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INSIDE

SEPTEMBER 1999

VOL. 9, NO. 9 (pages 101-112)

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OIG's blast of JCAHO/HCFA hospital surveys raises the bar for QI directors

Get ready for drop-in surveys and random file checks

Many hospital quality improvement directors and other hospital executives will be and are scrambling to fast-track their QI initiatives and upgrade their files due to the shot heard round the industry fired by the Office of the Inspector General (OIG) on July 20. The upshot of the OIG blast for QI managers is that inspections will be more frequent and unannounced, and files will be pulled for audit purposes on a random basis.

In the long-awaited report, the OIG takes aim at the hospital oversight process conducted by the Joint Commission for the Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and by the Health Care Financing Administration (HCFA) in Washington, DC. It charges that JCAHO is soft in its inspections and says that HCFA goes along with the survey practices.

In response, HCFA Administrator Nancy-Ann DeParle can point to the Hospital Quality Oversight Plan already offered by her agency that incorporates many of the OIG recommendations, especially the call for more frequent and unscheduled surveys by the Joint Commission. HCFA says the agency will:

Key Points

- A report following a two-year study by the Office of the Inspector General describes flaws throughout the hospital oversight system. The Joint Commission on the Accreditation of Healthcare Organizations is less than rigorous in its inspection style, and the Health Care Financing Administration is "deferential" to the practice, the report states.
- The report's recommendations include more public disclosure of data regarding the performance of hospitals as well as information about the reviewers and their processes.
- Likely developments will be unannounced surveys by JCAHO and random file checks.
- Other recommendations urge JCAHO to adopt a more regulatory approach to inspections, tempering the educational posture of recent years.

• require state agencies to conduct more surveys of nonaccredited hospitals;

• strengthen oversight of both the state agencies and JCAHO;

• make a better effort to balance the collegial and regulatory approaches to oversight.

The OIG report takes issue with the tone of "collegiality" that characterizes surveys in recent years. Further, it attacks the lack of public disclosure of survey findings, especially adverse events and lapses in patient safety measures. "The clear and disturbing conclusion of this report," concludes the OIG, is that both the Joint Commission and state agencies are only minimally accountable to HCFA for their performance in reviewing hospitals." In its response to the findings, HCFA promises more unannounced surveys and JCAHO vows to regulate as well as educate. Surveyors will be asked to pull and review files on a random basis.

HCFA also says that in an upcoming revision of its Conditions of Participation regulations (COPs) the agency will more clearly define its priorities for hospital surveys of basic health and safety issues, such as medication errors and surgery mix-ups. The final COPs are expected to be completed by fall 2000 and will include Inspector General June Gibbs Brown's recommendations and HCFA's Hospital Quality Oversight Plan.

As the product of an exhaustive two-year study by the Department of Health and Human Services' OIG, key findings from the series of four reports describe flaws throughout the hospital oversight system:

• The hospital review system's shift to a more collegial than regulatory style of oversight could result in less emphasis on practices that reduce the risk of poor patient care.

• HCFA fails to obtain meaningful or complete survey feedback from either JCAHO or the state agencies. The report describes HCFA's posture toward JCAHO as "more deferential than directive."

• Minimal public disclosure of either of the state agencies' findings or of JCAHO survey reports on hospitals hampers consumer evaluation of a hospital's performance.

• While JCAHO surveys lead to reduced risk and improvement of hospital care, they are not likely to find substandard patterns of care or to identify individual practitioners with "questionable skills."

• State agencies drop the ball in surveys of nonaccredited hospitals. About 50% of the nonaccredited hospitals, in 1997, fell below the industry standard of three-year survey cycles. Rarely do state agencies conduct routine surveys. Some nonaccredited hospitals in rural areas have gone for eight years without a survey.

HCFA should, according to the report, "hold the Joint Commission and state agencies more fully accountable by gathering more timely and useful performance data and strengthening mechanisms to provide performance feedback and policy guidance to the Joint Commission and state agencies."

In a set of recommendations for HCFA, the report directs the agency to negotiate with JCAHO to conduct more unannounced surveys and introduce more random selection of records into the survey process and conduct more rigorous review of hospitals' continuous quality improvement efforts.

'Tell about reviewers and performance'

The report states that public disclosure "conveys not only something about the hospitals' performance" but it also fosters public trust. In a response to the report, HCFA created a Hospital Quality Oversight Plan. By publicizing information about the reviewers, "HCFA conveys that it is monitoring the work they do on [the public's] behalf."

The Medicare supervisory agency announced that it is currently coordinating a pilot project to examine how to develop and distribute hospital performance data that will enable consumers to compare the quality of care among hospitals. No doubt, it's a worthwhile goal, "but we can't say we're good to go on that recommendation today,"

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asserts **Mary Grealy**, chief counsel for the American Hospital Association (AHA) in Washington, DC. Health care has a way to go before meaningful performance data will be ready to present to the public, she adds. Already there is a plethora of hospital comparison data out there on the Internet, but reliable public disclosure "needs to offer apples to apples comparisons," not information for information's sake. She reiterated the longstanding desire of hospitals for coordinated data reporting for HCFA and JCAHO.

