Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

NOVEMBER 2003
VOL. 10, NO. 11 • (pages 121-132)

Progress in data collection improves alignment but adds new challenges

With disparity among systems, it's hard to compare apples to apples

As the experts will attest, benchmarking is part science, part art. The science of data capture is becoming more sophisticated all the time, although a relatively small number of institutions currently are taking advantage of state-of-the-art, fully integrated systems.

"It's all going electronic," says **Stephen Lawless**, MD, MBA, chief knowledge officer of Wilmington, DE-based Nemours, one of the largest pediatric subspecialty practices in the country. "The next step, although only a few have delved into it, is an integrated system. Lots of people have electronic documentation systems of encounters, billing, pharmacy, or orders; but less than 1% or 2% of the country have systems that are integrated, which means those systems actually talk to each other."

"Benchmarking has evolved to be much more sophisticated," adds **Tania Bridgeman**, RN, PhD, director of clinical path development for the University of California at Irvine Medical Center, (UCIMC), a tertiary, full-service facility that has a fully integrated system. "There's more input, the sophistication of the data is better, and you have a higher confidence level when you go out there [to benchmark with other institutions]."

The advantages of system integration are many, Lawless says. "If you have complete data capture, and if, for example, you've admitted a child to your hospital, you have a record that the child has been seen, all orders are electronic, and most of the documentation

Key Points

- A relatively small percentage of hospitals have fully integrated systems.
- The term "completeness of record" takes on entirely new meaning.
- Vendors play critical role in the new world of electronic data capture.

is electronic. Then, when he is discharged, electronic summaries are sent out. Also, when he is seen for a follow-up in the doctor's office, the electronic system there is integrated with the hospital. That is the ideal, although surprisingly few people have such a totally integrated system," he observes.

What does complete integration mean to your benchmarking efforts? "In terms of benchmarking, it means you have all the elements," Lawless says.

One of the early benefits of electronic systems, he notes, was to take care of legibility problems, which were at the root of about 50% of all errors in prescription writing. "The other 50% were due to people prescribing duplicate drugs, the wrong dosage, drugs that were not appropriate for integration with other drugs, labs ordering in duplicate, or people making decisions in care based on a lack of information," he observes.

"Did the doctor know, for example, whether his patient had previously seen, say, a lung doctor?" he poses. "You often had to rely totally on word of mouth or on a phone call. Now integration is seamless. If the doc down the road has already seen my patient for a routine exam and has done a cholesterol screening, why would I want to duplicate that? From a benchmarking standpoint, completeness of record is no longer defined by whether you have a history. Now the key benchmarking question is, do you have all the elements of patient care in a continuum? The change in the benchmarking process is dynamic."

For example, Lawless says, assume your outcomes measure expresses how few school days your asthmatic patients miss compared to someone else's patients. "Now, with all the data elements captured, you can really compare and see if your *management style* is different from that of the doctor down the street; you're not just comparing patient age, sex, and race. Integration will be able to help us benchmark outcomes really nicely," he explains.

"It's not good when your systems can't talk with each other," Bridgeman says. "We've had a high degree of success with clinical path development because we're automated."

Part of her clinical path development focuses on benchmarking, she explains. "You *have* to benchmark. Let's say you want to address joint replacement; it doesn't behoove you to just sit down with everyone at your facility who does them and create a pathway; you have to go out and benchmark," Bridgeman says.

With a number of vendors in the field, there is more than one way to achieve integration. At UCIMC, they use two major systems — TDF, by Atlanta-based Eclypsis, a clinical documentation system, which interfaces with a decision support system from a company called Transition Systems I. "They manufacture the software for a hospital-wide database with everything in it — docs, discharge, diagnosis codes, complication rates, age, sex, and so on," she adds.

UCIMC has had TDF since Bridgeman joined the staff in 1999, and had the decision support software a couple of years before that. The two systems can talk to each other. "Decision support is resource-driven — everything that's charged in the hospital will show up," she says. "You can even tease it into getting clinical information by creating a dummy charge code."

