Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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Integrate benchmarking with your PI efforts for long-term success

Seamlessness keeps initiatives alive and vibrant, aiding compliance

Like many performance improvement activities, benchmarking has its own nomenclature, its own tools — and, in a way, even its own culture. But focusing on those differences, rather than on making benchmarking an integral part of your ongoing performance improvement program, can doom your efforts to early failure.

"Management is always looking for the next silver bullet or panacea, never realizing there are none," says **Robert G. Gift**, president of Systems Management Associates Inc. in Omaha, NE.

"What I mean is, you should pick a set of tools that is appropriate for what you are trying to address and keep at it. This requires diligence, and that's in short supply because everyone wants a quick fix," he adds.

"It's like anything else; if benchmarking is not an integral part of the performance improvement plan in your hospital, there are only so many 'flavors of the month' you can handle at one time, so many plates you can have in the air," explains **Sharon Lau**, a consultant with Los Angeles-based Medical Management Planning (MMP).

"There's only so much one manager can do. If it's like living and breathing — I do PI regularly, and benchmarking is just one tool — it's easier," she says.

Key Points

- Persistence and consistency are hallmarks of a strong program.
- Consider benchmarking just one of many performance improvement tools.
- Tools, structure, and accountability form the foundation of benchmarking.

"I think the problem for many people is if they treat the benchmarking effort as one of those books that come in periodically, they lose interest," notes **Kevin Hammeran**, CAO, James Whitcombe Riley Children's Hospital for Children, in Indianapolis. "They just look at it when it arrives, but they never really make full use of the data."

The knowledge triangle

Lau refers to a structure called the knowledge triangle to outline the keys to successful integration and ongoing success for benchmarking. The three points of the triangle are tools, structure, and accountability. **(See illustration, p. 51.)**

Speaking of the tools, Lau explains, "The organization has to have an established way to use data, to summarize and interpret data; and everyone in the hospital needs to know how to use the charts of performance improvement.

"They need to be trained so that they will have familiarity with those tools — this is what I look for in a Pareto chart; this is what a bar chart looks like, and so on," she adds.

When it comes to structure, it's important to have an organizational culture that promotes change and facilitates decision making, Lau notes.

"If you have this benchmarking data you see every month and you're excited about it, but your organization is not letting you do anything about it, that's a killer," she says. "The organization has to support you acting upon it."

Being well-trained is not enough, according to Lau; you also must be held accountable. "The squeaky wheel gets the oil, so if no one holds me accountable, I might do other things.

"Have regular meetings of the performance improvement council where managers come and present their data, tell how they're using them, and how they've improved performance; that's going to keep your benchmark efforts going," she suggests.

Gift agrees. "I really encourage organizations to put some kind of management accountability on whatever they are trying to achieve," he says. "It's really a matter of putting it in the performance evaluation; if you find a way to link it to people so it becomes important to them, they'll do it."

Following the knowledge triangle, Lau asserts, should form the basis of your efforts to either keep your benchmarking program vital, or to go back and revitalize a dormant program.

Maintaining momentum

Building upon similar principals, Hammeran says that one of the keys to maintaining your program's momentum is to make it *real*.

"Figure out how to take the information contained in your reports and *operationalize* it — build it into the basic system you use for building and maintaining organizational performance," he advises.

For example, he suggests, don't look at your data in a vacuum, but relate them to overall performance. "Your ED may have the best results in terms of worked hours per visit — say, the fewest hours per visit in the nation. [That may

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seem positive, but] if you tie that to your own patient satisfaction score, there should be an inverse correlation, or at least a point where satisfaction rates reach their peak," he observes.

"So, if you have the most efficient hospital, you probably also have the highest number of walkaways and the lowest satisfaction rates."

The goal, in this case, is to identify the point to which those hours might be raised and patients are satisfied, before satisfaction rises again as patients notice that "there are a lot of people sitting around doing nothing. The trick is to find that point where everything is maximized," says Hammeran.

"This is also how you make data come alive in conversations with doctors; it gives you a vehicle for discussion you might not have otherwise," he points out.

Your data also should create opportunities to interact with your peers at other institutions, he says.

"Some years ago we looked at our data and our cost per adjusted patient day was pretty high, which did not make sense," he recalls. "I picked up the phone and called some of our peers who seemed to be doing better."