Ruth Loncar, MBA, CPHQ, corporate director for Quality and Outcomes Management at Adventist Health in Roseville, CA, shares concerns about how the disclosure will happen. "If we use ORYX data, it is somewhat standard, but it's not risk-adjusted yet, so anyone looking at it would not be comparing apples to apples." Loncar also wonders how much explanation would be offered about the statistical significance of data changes on a quarterly basis. For example, the public might draw incorrect conclusions from a one-time increase in infection rates, unless the difference between trends and isolated events was explained.

In a response to the report, HCFA discloses that it is developing evidence-based quality measures. In progress are performance measures of the rate of beta-blockers prescribed for patients hospitalized following heart attacks, mortality rates following surgery, and infection rates following surgery.

As for an added reporting burden for QI managers, Loncar does not foresee much change if JCAHO uses the ORYX data that are already available. Anything beyond that could require added resources.

Unannounced surveys, random file audits

HCFA also will clarify JCAHO's responsibility for, and will cooperate with, the private organization to conduct more unannounced surveys. The Joint Commission is to "perform more rigorous assessments of each hospital's internal quality assurance process."

Larry Wall, president of the Colorado Health and Hospital Association in Denver, observes, "A difficulty with unannounced surveys is that often you're missing key folks that the surveyors need to talk to, so the surveyors are left without appropriate feedback for a good survey."

Loncar notes, "I would hope that unannounced surveys would not send QI managers scrambling to get their records in order." To keep its own house in order, the 20-hospital Adventist system conducts midcycle internal audits every 18 months to complement JCAHO's three-year survey process. Accustomed to unannounced state surveys, Loncar says a similar change by JCAHO "would not make any difference in how we do our operations."

The OIG is troubled by the collegial tone of survey visits. "As a guiding principle, [it instructs HCFA to] steer external reviews of hospital quality so that they ensure a balance between collegial and regulatory modes of oversight." The report concedes, however, that "Although a mix of cooperation and punishment is likely to be an optimal enforcement policy, the literature provides no clear guidance concerning what policy is optimal."

Grealy counters, "One of [AHA's] concerns is that you need a balance of the regulatory approach with the collegial or educational. It's important that we don't have a policing approach to surveys." In a letter to Inspector General June Gibbs Brown, Grealy wrote, "We find no evidence or discussion of whether the problems identified in the report, for example, the lack of ability to detect substandard patterns of care or individual practitioners with questionable skills, have grown worse as oversight organizations have emphasized a non-punitive approach. Additionally, there is very little discussion of why increasing punitive efforts will be more effective."

Wall challenges the "underlying assumption that the collegial approach does not improve the process of care." He continues, "Providers are not in business to provide bad care. With the exception of a few, if you can get quality information into their hands, they will use it.

"And who is better prepared than the Joint Commission, with their position of oversight and acquaintance with hospitals around the country, to spread the learning from good patient care practices?"

(Next month, QI/TQM *will bring you in-depth coverage of the report's implications for QI managers.)* ■

Need More Information?

For the full text of the four-part OIG report, visit:

- ❑ **Office of the Inspector General's Web site:** www.os.dhhs.gov/oig, then click on the "What's New" link.

Key Points

Location: Washington Regional Medical Center (WRMC), a 294-bed hospital in Fayetteville, AR

Situation: As a private, not-for-profit hospital, WRMC puts a good deal of its profits back into the community. Approximately $500,000 goes into Kids for Health, the nationally acclaimed health education program for public school children, grades K-3.

Solution: Figuring that every $1 invested in preventive health for children saves the health care system $7 later, WRMC's leaders teamed with the local school district in a win-win arrangement. State law mandates that public schools provide health education to young students. WRMC designed a program to meet the requirements at no cost to the school district. Now in its sixth year, Kids for Health shows a 51% average increase in health knowledge among students. The retention scores are equally impressive. The program's staff are exploring ways to market both the teacher-led and video versions to other school districts and health systems.

Health Tip from Kids for Health

For everything you choose to do,
Guess who's responsible - it's you!
When friends want you to join right in,
This is where your choice to do or not begins.
Risky or safe the choice may be.
Follow these 3-D steps to help you plainly see,
That there is a consequence for everything you do.
*Being a **Kids for Health**® smart kid is totally up to you!*

3-D Steps to Decision Making

1. Stop. Count to ten. List the choices.
2. Think about the choices and consequences. Talk them over with your parents or a trusted adult.
3. Make the best choice.

Smart Choices	Risky Choices
*Ride a bike with a bicycle helmet.	*Ride a bike without a bicycle helmet.
*Swim with a lifeguard present.	*Swim alone.
*Ask your parents before changing after school plans.	*Going home with a friend without letting your parents know.

Source: Washington Regional Center, Fayetteville, AR.