Healthcare Benchmarks and Quality Improvement (ISSN# 1541-1052) is published monthly by Thomson 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. USPS# 0012-967. POSTMASTER: Send address changes to **Healthcare Benchmarks and Quality Improvement**, 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 Monday-Thursday, 8:30-4:30 Friday, EST.

Subscription rates: U.S.A., one year (12 issues), $519. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $415 per year; 10 to 20 additional copies, $311 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 one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

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Decision support provides the internal data, such as the physician's name, DRG codes (for broad definitions) or ICD-9 codes (which, Bridgeman says, are superior), cost, length of stay, age, sex, financial category, charges, variable direct costs, total cost, and payer mix.

"Externally, we go out into the university health system consortium — UHC," she says. "This includes universities with affiliated hospitals, which input data from all over the country. You get morbidity, mortality, complication rates, race, age, sex, unexplained deaths, costs; you can even hone down into utilization in an OR or how many days critical care was used." It's the UHC, she says, that does the risk-adjusting.

Catholic Health Initiatives, a Minneapolis-based health care system with 60 hospitals across the country, works with a vendor called Soluciant, says **Mike Stoecklein**, senior operations consultant, who provides internal consulting resources for performance improvement, working with the hospitals' performance management teams.

"Our system works with Soluciant to provide benchmarking data under a program they call Action OI," he says. He adds that the system currently is installing "a more robust" version of the software.

"It looks at a variety of functions, both at the hospital level, like revenues, expenses, productivity, and it can also let you compare yourself against similar hospitals," Stoecklein says. "You can choose certain attributes. At a department level, you can pick and choose the comparison groups that make the most sense for you. You can also perform normalization of the data to look at individual differences and nuances of different facilities."

Scientific advances in benchmarking, and even complete integration, often are accompanied by a new set of challenges, says Lawless.

"It can create problems," he concedes. "Today, we presented our quality dashboard to our major board of managers at Nemours. The main issue they had was with benchmarking — looking at medical errors and rates."

The board asked if Lawless had any benchmark data to compare with other facilities. "I explained that we have electronic orders, electronic capture of data, and so on," Lawless says. "The trouble is, most people out there who publish data on medical errors use a paper system. Our data look 10 times better, but in the true spirit of benchmarking, we have to find out how well we do compared to those facilities *with other integrated electronic systems.*"

Most groups now use the same processes, he says, but electronic systems create brand new processes. "Once you have [an integrated system], data becomes so much more accessible; but once you have it, what do you do with it?" he asks.

With integration, defining terms becomes more critical, says Lawless. "For example, what is a patient encounter or visit? If someone asks, 'How many medical errors do you have per patient day,' what do you mean by medical error? Now that we can share the data so easily, those missed definitions are very crucial." The good news, he says, is that "if we define carefully, we can really compare one institution to another." Right now, however, there is no universal format for medical record numbers, he concedes. "So, how do you match up one [facility] to another?"

Bridgeman also sees definition challenges presented by integration. "We don't know if we're comparing the same elements. We don't *really* know what the other facilities are doing. When UHC, for example, applies what they call a ratio of cost to charge, you might not be sure what the other hospitals submitted — variable direct costs or actual costs. Also, while most of the participating institutions have colleges of medicine and research, we don't always know if they do. And if you do, your costs are higher."

Vendors also eventually must learn to speak the same language, Lawless says. "Vendors are crucial. I'd say that 25% of the large organizations are implementing electronic systems, but you have some vendors that are 'best in breed' for practice management, and others for patient care documentation," he asserts.

"What ends up happening is you create lots of interfaces. The next step is to make sure all the elements are defined the same way. If vendors could talk to each other or agree to certain nomenclature people would be comfortable with, you could buy

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different products and have them all interface," Lawless continues.