Revitalize benchmarking efforts

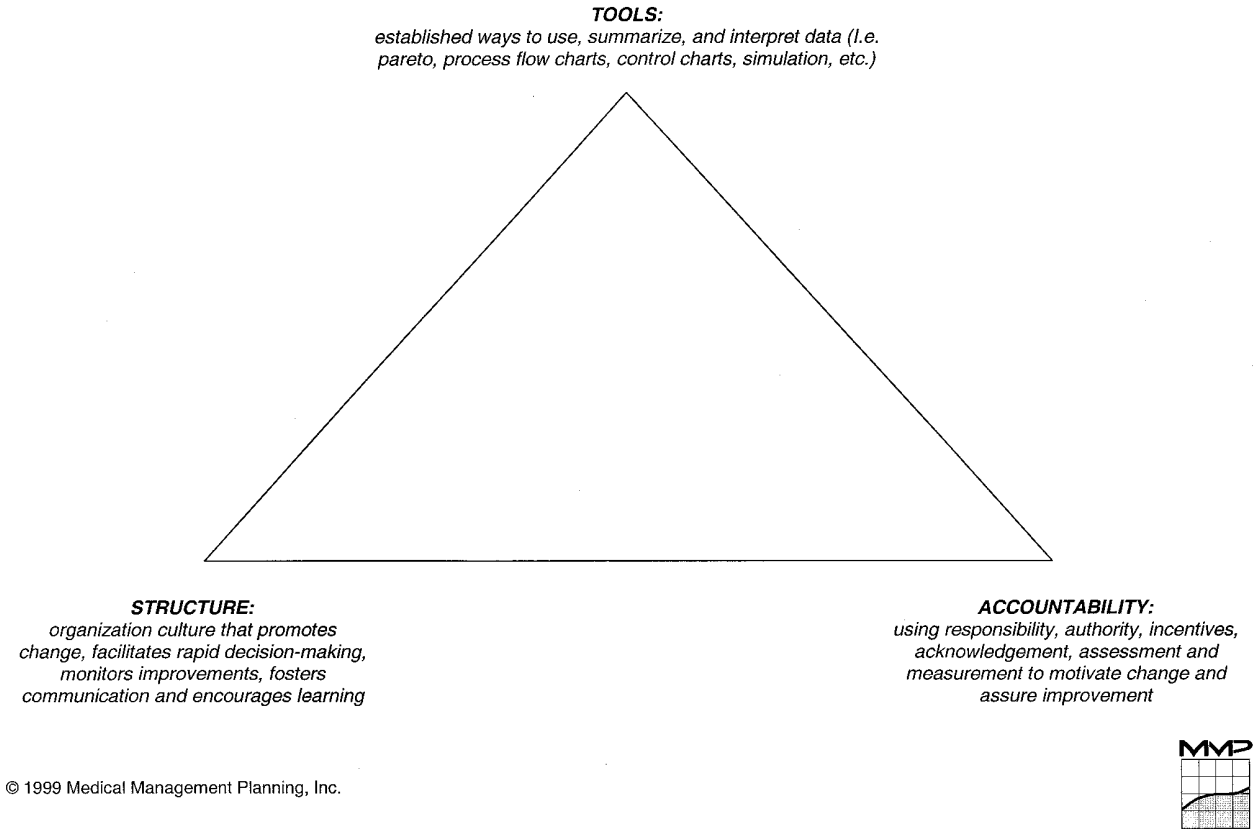
In some cases, the difference turned out to be a function of how the data were reported, but some other facilities were simply doing a better job. "One facility was handling registration at the bedside; I had never thought about putting a laptop on the cart," Hammeran notes.

When this type of interaction is translated to the departmental level, he adds, "The value is they will have contact with their peers."

"If people are looking to revitalize their efforts at benchmarking and are truly committed, what I try to encourage them to think about or do is to look for a different set of data or a different topic," adds Gift.

"For example, if the organization is always

Turning Data into Performance Improvement



Source: Medical Management Planning, Los Angeles.

benchmarking their cost position and using the same data, what I encourage them to do is maybe look at the criteria from the top 100 hospitals or some other criteria. After beating on costs for a given period of time, it gets pretty old and people get bored with it," he says.

That doesn't mean you forget about costs, however. "It's the same as offense and defense in football," Gift explains. "Offense is more glitzy, but if you look at the history of the Super Bowl, nine out of 10 times, the top defensive team wins. So if you're going to sustain performance, you need to look at costs."