Kids' program teams hospital with schools

Reaches 8,500 kids a week; $1 now saves $7 later

As a private, not-for-profit hospital, Washington Regional Medical Center (WRMC) in Fayetteville, AR, gives back a portion of its annual income to the community. For the 294-bed hospital, giving back involves more than event sponsorships or screening programs. WRMC runs several women's health clinics, a free outpatient clinic for those who cannot afford care, and an AIDS clinic.

The keystone of WRMC's community projects, however, is Kids for Health. "It's difficult to change behavior patterns in adults," notes **Charles Wilson**, EdD, director of education at WRMC, "but if you instill good habits in kids when they're in elementary school, you can help them to be healthy for life."

As for return on investment, Wilson explains that studies estimate a $7 saving to the health care system for every $1 spent on prevention. For the participating school districts, the value is immediate in that Kids for Health fulfills their state mandate for health teaching in elementary schools.

The award-winning Kids for Health originated with **Kandy Edmonson Johnson**, RN, the program's coordinator, and Connie Edmonston, who has since left her position with WRMC. "We surveyed every health curriculum we could get our hands on, and nothing was like what we wanted," Wilson recalls. That was about six years ago.

Realizing that adapting a copyrighted program would involve too many headaches, they created their own. "The advantage of developing our own is that we can revise it until it's exactly as we want it. And we don't have to get anybody's permission to do so," he notes.

Johnson describes the reception of the 1994 three-school pilot as overwhelmingly positive. The kids loved it. Although school staffs complained that class schedules were already too full for the 30-minute health classes, their resistance faded quickly when they saw what WRMC could offer without touching their budgets.

Although parental opposition was another potential stumbling block, it became a non-issue as parents themselves learn from the health tips their kids bring home to post on the refrigerator.

Since the district's teachers are present the whole time a WRMC staff teacher conducts a lesson, parents are secure that the schools know exactly what their children are exposed to. While Wilson expected at least a few parental complaints, not one has surfaced since the program started. **(See the sample health tip, p. 104.)**

"The exhibitry makes points with the kids," Wilson notes. Using standard stethoscopes from the hospital, they listen to their own hearts. They study a human heart, brain, and lung. After seeing a lung diseased from cigarette smoking, one child described it to his father, a smoker. The man eventually kicked the habit. **(For highlights of the educational content, see "Kids for Health at a Glance," p. 106.)**

Quality controls help program fulfill goals

Like clinical practice guidelines, standardized classroom lessons have many benefits. Johnson explains that Kids for Health teachers actually memorize the lesson scripts. "If one teacher starts a sentence from a lesson plan in one classroom, you could hear the teacher next door complete the sentence," she says.

The uniformity fulfills several objectives:

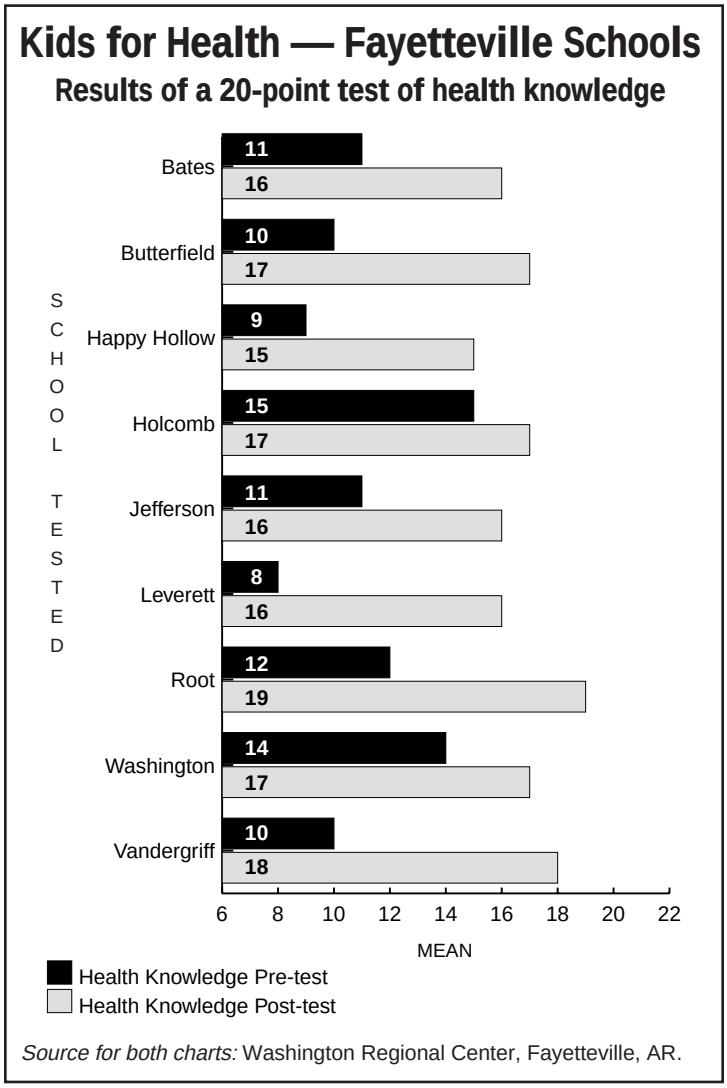
1. Provides valid data for controlled studies of the program's impact on children's health knowledge.

