually decreased total costs per visit," she says.

Stroud says she also has benchmarked lengths of stay data for specific DRGs. She has some advice for those looking to do the same: "Revenue benchmarks, costs, and numbers in general can be pretty straightforward, but issues can be buried as well; you can't just look at the surface."

"During one benchmark project, I had a blip on labor costs, and I had to go down behind the numbers and study the problem. What I found was that my psychiatric unit was markedly different from those in other kids' hospitals, so in that case, it told me the higher labor cost was appropriate," she says.

Productivity, fiscal performance

The two major areas in which Hammeran employs benchmarking are productivity and fiscal performance. His facility, a 262-bed hospital, is the only acute care children's hospital in Indiana.

"We're highly specialized, which is reflected in the case mix index [CMI], the second highest among the members of the National Association of Childrens' Hospitals and Related Institutions [NACRI]," he says.

CMI, Hammeran notes, is a measure of case complexity, but it also can be used as a proxy measure of acuity.

When it comes to productivity benchmarking, "We measure most major departments in terms of worked hours per patient day, and ancillary services by worked hours per test or procedure, and larger support areas like maintenance in worked hours per square foot," he says.

"These are the most relevant indicators of actual production or workload. While they are not adjusted for acuity, to the extent you can cluster similar patients in each unit, it is helpful," Hammeran explains.

In fiscal areas, his staff look at measures such as cost per adjusted patient day and other indicators of fiscal health like profit before and after disproportionate share revenues.

"We consider operating margin, what our salary and benefit costs are per FTE, benefits as a percentage of salary, number and vacancy rates per RNs, supply expenses, and energy costs per patient days," Hammeran notes. "This way we get some sense of how we're faring within the local market."

His competition basically is not other children's hospitals, but community hospitals in the surrounding area, he explains.

"If we get too big a distance between us and them in our charges or in our costs per patient day, insurers will simply have patients sent someplace else," he says.

"In theory, ultimately children's hospitals would become places where only transplants are done, and they will be the most expensive hospitals around," Hammeran points out. "To avoid that, we depend on a certain amount of 'bread-and-butter cases,' and in turn, we have to be reasonable on what these cases cost."

Accordingly, his hospital used benchmarking to help determine where its rate structure should be. "We wanted to be the most economic facility we could, despite our high case mix," he says.

"Some insurers will refer patients out to us across state lines, because we are one of the best places to send patients for transplants," adds Hammeran. "But our charges are probably some of the best in the country among children's hospitals, and our outcome survival rates are superior, so we are a very good buy."

Part of the culture

Benchmarking can be used very effectively as a way to identify opportunities for improvement in financial management, Lau says, but it's more effective if it becomes part of the culture.

"Benchmarking is like any other tool; if you use it at the 11th hour, it will just be seen as a slash-and-burn tool," she notes. "This makes frontline managers afraid of it."

You should keep your expectations reasonable, Lau adds. "We don't expect clients to get to the top right away. We set a reasonable target, say 80% of your ultimate goal, for the first year. Then, you can go for 90% the second year, and so on. But make it part of the whole culture of your organization; don't wait until you have a dire situation to use it."

Despite the undisputed value of benchmarking in financial endeavors, you shouldn't operate

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with blinders on, Hammeran warns.

"One of the problems all administrators have is that they spend a disproportionately large amount of time on the fiscal end of the house and not enough on clinical care indicators," he says.

"In a very real sense, if you do the right things clinically, economics will take care of itself. I prefer to look at what our measures are in the clinical realm compared to other children's hospitals: cardiac mortality rate, catheterization complication rates, five-year survival rates, and so on. If you don't have the best rates or you're not in close proximity to the best, you should be doing a gap analysis to find out why other institutions have better rates than you," Hammeran adds. ■

It's back to school for system leaders

Institute teaches leadership skills, cooperation

Health care leaders in Ann Arbor, MI, are returning to school so they can learn how to better care for a highly complex patient: the multisite, multispecialty academic medical center known as the U-M (University of Michigan) Health System.