When it comes to maintaining your momentum, never forget the all-important role of leadership. "Having a champion is critical — first and foremost — and it has to be executive leadership," notes **Tammy Gray**, CPHQ, bench coordinator for Children's Memorial Hospital in Chicago.

"Our program lost its luster; the original champion of the project was our CEO, who then retired. Somehow, the whole thing lost its way," she says.

Gift says when projects lose their momentum, "Part of it has to do with leadership's inability to sustain any kind of initiative."

Creativity a plus

Creative initiatives also can help your program retain its vibrancy, Lau says. "Everything needs to be revived and revised every once in awhile," she asserts.

Lau recalls two particularly creative programs she instituted when she was a manager at a hospital. "I supervised material management, so I had supply and laundry [nonclinical] people on the staff," she says.

"Every Wednesday we would have 'Matman' [material management] education, where someone from another department, like nursing or the pharmacy, would talk about what they do. So later on, when a nurse said she needed something stat, the staff knew why," Lau adds.

Once a year, during Matman Week, Lau would organize a Matman Olympics. "I'd come running down the hall holding a flashlight aloft to open the ceremonies," she says.

Some of the events included "mail sort and toss" and "sterile wrap and pack," in which the hospital had VPs compete. "Again, this created structure of learning about the value of data — we benchmarked against how we did the year before," she says. "Everyone participated, and we publicized the results, but we also gave people a lot of tools."

Another way tools and results were shared, she says, was the annual benchmarking fair, where different departments set up booths and told fellow staff members what they were doing in terms of benchmarking.

Gray basically was handed a clean slate when she took over the program at Children's Memorial in 1997.

"At that time, essentially no one was handing in any data," she recalls. Her hospital had been given an ultimatum by the other members of the BENCHmarking Effort for Networking Children's Hospitals (BENCH), a project of MMP, that if it did not submit any data, it could not get any data from the other members of the group.

Data collection

"We had to structure ways in which the stakeholders were reminded [to submit data] and provide tools to collect the data in a timely manner," says Gray.

"E-mail was a good vehicle, but we also sent them hard-copy reminders with very colorful cover sheets that had the stakeholder's name and what they were responsible for, as well as due dates," she adds.

Two other events proved to be turning points. A new chief nurse executive came on board three years ago from one of the other member hospitals of the MMP benchmarking group — one with a

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record of very good compliance. "We didn't really have a senior leader embracing the project at that time, and we formed a really good bond," Gray says.

Then, about one year ago, a steering committee was formed, representing all the stakeholder leaders — emergency department, infection control, all critical care areas — finance, and the pharmacy. "We knew we had to do some inter-rater reliability activities to make sure we were collecting data in the way they were intended to be collected," says Gray.

"Together we assessed our data sources and talked about how we were using the data," she continues. "That's the other key piece; if you collect data, but you don't talk about how you're going to use them, then it's pointless."

Gray must be doing something right. "My first year here we were about 66% compliant [with BENCH's requirements]; now, we're in the 90s," she reports.

Finally, Gift says, it's essential that you have a good idea of what you're going to do with your data *before* you begin benchmarking.

"I always get concerned when someone calls me and says, 'We want to do benchmarking.' What I want to know is, what are they trying to accomplish?" he asks. ■

Closed-circuit TV wins fans in children's hospital

All can participate via interactive programming

An innovative closed-circuit TV (CCTV) network at a children's hospital in Atlanta has made a significant contribution to patient and family satisfaction while boosting the morale and self-esteem of bedridden children.

"Children's TV" is provided to patients at the Scottish Rite and Egleston campuses of Children's Healthcare of Atlanta. (Each campus offers its own separate programming.) The programs are attended in person by ambulatory patients, but also can be seen in patients' rooms.

Children's TV is part of a broader initiative called Child Life programming, but, "This is the only Child Life programming in the hospital that can be seen in a child's room," notes **Paula R. Fine**, MS, who joined the staff in 1993 as a Child Life specialist and host/producer of Children's TV at the Scottish Rite campus.

"This can reach everybody; it reaches the emergency department, the intensive care unit — even our clinics across the street," she points out.

Children's TV, which is aired once a week, provides a wide variety of programming, from interviews with local celebrities (such as former Atlanta Braves pitcher Dale Murphy, heavyweight boxer Evander Holyfield, CNN anchors, and local DJs) and national celebrities such as astronauts, to educational shows on the health risks of tobacco or the role of therapy pets, to fun events such as bingo. Other programs are dedicated to national holidays, such as Martin Luther King Jr. Day.