2. Enables the public school staff to explain to parents what their children will study. The school personnel have complete confidence that classroom activities reflect printed lesson plans. Such assurances were critical in the early days of the program when parents occasionally called to ask what their children would be learning.

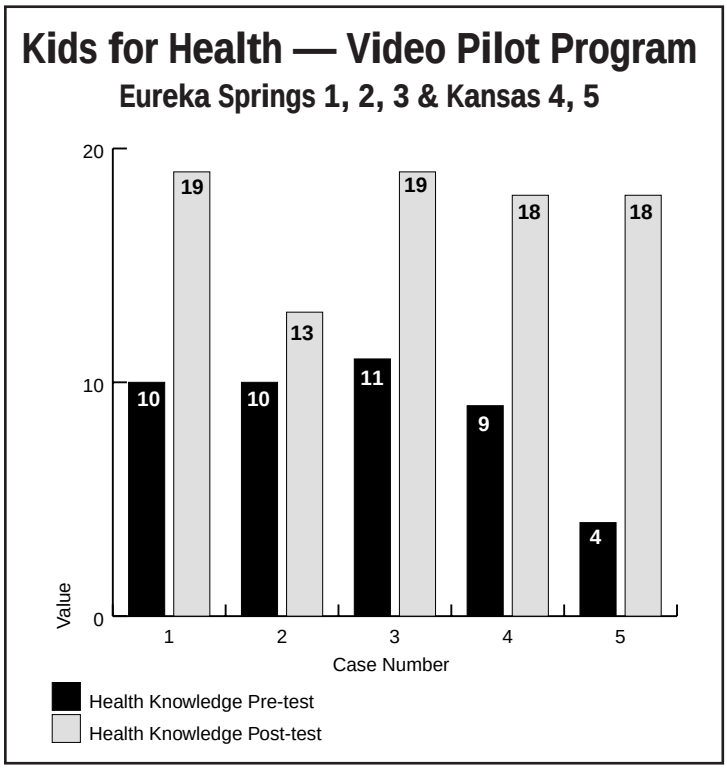
3. Makes lessons replicable with similar results.

Controlled studies conducted by WRMC show that Kids for Health results in a seven- to 11-fold increase in health knowledge. "Retention rates are good," adds Johnson. "Compared to other health teaching, this one does more than fulfill the letter of the requirements of the state laws," she says. In fact, Kids for Health achieves a 51% average increase in health knowledge per school. **(For recent scores from the Fayetteville schools, see graph, above right.)**

Kids for Health costs $63 per child per year. "Parents couldn't buy that much prevention for that amount of money," Wilson notes. Annually, Kids for Health costs WRMC $500,000. "If we can prevent one disease process from developing in each school population a year, we will have



Source for both charts: Washington Regional Center, Fayetteville, AR.



Kids for Health at a Glance

Washington Regional Medical Center (WRMC) in Fayetteville, AR, sponsors a health education program for young children. Organized around five major curriculum points, Kids for Health introduces a holistic view of health.

The lessons present the information in 30-minute sessions each week, at levels appropriate for kindergarten through third grade. Each year, students study the following units, building on knowledge from the previous grade:

1. **My self**
   Self-esteem, interactions, stress, and communication
2. **My body**
   Body systems: brain, heart, lung, digestion, muscle, and bone
3. **My health**
   Nutrition and fitness
4. **My choice**
   Hygiene, safety, and drugs
5. **My world**
   Environmental health, consumerism, and orientation to health care

Also of interest:

- Washington Regional Medical Center employs 11 Kids for Health instructors.
- Since the 1995-96 school year, Kids for Health has been taught in 26 elementary schools in the Fayetteville area.
- Each week, the program reaches 8,500 public school children.

Need More Information?

- ❑ **Charles Wilson**, Director of Education, Washington Regional Medical Center, 1125 N. College Ave., Fayetteville, AR 72703. Telephone: (501) 442-1299.
- ❑ **Kandy Edmonson Johnson**, Kids for Health Coordinator, Washington Regional Medical Center, Fayetteville, AR. Telephone: (501) 521-9056.
- ❑ **American Hospital Association**, One N. Franklin, Chicago, IL 60606. Telephone: (312) 422-2704. World Wide Web: www.aha.org.

saved that year's program costs," Wilson notes.

On the strength of a solid track record and measurable results from the live program, WRMC is testing an interactive video version. The hospital wants to determine if a less expensive (costs under $1 per child) mode of delivery achieves similar results. Preliminary studies look promising with health knowledge increases of nearly 100%. **(See graph on video pilot program, p. 105.)**

While WRMC and the hospital auxiliary currently support Kids for Health, plans are on the drawing board to market it to other school systems. Actually, sales inquiries are coming in from other school districts and health programs.