In collaboration with the U-M Business School, the Health System recently has kicked off its new Health Care Leadership Institute.

The new institute's program will graduate hundreds of leaders with a shared vision to implement health care strategies simultaneously at U-M Health System.

Hospital, medical school, and health maintenance organization executives are using the 10-month "business of health care" program to advance their skills in health care management and leadership in order to improve the way medicine is delivered at the U-M Health System.

"There are a couple of things underpinning what we're trying to do," says **Allen Lichter**, MD, dean of the U-M Medical School.

"The first is that many of us, at least on the physician side, come to leadership without a lot of training in leadership and management. There are a lot of basic skill sets physician leaders especially need to be educated on, and we wanted to provide that forum," he says.

The second driving force of the program, Lichter explains, is bringing all of the system's top leadership through the same educational process.

"In our complex organization, we will have physician leaders, administrators in the hospital and in the medical school, and leaders in our HMO all speaking the same language and discussing issues together. I believe there is tremendous strength we create when all of us are working together," he declares

Expertise close at hand

To design the curriculum, health care leaders had to look no further than the U-M campus. The design, development, and delivery of the program were directed by the Executive Education Center of the U-M Business School in collaboration with the Medical School. The U-M School of Public Health also is a program contributor.

"The business school is expert at executive education," Lichter observes, noting that the school provides the faculty for the program.

The program is a multidisciplinary learning experience and involves preparatory assignments, class sessions, and "action learning" projects, in

Key Points

- Hundreds of leaders will graduate with a shared vision of health care strategies.
- Physician leaders and HMO, hospital, and medical school administrators participate.
- Health system piggybacks on expertise of business school.

which participants analyze and recommend solutions to current U-M Health System leadership on management issues. Participants learn and apply concepts and tools in the areas of strategy; financial management; change management; managerial leadership; marketing strategy and positioning; operations management; information and business process; research and development; innovation, negotiation, and decision making; and strategic human resource management.

In the current class of 2003, examples of the action-learning projects include:

- Managing the Supply Chain: The Case of High-Cost Intermediate Products;
- Obstetrics/Gynecology: Short-Term Capacity vs. Long-Term Planning;
- Blue Cross/Blue Shield: The Value Proposition;
- Clinical Simulation: The Impact of Education and Care.

No more silos?

Among the perceived benefits of the program is the breaking down of the silos so typical in an academic medical center setting. "We tend to function, at times, in our organization as multiple independent businesses," Lichter says.

"As health care has evolved, however, we find patients cross multiple lines, needing to be seen in several different areas. On the financial side, investments may be made in one area, but they can affect several, so we have to start functioning as one organization," he adds.

U-M leaders also believe the new program will ultimately improve the way medicine is delivered at the U-M Health System.

"When we talk about medical care delivery, part of that has to do with efficiency — how our patients see us and how our co-workers see us — and those are some of the areas we are getting into," says **Darrell Campbell**, MD, chief of staff at the U-M Health System and a student in the program.

Leadership principles not normally studied by physicians will help improve patient safety, he asserts.

"Patient safety is all about communication, at the very lowest levels to the very highest," Campbell explains. "What we're trying to do as leaders is point out the value and the importance of communication from the front line to the top, and know where the potential mistakes are," he adds.

"Patients need and expect a seamlessness in their care," Lichter says. "Handoffs are not their problem; they are *ours*. If we do it well, patients and their referring physicians will receive much more efficient and effective health care."

Satisfied students

Campbell and Lichter, both of whom will be part of the institute's first graduating class, are enthusiastic about their experiences to date.

"We've completed four or five sessions, and I think it's been terrific," Campbell says. "There are a lot of aspects of running a business for which doctors are not very well-prepared. The idea is to merge the different medical interests and work on areas doctors don't know much about."

For example, he notes, his last session was devoted to developing a team culture and an optimal working environment.