"The variety and diverse programming that I offer, most children would not otherwise have an opportunity to see," says Fine. "We also try to offer multicultural programming."

"The CCTV initiative started because, while we have play rooms on each of the floors, they only service the kids who can get out of bed," explains **Roni Mintz**, CCLF, coordinator of the Child Life department, on the Scottish Rite campus.

"CCTV reaches [children] who cannot get out of bed, so they can participate and have the feeling of socializing with their peers," she points out.

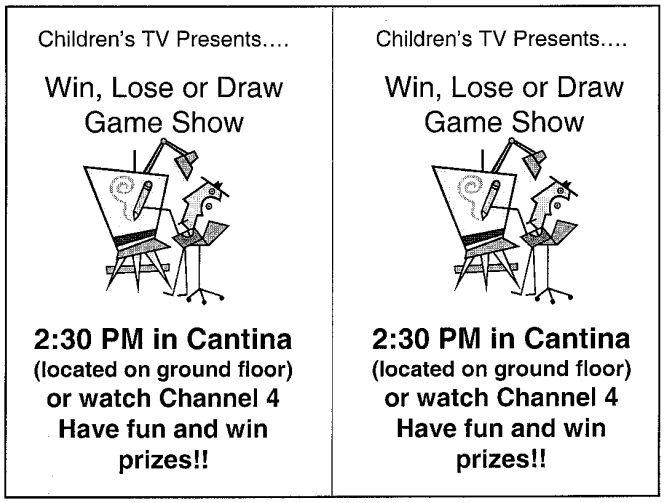
Key Points

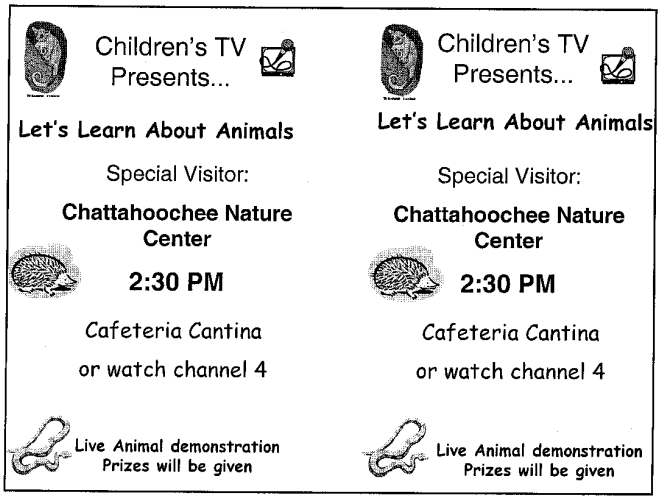
- Programming eases sense of isolation, promotes family bonding.
- Patients can watch in rooms, clinics, emergency department, and intensive care unit.
- Child Life specialists help normalize stay, relieve pre-procedure anxiety.

Interactivity a key factor

It is the interactive capacity of the program that enables this socialization. Patients and their families are notified about upcoming programs through fliers, and through *Hospital Happenings,* a weekly schedule of all the fun programming in the hospital. **(See examples of program fliers, p. 54.)** Then, the programs are announced on the PA system 30 minutes and 15 minutes before airing. Sometimes, Fine will deliver a personal flier to the room.

Children in their rooms are instructed to tune to Channel 4 and given a telephone extension





Source: Children's Healthcare of Atlanta.

that links them to the show, enabling them to ask celebrities questions, to participate in the wide range of contest shows that are offered, and to have the same chance to win prizes as those in the audience. They can even play bingo from their beds or create art projects that are shown on TV.

Decreasing isolation

"This decreases their sense of isolation, which in turn, helps children feel positive and builds their self-esteem," says Fine. "When they call up or get their art project shown on the air, they feel part of a group, which benefits their health."

Goals for the program include:

- provide alternatives to commercial television;
- provide entertaining and educational programming;
- inform patients and their families about safety and health care issues;
- provide information to decrease anxiety about hospitalization;
- decrease feelings of isolation;
- provide opportunities for self-expression and peer support.

Children's TV, she adds, actually is a product that encompasses two separate education channels. One is for families and children, and the other is for adult education. A variety of videos are shown with safety, health care, parenting, and nutrition information.