Bridgeman cites a real-world example of problems that also arise with external databases. "We use the Office of Statewide Health Planning Department, based in Washington, DC, and [like UHC] they also depend on what the other hospitals submit. They provide data on ethnicity, sex, age, comorbid conditions, mortality, payer mix. They also quote median income per capita per region, which makes the data useful for marketing, by getting patient populations within certain rings. The issue with them, however, is that their data are normally around 18 months old."

Still, she insists, "Both are fabulous databases." As for her software vendors, both of them have hotlines. Here, too, however, definitions are critical. "Both are dependent on having a very accurate query. Otherwise, with the wrong ICD-9 code, for example, you're likely to get flawed data."

Bridgeman predicts the move to integration will grow in the future. "I think it's the way to go. The huge thrust today is for safe health care, and as the Joint Commission [on Accreditation of Healthcare Organizations] says, the more driven by informatics you are, the safer you will be."

Despite the challenges, systems integration "will create a new bar, and that will only benefit patients," Lawless adds.

However, Stoecklein cautions, it probably will be impossible to ever be sure that you are completely comparing apples and apples. "I don't know if you'll ever have all apples, but you *will* have red fruit and red fruit. People want to find somebody *exactly* like them, and I don't think you'll ever see two hospitals that are exactly the same. But the real value in benchmarking is finding somebody you can learn from — which may be somebody who is not like you at all." ■

East-West synthesis drives change model

Sessions are heart of customer service improvement

The unique fusion of a process for major change created at the Harvard School of Business and a Japanese business culture model where change is driven by department managers and staff rather than by top leadership has helped power a successful customer service initiative at the University of Texas M.D. Anderson Cancer Center in Houston.

Key Points

- Each team is given six weeks to complete a change project.
- For effective change to occur, the entire staff must undergo the process.
- The pharmacy, information line, and diagnostic center are initial target areas.

The eight-stage process of creating major change, developed by John T. Kotter,[1] is set out as follows:

1. establishing a sense of urgency;
2. creating the guiding coalition;
3. developing a vision and a strategy;
4. communicating the change vision;
5. empowering broad-based action;
6. generating short-term wins;
7. consolidating gains and producing more change;
8. anchoring new approaches in the culture.

"This was the coat rack on which we hung other elements of the initiative," says **Duke Rohe**, a systems improvement specialist in the office of performance improvement.

A key Japanese tool for change, Kaizen sessions, helped get the staff used to change, he continues. "They are little 15-minute crafted meetings, requiring all the staff to do the same thing," he says. "Perhaps a little assignment is given — to come back to the next session with at least one small idea on an idea card that will make them or the department better."