"We've looked at how we communicate, the best ways to communicate, understanding stressful conditions, and we shared surveys on how other people see us and characterize our performance and our style," Campbell says. "We also had a daylong session on the basic principles of accounting."

"It has been terrific," says Lichter of his experience as a student. "We have had sessions on basic finance, which has really opened our eyes in terms of how we can use the financial data we have to make better decisions about potential investments. We spent a day talking about the concept of strategy, how one can take an organization, look down the road, and anticipate what will happen in the industry.

"This way, you can make sure you are not only prepared to face those problems, but to even shape how the industry's future will unfold. We spent our last session talking about organizational culture — what it is, how to measure it, why it's important, and how it can be changed," he says.

The full-day class sessions take place one day a month for 10 months. Between sessions, participants divide into work groups to take on the action-learning projects.

Essential to each project is the work group's cross-disciplinary composition, which creates a collaborative experience so that participants gain a clearer understanding of other disciplines and can build more effective relationships across these boundaries. Work groups will spend approximately six hours a month on their action project,

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which culminates in an oral presentation and a written report.

"We broke up into six teams to tackle six very interesting problems," says Lichter. "There were six members on each team, all from different parts of the organization. We are working on creating a center for spine care, but doing that inside this complex organization is not easy; we're looking at how we price products, at our interaction with Blue Cross/Blue Shield, and asking what value we can demonstrate that we bring to this interaction."

Looking to the future

Lichter notes that the program will run on a yearly basis, "Until we bring large numbers of leaders through it." As each succeeding class graduates, the U-M Health System expects to see an overall improvement in the business management of health care, as well as in the ability to deliver quality products and outcomes to consumers, payers and other business partners in this 15,400-employee organization.

While the program, for the time being, is open only to internal candidates, future plans for the Institute involve opening up the nondegreed program to health care executives from outside the U-M sphere.

"To the extent that our business school and some of our leaders see value in this, and other health care leaders feel they could benefit, it's quite possible we could open courses like this for other institutions," says Lichter.

Beyond the obvious tangible benefits of the program, Campbell sees some intangible benefits as well. "One is the camaraderie between the 30 leaders currently participating," he says.

"We don't often have that opportunity to look at the big picture. We have a whole day during which we can turn off our pagers and think about making this place better. That's incredibly important," Campbell says. ■

Lower mortality, LOS seen with intensivists

Mortality differences shown in ICUs, hospitalwide

Closed intensive care units (ICUs) — those in which an intensivist is the patient's primary attending physician — or ICUs that require mandatory critical care consultation with an intensivist experience lower mortality rates and shorter lengths of stay (LOS), according to a study published in the Nov. 6, 2002, *Journal of the American Medical Association (JAMA),* "Physician staffing patterns and clinical outcomes in critically ill patients."

The report, which examined 2,590 abstracts and identified 26 studies, resulted in 27 comparisons of alternative staffing strategies regarding ICU attending physician staffing strategies and the outcomes of hospital and ICU mortality and LOS.

Among the results of the study:

- High-intensity staffing was associated with lower hospitality mortality in 16 of 17 studies (94%).
- High-intensity staffing also was associated with lower ICU mortality in 14 of 15 studies (93%).
- High-intensity staffing reduced hospital LOS in 10 of 13 studies.

The *JAMA* authors used the term "high-intensity" to denote hospitals that used either a closed ICU or required mandatory critical care consulting.

"When we pooled all the evidence together, as if it were one large study, the total body of evidence suggested high-intensity staffing would reduce hospital LOS by 29% and hospital mortality by 39%," adds **Peter J. Pronovost**, MD, PhD, lead author of the study and associate professor of anesthesiology and critical care medicine at Johns Hopkins University School of Medicine in Baltimore, which cosponsored the study along with the University of Pittsburgh.

Key Points

- Combination of knowledge, presence in hospital seem to make the difference.
- Despite lower cost, intensivist staffing seen at small minority of hospitals.
- It's up to hospital leadership to change strategies in staffing.