Children's TV fits neatly into the Child Life concept, says Mintz, who oversees 15 Child Life specialists.

"Child Life includes various services to the child and family," she notes. These include activities such as pet therapy or family nights, which are not part of Children's TV.

All Child Life components have three main objectives:

- preparation and teaching — explaining the procedures that will happen;
- teaching children various coping techniques to use during painful procedures and other uncomfortable situations;
- children's play aspect (Children's TV).

The sense of normalization created by Children's TV is critical, says Mintz. "Just like an adult's workday gives him self-esteem and a sense of purpose, Children's TV gives the children something to do, and an opportunity to act out whatever is going on. "Its message is, 'I may be sick, but I can certainly keep up with other things in my life.'"

Typically, what happens is there is a much stronger sense of compliance with regard to procedures, such as IV starts, because of the Child Life program.

"There is an understanding of what is going to happen," Mintz explains. "We generally rehearse the procedure with the child [with puppets and other amusing devices]. Research has proven that lengths of stay are probably shorter when there is increased compliance."

Benefits are many

Mintz says that Children's TV has proved to be a valuable tool in both boosting satisfaction and improving quality of care.

"The anxiety level is very high when children

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are first admitted," she notes. "TV helps reduce that anxiety, and when anxiety is reduced, you typically get better compliance."

In addition, Mintz considers the program an effective self-esteem booster. "The child gains some sense of control back," she notes. "If Paula's playing bingo, and the child can call up and say 'I won!' over the air, they feel in control. This absolutely lowers stress levels."

It also is a family bonding tool. "Typically, the family will do something together, like the art project or bingo," notes Mintz. "It might have been a stressful day medically, but families can do this together and have fun."

"It definitely builds parent loyalty," Fine adds. "They'll come up to me and say things like, 'My child was so blue all day until you delivered that prize to them.' Another parent of a kid with leukemia told me how having his artwork shown on TV made him feel so happy." ■

Alliance will evaluate clinical excellence

Outcomes, customer service measured together

In what the principals claim is a health care industry first, HealthGrades Inc. and J.D. Power and Associates have formed a strategic alliance to recognize hospitals for excellence in both service and clinical outcomes.

The Distinguished Hospital Performance Program, they say, will cover "the full spectrum of hospital quality issues."

"One issue that has really plagued the health care industry as a whole is that it suffers from a lack of measurable goals," asserts **Kerry R. Hicks**, president and CEO of Denver-based HealthGrades. "This will offer organizationwide goals to hold out and achieve year after year."

"We have been in business for 35 years, basically bringing the voice of the customer into the industries we serve, helping decision makers to make better decisions, and businesses to do a better job of providing services and improving performance," adds **Steven D. Wood**, PhD, executive director of the health care division for Westlake Village, CA-based J.D. Power.

Noting his company's entry into the health care field, Wood observes that "health care is a very large and important industry, and will be increasingly important as the population ages. We know we've learned a lot of lessons in other industries — for example, what motivates people to make good decisions about goods and services — and the lessons we've learned in other industries can be applied to health care as well."

Integrating with clinical outcomes

In entering the industry, he continues, J.D. Power wanted to make sure it had a good sense of clinical entities.

"HealthGrades provides one of the purest forms of clinical evaluations in terms of looking at outcomes," Wood notes. (HealthGrades claims to be the only hospital-quality consulting company that rates all 5,000 hospitals in the United States and publishes the data on its web site.)

"We wanted to have a partner that not only managed that area, but that could integrate its experience with clinical outcomes [with ours in customer service] to provide organizations with the information that in terms of their performance it was important they be linked," Wood explains.

"The evidence suggests that the more satisfied

Key Points

- Intent is to provide organizationwide, measurable goals for hospitals.
- All 5,000 hospitals in the United States are being rated on clinical outcomes.
- Evaluations will examine 20 procedures in six different specialty areas.

people are with what is being done, the more likely they are to be compliant; this motivates very good behaviors, which probably means we have a good chance to improve outcomes," he says.

In measuring the clinical excellence portion of the program, HealthGrades evaluates clinical quality on a national basis across 20 procedures and diagnoses in six clinical specialties: cardiac surgery, cardiology, orthopedic surgery, neuroscience, pulmonary, and vascular surgery.

HealthGrades statistically aggregates the service-line ratings to create a hospitalwide evaluation of quality. Full-service hospitals that score among the top 20% nationwide are eligible for a HealthGrades Distinguished Hospital for Clinical Excellence award.