To top off its success, Kids for Health won a 1999 NOVA award from the American Hospital Association. The NOVA award honors hospitals for innovative, collaborative projects designed to improve community health. ■

EOL care improvements help patients, caregivers

Family conferences win all-around support

Advance directives and do not resuscitate (DNR) orders are some of the tools available to help patients, families — and ourselves, as providers — through difficult end-of-life health care decisions. To request a DNR order is not a casual step for patients or for their families. They expect their providers to take it just as seriously. However, many facilities have poorly articulated policies for clinicians and do little to enlighten patients about the choices at the end of life (EOL). Consequently, some patients endure unwanted resuscitation and nonbeneficial care.

Common misunderstandings that occur among patients and families include:

☐ They think living wills and medical durable powers of attorney include automatic protection against unwanted resuscitation either by cardiopulmonary resuscitation or mechanical ventilation.

☐ They don't realize that DNR orders written outside of the hospital are invalid at the hospital unless somebody presents the properly executed form to staff on the inpatient unit. (Laws regarding these types of orders vary from state to state.)

Key Points

Location: Saint John's Hospital, Santa Monica, CA
Situation: Procedures for Do Not Resuscitate (DNR) orders were confusing for patients and staff. Providers expressed frustration at the lack of opportunities for communication with patients and family regarding care at the end of life.
Solution: The palliative care task force designed a DNR order form which serves not only as a physician's order but as a plan of care as well. Other improvements stemming from the task force include a protocol for a 45-minute patient care conference in which providers and family develop a course of treatment for a terminally ill patient. Physicians have come to rely on the conferences and other end-of-life procedures as resources in care of the dying. Measurement of improvements is under way.

Misunderstandings like those described were among the issues facing the palliative care task force at Saint John's Health Center in Santa Monica, CA. The facility's bioethics program coordinator, **Gretchen A. Case**, MPH, says, "We are still learning how to provide palliative care in this country. But instead of pointing fingers at who is to blame for how bad end-of-life care is, we must develop tools to change the delivery process."

Chart reviews and focus groups defined the problem as it existed at Saint John's. While the task force developed a process that other facilities can replicate or adapt, Case warns against pushing for rapid change on EOL care issues. Due to the emotional charge, it's best to involve providers at each stage, all the way from planning through implementing alterations in the way they care for the terminally ill. **(For more on quality improvements in EOL care nationally, see *QI/TQM*, March 1999, cover story.)**

In 1995, the palliative care task force assessed Saint John's practices of caring for the terminally ill. Participants included staff from bioethics, intensive care, nursing, oncology, pharmacy, quality improvement, and social work, as well as physicians. The task force took these steps:

Stage 1

☐ E**xpression of long-felt frustrations about the state of care** for terminal patients. Hospital staff and physicians alike joined the chorus. While it took time, airing of frustration was critical to the success of the project.

☐ **Identification of improvement targets.** DNR policies came up repeatedly as did communication with staff and family, pain and symptom management, policies for PCA (patient-controlled analgesia) pumps, advance directives, and nonbeneficial care.

Stage 2

☐ **Design of new DNR order form.** Using a form from another health care system, the task force made the first round of adaptations.

☐ **Refinement of DNR order form.** Case was surprised at the lively interest in the form demonstrated by revision notes on copies posted in the nursing and physician lounges and presented to medical staff committees. Typical feedback was, "At last you've given us a form we can use." All concerns were addressed, and the final version was drafted.

Like at other institutions, DNR instructions at Saint John's are physician orders. However, Saint John's took them a step further than most. They are now written on the separate "Order Set-DNR" form, which includes the plan of care. It goes into the patient's chart; its blue tab and extra half-inch width make it easy for all to see. "Do Not Thin" instructions in the right margin alert the clerical staff to keep it in the chart.

A "Do Not Resuscitate Status" sticker on the front of the chart alerts providers to the DNR order within. "The new policy facilitates planning of care for the patient and facilitates communication between the providers and families," Case notes. **(See copy of the "Do Not Resuscitate Status" sticker, below.)**

Other products from the EOL task force include:

☐ **Standard procedures to back up the DNR policy.**

DO NOT RESUSCITATE STATUS: (check status that applies)

☐ UNCONDITIONAL DO NOT RESUSCITATE (no CPR, no CODE)
☐ MODIFIED DO NOT RESUSCITATE (indicate special condition(s) below)

Intubation or mechanical ventilation for respiratory failure	☐ YES	☐ NO
Chest compression	☐ YES	☐ NO
Electrical defibrillation	☐ YES	☐ NO
Drug therapy for Arrhythmias	☐ YES	☐ NO
Pressor/Inotrope for Hypotension	☐ YES	☐ NO

☐ OTHER: _____

DURATION:
☐ Duration of hospital stay
☐ Other (Specify): _____

Source: Saint John's Health Center, Santa Monica, CA

☐ **Protocol for a patient care conference (PCC) for complicated cases.** Attending the conferences are the family and hospital staff, as well as attending and consulting physicians.