"We think that what makes the difference is the combination of knowledge and presence [in the ICU] — knowing what to do; which is greater, we don't know," he says.

There is a distinct difference in the amount of training an intensivist has received, as opposed to a typical attending physician in an ICU that does not employ high-intensity staffing.

"An intensivist has usually been trained in either surgical medicine or in pediatrics, and has then gone on to do a fellowship in critical care," Pronovost notes. "In the nonintensive model, you have mostly primary care docs."

In addition to not having the same training, these physicians are not present in the ICU during the day like intensivists are. "During the day, they go to the office, while intensivist staffing stays in the hospital," Pronovost observes.

This offers a double advantage. First, the intensivists quickly develop many more hours' experience in the ICU. In addition, "Since they are actually present in the ICU instead of in the office, they are there and available to make a decision on the spot," he points out.

A no-brainer?

No official numbers are available, but estimates are that only about 10% of hospitals in the United States employ the intensivist model. Is this because of financial limitations?

Quite the contrary, says Pronovost. "We've published studies that show hospitals can save millions of dollars a year if they used the intensivist model," Pronovost says. (The studies can be found on the Leapfrog Group web site: www.leapfrog group.org.)

"It's more of a hospital leadership issue," he asserts. "If you changed the structure, several people would have to bite some bullets — docs won't be billed for consultations, and so on. Hospital leaders need to stand up and say, 'We should do this.'"

There also may be some shortages of intensivists, Pronovost concedes, but he quickly adds, "Many hospitals have not made the effort to find out if the shortage is real."

(Editor's note: The corresponding author for the JAMA *study is: Derek C. Angus, MB, ChB, MPH, 604 Scifel, CRSA Laboratory, Department of Critical Care Medicine, University of Pittsburgh, 200 Lothrop St., Pittsburgh PA 15213. E-mail: angusdc@ccm.upmc.edu.)* ■

Ongoing studies cite clinical best practices

AAAHC IQI seeks to provide QI benchmarking

The Wilmette, IL-based Accreditation Association for Ambulatory Health Care Institute for Quality Improvement (AAAHC IQI) is seeking to provide quality improvement opportunities for health care professionals through a series of clinical performance studies, which began when the organization was established in 1999.

To date, 11 such studies have been performed, covering ambulatory care areas such as colonoscopy, knee arthroscopy, and cataract extraction; and disease management issues such as asthma.

These studies have a distinctive philosophical approach, explains **Sam J.W. Romeo**, MD, MBA, head of the association's performance measurement initiative and a medical administration consultant in Turlock, CA.

"To survey or review the literature is an episode of confirmation, but it does not demonstrate an ongoing culture of commitment to quality," says Romeo.

"We need to do that on our own initiative. I've been appalled more often than not by the initiatives coming from payers, but if we as a profession don't belly up to the bar and demonstrate what quality is, we have every right to be criticized," he adds.

The studies, he explains, "must be based both on what is known objectively and what we learn empirically."

Romeo's goal was to put in place a mechanism to create an ongoing current and prospective way of measuring quality.

"Heretofore, almost all studies have been done on a retrospective basis; by the time they appeared, the horse was often out of the barn, and many 'errors' would appear simply because the knowledge had changed," he observes.

Key Points

- Ongoing, prospective studies seen as more beneficial for benchmarking.
- Identified best practices may be transferable to many clinical areas.
- Study participants submit flowsheets to facilitate comparisons.

Need More Information?

For more information, contact:

- **AAAHC IQI**, 3201 Old Glenview Road, Suite 300, Wilmette, IL 60091-2992. Telephone: (847) 853-6060. Fax: (847) 853-9028. E-mail: info@aaahciqi.org.
- **Sam J.W. Romeo**, MD, MBA: 334 Sunday Drive, Turlock, CA 95382. Telephone: (209) 535-1693.

When Romeo's group decides to conduct a study, "We put together people in that field, review the literature to find the most appropriate care, then determine the data elements we can aggregate to make the process current and reasonable for people to do, and we do all this on a concurrent basis."