Since HealthGrades has been rating hospitals for five years, "We've already received all of our data," notes Hicks.

HealthGrades regularly has been providing Hospital Report Cards, which offer star ratings of from one (poor) to five (best) stars. "We took the top 20%, which came to 163 hospitals," says Hicks. The winners were to be announced at the end of April.

Five core concepts

How will J.D. Power measure customer service?

"We did exhaustive secondary research on how that should be measured in the hospital and came up with what we felt was the essence of the experience — what really motivates people to make their selection and to be an advocate," says Wood. The company identified these five core concepts:

- **Information and communication.**

What is it about the service provided that reduces anxiety and helps the patient understand what is happening?

- **Dignity and respect.**

"In our analysis of many industries, people have a strong need for courtesy and respect. They want to be treated as a person, not just as a case or a test," Wood explains.

- **Physical comfort.**

Patients know that while they are in the hospital there may be some discomfort, but they want to know if the organization is dedicated to minimizing that discomfort, including pain management, to make the experience as comfortable as is reasonably possible.

- **Emotional support.**

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Does the individual truly have the feeling he or she is being cared for and that the caregiver is compassionate?

- **Speed and efficiency.**

The patient does not have the feeling his care is being disturbed by inefficiencies in the process, or that he is kept waiting an unreasonable length of time. "We have done a large national study of recently discharged patients and asked them a significant number of questions based on these five core concepts," says Wood.

"We will offer hospitals the opportunity to be benchmarked against this study. If they submit a group of recently discharged patients and achieve a high rating level, we will designate them as a Distinguished Hospital for Provider Excellence," he adds.

Improving quality

What do the partners hope to achieve? "Our goal is to improve the overall quality of health care delivered on behalf of the nation's hospitals," says Hicks. "We will be setting a quality benchmark, both from a clinical and patient experience perspective. The winners will represent a world-class level of quality."

"Our partnership is unique, in that we will integrate HealthGrades' data with regard to top clinical outcomes and ours, which we hope will take health care quality to the next level," adds Wood. "The bottom line is that we want people to understand that those who achieve this award are truly committed to quality care."

It also is an opportunity for employees to be recognized for this achievement, which will improve morale and, as a result, their level of care, Wood adds.

"We believe they will pay continued attention to wanting to do their jobs with distinction; it's a very prideful thing," he concludes. ■

Leapfrog finalizing new incentive plans

Will offset some of additional costs of compliance

The Leapfrog Group, the Washington, DC-based organization that seeks to foster improved patient safety, soon will complete a tool to help realign incentives for health care facilities that invest in meeting Leapfrog recommendations.

Leapfrog steering committee member **Francois de Brantes** recently explained to a meeting of the Healthcare Information and Management Systems Society in San Diego that the employer group recognizes the cost of implementing Leapfrog recommendations in areas such as computerized physician order entry systems, employing intensivists, and evidence-based hospital referrals can exceed what hospitals get from payers as a result of making those changes.

"Shame on us purchasers, shame on this country, to have created a system where better quality costs hospitals money," de Brantes said.

He added, however, that Leapfrog is developing a procedure to examine the cost of fulfilling these recommendations, forecast their fiscal impact, and help cover the difference, usually through direct payments by Leapfrog members themselves or by telling their insurers to redirect premium payments to the hospitals.

Incentives and rewards

De Brantes runs the multistakeholder Incentives and Rewards Lily Pad for Leapfrog, according to **Suzanne Delbanco**, PhD, executive director.

"Hospital representatives, physicians, consumers, health plans, and actuaries have been working with us for almost a year to try to figure out tools we could create for our members to figure out a sensible way to realign incentives properly," she notes.

Key Points

- Incentives to be realigned for facilities meeting recommendations.
- Each practice brings different potential savings and costs, based on payer mix.
- Leapfrog will provide hospitals with a formula for calculating savings.

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Such tools are needed, she explains, because each practice brings different potential savings and costs, which accrue differently depending on payer mix (i.e., per diem vs. DRG) and upon how the employer is paying the hospital through the health plan.

"The work group still has its calculators out, but we hope in the next month or two to put out some basic calculations and worksheets to enable people to figure out the situations in their markets, and how to put together a rationally thought out rewards program," Delbanco says.