☐ **Physician's guidelines on the use of narcotics for the terminally ill.**

☐ **Recruitment of full-time staff physician specialists in pain management and palliative care.**

The palliative care task force's work created ways to close the communications and knowledge gaps that make EOL care more difficult than it is anyway through these steps:

☐ **New DNR orders are flexible**, lasting either for a specified duration or throughout the hospital stay.

☐ **PCCs, which run about 45 minutes, bring families and providers together to discuss the patient's wishes** regarding treatment as life ends, including pain management and aggressiveness of care. Doctors' anxieties about litigation usually diminish when they've talked over the case with the family.

Designed around the physician's schedule, conferences go like this:

1. Case review (about 20 minutes). Providers establish goals for the family meeting. Participants include representatives of the palliative care task force, bioethics committee, social work, attending and consulting physicians, case manager, and nurse on duty.

2. Family meeting (about 20 to 25 minutes). At this point, some of the clinical staff leave so the family will not be intimidated by a roomful of white coats. Clinicians explain the medical status and suggest benchmarks that will be used to determine the level of future care.

'Carry an administrator in your pocket'

The palliative care task force's goal was to create resources for the medical staff, freeing them from the tendency to base care decisions on litigation fears. But without medical staff input at each stage, Case notes, nonsupporters could have ignored the whole thing. "We didn't want them saying, 'Have a conference or do what you will, my care won't change.'"

Fortunately, Saint John's executive medical director, **Charles Pietrafesa**, MD, was willing to enforce the facility's medical staff bylaws requiring doctors to attend conferences and meetings. Case would never suggest applying administrative mandates with a heavy hand, but when you're in a pinch, they help. Her rule of thumb is this: "Talk softly and carry an administrator in your pocket.

"We knew we were successful," she adds, "when our biggest opponent [of PCCs] came to us one day and said, 'I need help with this family.'"

Lessons of experience

If she had it to do over again, Case would have urged the palliative care task force to write standard procedures for PCCs as they developed the DNR forms, rather than wait until the forms were already in use. "People say that procedures just sit in a drawer, but there are moments when somebody challenges a policy, and having it on paper helps to maintain objectivity," she explains. "Even after we write procedures, we can tailor them. They're always a work in progress. But we should have had something in place first."

On the other hand, Case is pleased that the task force took time to build a tight case for better EOL care. Case says they needed the documentation to generate full support of the hospital and medical staff. Chart reviews and focus group feedback cinched it so nobody could argue the point.

However, she cautions interested *QI/TQM* readers, "Don't just try to take forms that worked in other systems and throw them at your people. They'll fight it. You have to go through the steps to get consensus first." Case estimates it could take up to two years to put the changes in place.

Improvement measures are still in the works. Case says that most of the data collection will be retrospective. Analysis will probably compare the use of DNR orders before and after the palliative care initiative. For example, for patients having similar medical profiles, were DNR orders implemented more often and sooner in the patient's stay after the project than before? ■

Need More Information?

For information on improving the process of health care communication, decision making, and care at the end of life, contact:

❑ **Gretchen A. Case**, MPH, Bioethics Program Coordinator, Saint John's Health Center, Santa Monica, CA. E-mail contacts preferred: Gretchen.Case@stjohns.org. Telephone: (310) 582-7140.

Y2K: FDA lists devices with high-risk potential

Date-sensitive items pose particular hazards

The Food and Drug Administration (FDA) has compiled a list of computer-controlled devices that would endanger patients should they fail because of date-related problems. The list of approximately 80 devices is subject to periodic updates. The agency notes that inclusion of a type of device on the list does not mean that all devices of this type are Y2K-noncompliant.

The FDA list includes the types of computer-controlled devices whose failure to function as designed or expected could cause immediate or serious health consequences. The three categories of items are:

1. used in the direct treatment of a patient where device failure could compromise the treatment or could injure the patient;
2. used in monitoring vital patient parameters whose data are immediately necessary for effective treatment;
3. necessary to support or sustain life during treatment or care.

Here are a few examples of items from the list as it stood at press time:

- lung water monitor;
- portable oxygen generator;
- continuous ventilator;
- arrhythmia detector and alarm;
- pacemaker programmers;
- neonatal incubator.

The FDA has published the list both as a guide to health care facilities and for the agency's use in identifying manufacturers who will be candidates for FDA oversight. The agency will ascertain whether the manufacturers have made available to users Y2K information on equipment status and remedial measures. ■

Need More Information?

❑ **Food and Drug Administration**, World Wide Web: www.fda.gov/cdrh/yr2000.

QUALITY TALK

Provider report cards: How helpful are they?

This month's guest is Patrice L. Spath, a health care quality and resource management consultant. In addition to QI, her expertise includes utilization review, case management, clinical paths, and outcomes management. Spath's latest book is Provider Report Cards: A Guide for Promoting Health Care Quality to the Public *(AHA Press, Chicago).*

Q. As you planned the book that you edited on provider report cards, what issues did you particularly want to explore for QI specialists?