For benchmarking purposes, all those who participate in the study submit flowsheets that are subsequently analyzed and compared. "You know who you are, but nobody else does; your facility is just given a number," Romeo explains. Institutions can participate by contacting the association (www.aaahciqi.org). The fee is about $400.

"What's most important is that this process is novel," he says. "Nobody else has demonstrable results of a concurrent and prospective study."

What has been learned

In the past three years, much of value has been learned about best practices, Romeo says. Here are a few examples:

- **Knee arthroscopy.**

"One thing we discovered was that the post-op recovery time can be reduced as much as 45 minutes if you use a local anesthetic and conscious sedation as opposed to a general. And if you use IV sedation and a local, you can save $150 a case."

- **Colonoscopy.**

Those patients who had effective analgesia during their procedures and reported less discomfort were much more likely to agree to come back on a 10-year basis, which is what is recommended. "If you hurt people too much, they just won't think it's worth it to come back," Romeo explains.

- **Asthma disease management.**

Those patients who had the opportunity to spend more time in education had fewer visits to the ED and had less serious attacks, demonstrating that patient education can reduce costs.

Some of the knowledge derived from studies in a specific area can transfer into other areas, Romeo notes.

"For example, the finding that using IV sedation and a local [as in knee arthroscopy] is now being applied in multispecialty cases," he reports. ■

Hospitals to share quality information

The American Hospital Association (AHA) in Chicago, the Association of American Medical Colleges, and the Federation of American Hospitals, along with accrediting organizations, government agencies, and quality and consumer groups have begun a new voluntary initiative that will collect and share with consumers standardized quality measures of patient care in hospitals.

At a press briefing in Washington, DC, AHA president **Dick Davidson** said that the initiative will begin by looking at 10 quality measures involving heart attacks, heart failure, and pneumonia. "Providing high-quality care demands that patients be informed partners in decisions about their care every step of the way," he said in a prepared statement. "Providing helpful information can only enhance a patient experience." ▼

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Hospitalists save money

Patients of hospitalists appear to have shorter and less costly hospital stays than nonhospitalists' patients, according to a recent report in the *Annals of Internal Medicine.* However, these effects appeared only in the second year of use of hospitalists. One possible explanation is that hospitalists, physicians who spend their entire day caring for hospitalized patients as opposed to seeing patients in the office, may have learning curves, and some benefits of their care may not be clear until they have been practicing hospital medicine for more than a year.

Findings from 5,710 medical records at a community-based teaching hospital show that by year two of the study, hospitalists' patients stayed in the hospital an average of about half a day less than nonhospitalists' patients. Average hospital costs were $822 lower for hospitalists in the second year.

For more information on the report, go to the publication's web site: www.annals.org. ▼

Veterans Health Initiative announced

The U.S. Department of Veterans Affairs, in collaboration with the Office of Public Health and Environmental Hazards and the Employee Education System, has developed an on-line program that focuses on the special health concerns of veterans. The program, known as the Veterans Health Initiative (VHI), currently comprises 10 independent study modules that provide in-depth information about important and unique health issues of veterans and their health needs.

The program allows military medical history to be better documented and the connection between certain health effects and military service to be better understood. It is designed to prepare health care providers to better serve their veteran patients and to establish a database for further study.

The 10 modules available are: Agent Orange; Cold Injury; Gulf War; Post-Traumatic Stress Disorder; Ex-Prisoner of War; Radiation; Spinal Cord Injury; Visual Impairment; Hearing Impairment; and Traumatic Amputation and Prosthetics.

At the end of each module, readers may take an on-line test on their knowledge of the subject.

Future plans include five new modules: Military Sexual Trauma; Infectious Disease Threats in Southwest Asia; Traumatic Brain Injury; Occupational Lung Diseases of Military Significance; and Health Effects of Chemical, Biological, and Radiological Agents on Military Personnel. These new modules are expected to be available by May 2004.

The VHI modules are available on the web at www.va.gov/vhi. ■