Using the data

In each case, real data would be used from a given area, Delbanco says. "For example, an employer might ask one of its health plans how many admissions there are in each hospital where these practices apply, what that payer mix is, and how the employer pays the hospitals."

"We would provide them with the formula for calculating savings, and they would plug in their number to understand and estimate what the savings would be in their neck of the woods," she observes.

Hospitals only will report where they are vis-a-vis their practices, Delbanco emphasizes.

"Leapfrog will then calculate costs based on what data we have available and share the information with our members. That's the purpose of the tool," she asserts.

Based on that estimate, the employers might choose to provide incentives. "For example, Empire Blue Cross/Blue Shield in New York did it with a quarterly bonus payment," Delbanco notes.

"They said, for example, 'OK, we paid this hospital "x" last quarter, but we'll tag 3% on top of that as a bonus.' The Empire model is a direct model. The hospitals don't get the check from IBM, for example, but from the insurer; the pass-through just eases administration," she adds.

Ideally, at the local level, you would have employers talking with hospitals, and if they want, structuring their own refinements to the incentive plan, Delbanco says. "That would be ideal. What we'll do is provide the tools to get them started."

Delbanco refuses to set a hard deadline for the finalization of the tool. "We're trying to get it right, rather than get it out fast," she says. ■

Simple 'PUSH' spells improved senior health

Basic exercise significantly reduces falls, fractures

One out of three seniors who breaks a hip this year will die as a result of complications from the fracture, but simple fitness measures can greatly reduce a senior's risk of falling, say University of Arkansas at Fayetteville (UA) researchers.

A pilot outreach project, sponsored by the UA Office for the Studies on Aging, proved that in a matter of weeks, seniors could achieve significant gains in strength and balance by following a simple exercise program that places minimal strain on the body or budget.

UA researchers developed PUSH (Project Urging Senior Health) to demonstrate the ease of establishing and maintaining senior exercise programs in the community. As a trial run, the researchers initiated simple fitness regimens at two senior centers in Arkansas.

Significant results achieved

But the results they noticed among seniors who participated were so significant, they now suggest that similar programs across the nation could significantly reduce the number of senior citizens who suffer from falls and fractures each year.

Key Points

- Seniors can achieve significant gains in strength and balance in weeks.
- Even the researchers find the results surprising.
- Study finds connections between mental state and physical performance.

"Our scheme was to go into senior centers and teach the staff that exercise programs could be easily integrated into their services — that fitness could be inexpensive, easily administered, and fun," says **Ro DiBrezzo**, PhD, UA professor of exercise science and director of the Human Performance Laboratory.

"We didn't expect to see any statistically measurable changes in senior health in only 10 weeks, but when we looked at the data, our participants had made surprising gains," she adds.

Data collected

Though they regarded PUSH primarily as an outreach program, the researchers collected data, hoping results would bolster the case for providing exercise services to the elderly.

They tracked 19 participants from the two Arkansas senior centers, conducting physical and mental assessments at the beginning of the program and then testing again at the end of 10 weeks. The participants ranged in age from 60 to 90 with a significant representation in the range of 80 and older.

The physical assessment led seniors through eight tests of strength, balance, flexibility, and dynamic balance — or the ability to balance while in motion. According to the researchers, initial results showed Arkansas seniors to be significantly below national fitness norms for the elderly.

For 40 minutes a day, three times a week, the seniors then performed stretching and strengthening exercises, using therabands and exercise balls and learning proper exercise technique.

At the end of 10 weeks, the physical assessment tests showed statistically significant improvement in measures of balance, strength, and dynamic balance. In addition, the participants improved their levels of HDL, the "good" form of cholesterol.

"According to fitness norms for the elderly, the participants in this program ranked in the 10th percentile in strength and dynamic balance when we started. But just performing simple exercises over a couple of months, they moved from the 10th percentile to the 65th," DiBrezzo says.

"We had people on oxygen doing these exercises — people using walkers. That's a huge leap for people who are so frail," she continues.

And the benefits were not exclusively physical. The mental assessment the researchers conducted tested more than cognitive functioning.

The assessment included a questionnaire that

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asked how active the participants were on a daily basis and recorded their general states of mind — whether they usually felt anxious or calm, energetic or worn out.

"We found connections between mental state and both initial and final physical performance scores," says **Barbara Shadden**, a UA professor of communication disorders.

"Mind and body interact more than you'd think, and both are important to our quality of life as we age," she adds.