A. I think a very important issue for QI specialists to remember is that there are really two classes of consumers: those people who need health care services regularly because of a chronic disease and those who need them just periodically. Periodic users are basically well people who have an occasional broken leg or something like that. When you create a report card for them, remember they have information needs that are different from people with chronic disease. When you are marketing to these two groups of consumers, give them what they want to know.

Q. Are provider report cards a cost-effective way for health care organizations to offer their consumers useful information?

A. Probably satisfaction data are the most useful to consumers. But, frankly, I think consumers use their neighbors' opinion more than anything else to judge quality. On the other hand, I think that since consumers are most interested in the satisfaction components, providers should routinely

Clarification

The correct reference to Noel Chrisman's Quality Talk column in the August 1999 issue of *QI/TQM* should be the following:

Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. *N Engl J Med* 1999; 340:618-626. ■

measure satisfaction to see where they could improve quality — from a consumer standpoint.

Q. How would a well-conceived report card serve a provider?

A. Providers need to define what they want from the report card. In fact, one of the first steps in creating a report card is the planning phase: determining what your purpose is. Again, we come back to the two different consumers, the sick one and the well one. For each consumer group, you may have different purposes and information, and perhaps slightly different types of report cards.

For the sick people, for example, your purpose may be to reassure them that they won't have to wait long to see their provider. Also, it's important to those patients that providers have compassion. One way to show that might be to explain how well they manage pain. Well patients care a lot about whether they can pick their provider. They want to know whether you have preventive services and wellness care and classes. Once you know your purpose, you can pick a whole variety of objectives:

✔ Objective #1 — Marketing

You might say, for example, "We want that well person to come into our hospital when they get sick because they liked the classes they attended." However, if the people of the community don't have a choice of hospitals, then I don't know how effective that marketing will be unless you've lost market share to facilities a hundred miles away.

✔ Objective #2 — Consumer education

You might say, "We want our consumers to be more knowledgeable about how to measure quality." So, you share information with enough narrative to help them understand, for instance, that a high postoperative infection rate is not a good thing. You would want to include postoperative infection rates on your report card. Or you might want to inform them that a very high cesarean rate is not a good thing, and your rate is low. With that kind of report card, you would be helping the consumers define how to measure health care quality.

✔ Objective #3 — Fulfillment of public expectations

Your facility might put out a report card because there are so many organizations making a variety of performance measurements available. You could get to a point where your consumers say, "Everybody else has a report card, why don't you?"

Q. In one chapter, written by a guest expert, the author describes some of the legal issues surrounding provider report cards. For example, she warns organizations against making absolute statements such as "Our doctors are the best." Are there any rules of thumb about reducing the legal risk involved in publishing a provider report card?

A. Subjective claims are going to haunt you more than sharing some kind of comparative data that show, for example, your CABG (coronary artery bypass graft surgery) mortality rate vs. some other hospital. It's really the promises and guarantees that get you in trouble. But I still think that people are concerned about showing even comparative data because they feel it may increase liability. **(For a reference to basic liability prevention tips with regard to provider report cards, see the editor's notes at the end of *Quality Talk*.)**

Q. In the past, you have expressed some doubt that consumers even use the report cards that providers so conscientiously put out — do you still believe that?

A. I don't know if we'd have conscientiously put them out if somebody hadn't made us do it. I have an opinion that those consumers who don't have a whole lot of choices — in other words, they live in a town that has one hospital — are less likely to pay attention to any kind of report card data than those people who live where they have choices. Because if you don't have choices, why even look at the data to see what your choices are?

However, I am beginning to see, in those well populations of patients, that they are willing to travel out of town to undergo elective surgery. Sometimes they'll go 50 to 100 miles away because they think they'll get better care in another hospital. But that decision is not usually based upon a report card. It's usually about how prestigious the other hospital might appear.

For example, consumers tend to think that a university hospital provides better quality care just because it's a teaching facility and it has the latest technology. It's interesting, when you go into smaller communities and talk to the hospital administrators, they say that they are trying to change these attitudes. Consumers think that driving 100 miles to the university hospital gives them better technology when, many times, the community hospital has the same technology. A lot of it is consumer perception that if you put

that "university" label on it, people think you somehow get better care.

Q. Are you saying that report cards don't have much to do with that perception?

A. Not right now — but I think they can. Some of the community hospitals are now presenting their data to show that their outcomes are just as good or better than the hospital down the road.

Q. In your book, you included a chapter on measuring whether your health care organization is meeting the health needs of its community. Isn't that a hard thing to sell to institutions that are struggling to contain costs?

A. Measuring whether or not you're meeting the community's needs and their satisfaction with your facility, I think, is an important component of an overall marketing effort. We tend to measure satisfaction by surveying people who have been to our facility. They are the population we ask, "How do you like it?" What we don't do is ask someone who has never been to our facility, "How do you like it?" By doing that, a provider could find out what kind of community initiatives would meet the health care and wellness needs of their community.