If senior centers across the nation were to offer simple exercises programs such as the one used in PUSH, elderly Americans could improve their overall health, reduce their risk of falling, and reap mental health benefits that could keep them active and involved in the community, the PUSH researchers say.

They intend to expand the reach of PUSH this spring by conducting a training seminar for individuals involved in senior services. The workshop will train people in how to properly implement senior exercise programs in a manner that is both safe and cost-effective.

"Pretty much anyone who works with older adults is in a position to implement this program," notes Shadden.

"Starting an exercise program in a couple of senior centers isn't going to fully serve the elderly population. The point is to train as many people as possible how to do it," she says. ■

NEWS BRIEFS

AHA toolkit fosters evidence-based medicine

The Chicago-based American Hospital Association (AHA) has mailed all hospitals in the United States a patient safety and quality toolkit designed to help hospitals and their medical staffs practice evidence-based medicine.

The kit, *"Strategies for Leadership: Evidence-based Medicine for Effective Patient Care,"* was developed with UnitedHealth Foundation. It includes print and CD-ROM copies of "Clinical Evidence," a publication by BMJ Publishing Group containing the latest clinical evidence from a variety of medical disciplines. The kit also contains information on how to use clinical-based evidence in hospitals and in developing clinical information systems.

Recipients are eligible for a six-month trial subscription to *Clinical Evidence Online*, which features monthly updates. For more information, go to www.aha.org and click on "Quality and Patient Safety," then "What's New." ▼

CDC stresses smallpox vaccination site care

The Atlanta-based Centers for Disease Control and Prevention (CDC) recently issued a report highlighting the importance of proper care of the place on the arm where the smallpox vaccine is administered. The report details adverse reactions experienced by two women exposed to the vaccination sites of military vaccinees.

A 26-year-old woman in close contact with a man who often kept his vaccination site uncovered became ill with swelling, pain, and discharge from the right eye, which progressed to

COMING IN FUTURE MONTHS

- ■ Reminders, standing orders, checklists improve MI patient care
- ■ HHS wants bar coding on medication labels to help reduce errors
- ■ A new paradigm suggested for looking at causes of coronary artery disease
- ■ What in the world is 'Muda,' and how can it help improve performance?

swelling of the entire right side of her face, according to the *Morbidity and Mortality Weekly Report (MMWR)*. The woman was discharged from the hospital after treatment including vaccinia immune globulin.

Also, an 18-year-old woman who handled the bandage of a military vaccinee later developed skin lesions and swelling in her right eye. Her condition improved after treatment including antibiotics. The CDC said close contacts of vaccinees should not touch the vaccination site or materials that might be contaminated, including bandages, clothing, towels, or sheets.

For more information, go to: www.cdc.gov/mmwr/mmwr_wk.html. ▼

St. Louis hospitals sign preparedness agreement

St. Louis area hospitals have unveiled an agreement to assist each other with volunteer medical professionals and supplies in the event of a disaster involving mass casualties. "At a time of uncertainty in our world, this agreement provides reassurance to the citizens of Missouri that the world-class health care facilities in St. Louis will be able to work together swiftly and efficiently if a disaster occurs," said **Michael Zilm**, president of the St. Louis Metropolitan Hospital Council, in making the announcement. A total of 35 hospitals signed the mutual aid agreement, which Mayor Francis Slay called a model for other communities. ▼

HHS seeks safer smallpox vaccines

U.S. Department of Health and Human Services (HHS) Secretary **Tommy Thompson** announced HHS has awarded two contracts totaling up to $20 million in first-year funding to develop safer smallpox vaccines.

"To protect ourselves from the remote but extremely grave threat of a deliberate release of smallpox virus, we need a vaccine that can be safely given to all Americans. The new contracts will help us meet this need by accelerating research on second-generation smallpox vaccines," he said.

Under the three-year contracts, Bavarian Nordic A/S of Copenhagen, Denmark, and Acambis Inc. of Cambridge, MA, will develop, manufacture, and conduct safety trials of modified vaccinia virus Ankara (MVA) vaccine candidates. MVA is a strain of vaccinia that cannot replicate inside human cells and therefore cannot cause dispersed infection.

An MVA-based vaccine given to more than 120,000 people during the smallpox eradication campaign in Germany in the 1970s had an excellent safety record, HHS said. For more information, go to: www.hhs.gov/news/press/2003.html. ■