Of course, if you're in an urban setting, it becomes a little difficult to define your community. Let's take Denver, for example. The hospitals' communities overlap one another. When you get out into smaller suburbs and rural areas, you do have a defined community. If you're meeting the needs of that community through your wellness program, they are going to view you as the provider of choice. They are less apt to drive 100 miles to another hospital when they view you as the primary provider of health care services.

I think it's important, too, that we listen informally to what our community is saying. When you go to your dentist or your hairdresser, for example, ask the people who don't know anything about health care which hospital they would go to and why. It gives you a perspective that I think we lose once we work for a provider.

Generally, you're going to find that people who are just periodic users of hospitals tend to choose a facility based on very soft measures of quality. My dental technician, who is pregnant, said, "I'm going to go to Hospital A [actual name withheld] to have my baby."

I think that Hospital A is a high-quality provider, but it's also an hour's drive from her home. I asked her why she is going to Hospital A when there is another hospital 10 minutes away. She said, "I've just heard some bad things about this other hospital from my friends. And I heard that Hospital A has got a nice new facility and everything is clean and the nurses are so nice. People are really friendly and I want to go there."

Did she say she went to the Internet to find out what Hospital A looks like vs. this other hospital? No. Did she pick up some report card to see how their outcomes compare? No. She's willing to drive an hour rather than 10 minutes — while in labor — because she perceives, through word of mouth, that Hospital A is better.

I would encourage people to have these types of conversations with the general public in their community when they have a chance to, especially if they don't know that you work for a health care entity. See what they're saying about how they choose providers. I would encourage quality

QI/TQM® (ISSN# 1075-0541) is published monthly by American Health Consultants®, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid in Atlanta, GA 30304. POSTMASTER: Send address changes to **QI/TQM**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291. E-mail: customerservice@ahcpub.com. Hours of operation: 8:30-6:00 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $459. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $367 per year; 10 to 20 additional copies, $275 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $77 each. (GST registration number R128870672.)

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GRASS-ROOTS QI

Advocate Health Centers in Chicago regard the emotional element of diabetes as a high priority in successful treatment. The day that patients receive the diagnosis, doctors send them to **Mildred Blanchard**, RN, nurse visit coordinator. "It's a very stressful time," she observes. "Patients usually feel they're the only ones who have the problem. Somehow, when a nurse explains insulin injections, they can accept it better. I have time to hear their emotional concerns and to answer their questions."

✔ SOLUTIONS

Blanchard holds 10 90-minute group visits or classes each month. Attendance is voluntary and anybody is invited. "People come out in droves," she notes. Attendance averages 15 to 20 regulars, with most in their 60s and 70s. Blanchard introduces current diabetes management techniques, answers questions, and does foot exams. Members share information and emotional support. Ninety-eight percent routinely monitor their blood sugars. Classes sometimes run an extra hour, until all questions are answered. Instead of touting the benefit of exercise, Blanchard shows them. On a recent 15-minute walk in a shopping mall, one lady's blood sugar dropped from high to normal. "Patients can hardly believe the value of that little bit of exercise!" At the class members' request, Blanchard is looking into water exercise opportunities.

✔ RESULTS

Eighteen months into the program, before-and-after data look like this: Number of participants who receive the following on a regular schedule:

- Hemoglobin $A1_c$ tests — 93% (63% pre-program)
- Blood pressure checks — 98% (96% pre-program)
- Foot exams — 73% (37% pre-program)
- Eye exams — 63% (54% pre-program)

✔ KEYS TO SUCCESS

"I emphasize to people that even though they have diabetes, there's no reason they can't enjoy good health if they take care of themselves," explains Blanchard.

✔ CONTACT

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managers to talk to the people in their community and then develop report cards that give them the information they most want to know.

[Editor's notes: See Spath's book, chapter four, "Recognizing the legal issues surrounding provider report cards" by Alice G. Gosfield, Esq.

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Annual Compliance Institute comprehensive for all

Whether you are a seasoned veteran or new to health care corporate compliance, whether you work in a hospital, home health agency, nursing home, or physician practice, the Health Care Compliance Association's (HCCA) 3rd Annual Compliance Institute, scheduled for Oct. 24-27 at the Chicago Marriott, will answer all your training needs.

This year's institute, "Advanced Compliance: Discovering the Hallmarks of Effective Compliance Programs, a Critical Step in Compliance," is designed to provide practical workshops for experienced compliance professionals. To assist those attending the Institute, HCCA has labeled all sessions basic, intermediate, or advanced. The Institute will also devote an entire track to case studies, offering specific examples on various aspects of compliance programs.

For the beginner, HCCA will offer Compliance 101, a three-hour compliance primer, during a preconference on Sunday, Oct. 24. To learn more about HCCA's Annual Compliance Institute or to register, please call (888) 580-8373 or visit Conference Central on HCCA's Web site: www.hcca-info.org and register on-line. ■