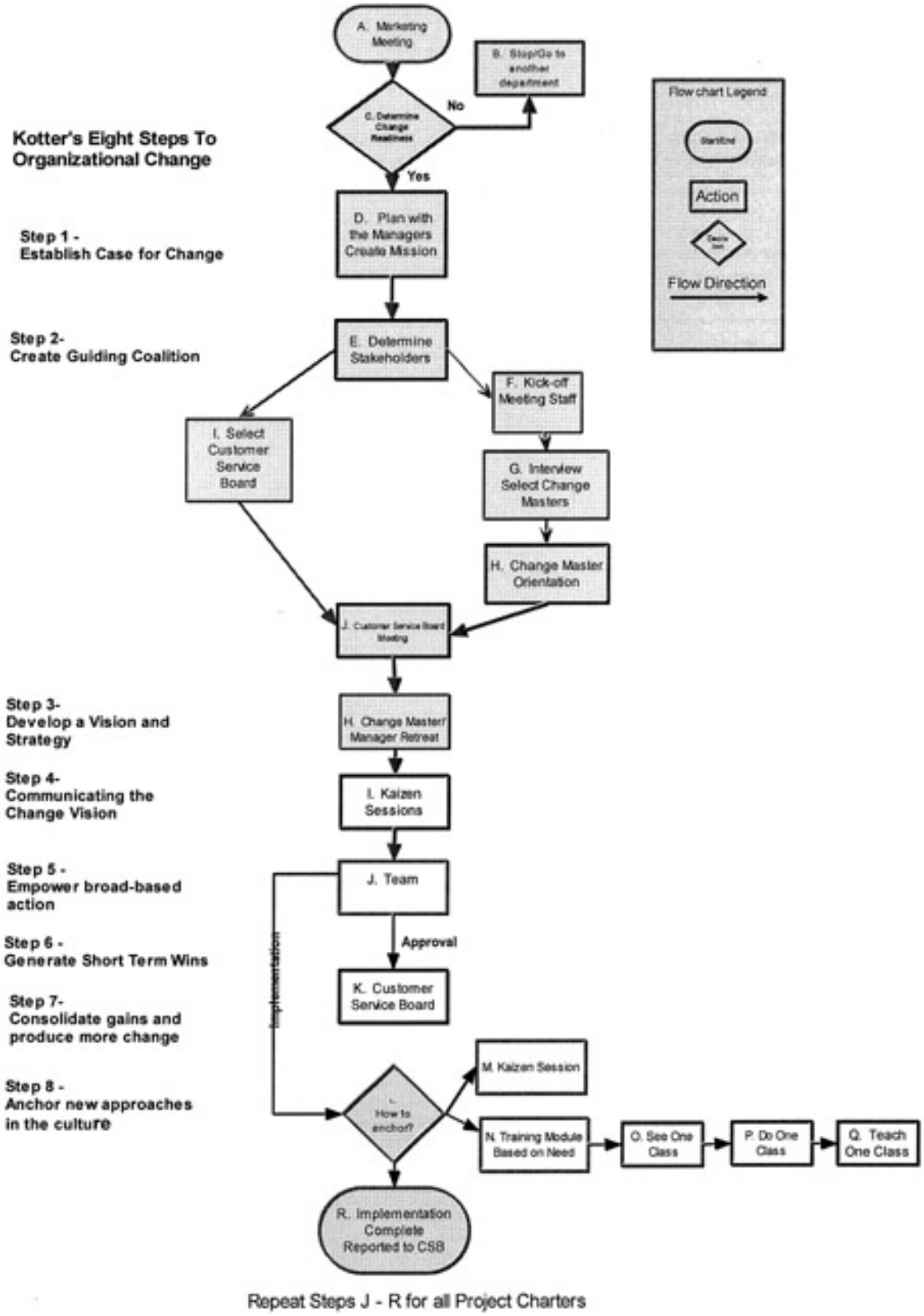
The whole staff has to participate, says Rohe, noting that for effective change to take place, "everyone has to change. It's like [developing] a muscle; you start easy, but you get stronger." **(The interrelationship of Kotter's model, the Kaizen sessions, and the structure of the customer initiative process are shown in the diagram, p. 125.)**

The initiative was born about three years ago, and was undertaken by the Institute for Healthcare Excellence (IHE), which was created to work in conjunction with M.D. Anderson's office for performance improvement to pilot new programs and new ideas. Working through the vehicle of the IHE, M.D. Anderson and **Paula Descant**, MAO, education specialist, spearheaded the effort.

"We set up the initiative to improve quality institutionwide and developed a program that

(Continued on page 126)

Customer Service Process



Source: Institute for Healthcare Excellence, M.D. Anderson Cancer Center, Houston.

was a combination of learnings and models that Paula and I have absorbed through school and through practical experience," Rohe says. "I come from the process side; if you don't change your process to support great service, you fail the customer [the patient] time and again."

"We looked at several key factors," says Descant, who developed six modules of basic customer service needs. "The better service we give our customers more efficiently, the happier your customers and employees will be."

The initiative targeted three main pilot areas: the pharmacy, the information line, and the diagnostic center. "We ended up changing people — or the people changed themselves," Rohe explains. "We gave them the tools, and staff behaviors changed; they become the improvement finders, instead of the top leaders, which is more often the norm."

This structure, again, is more typical of Japanese culture, Descant observes.

Achieving change

The change process began with Rohe and Descant "selling" the customer service initiative to department management. "Everyone thinks they need customer service," Descant says. "Our department is known for this."

"What they don't understand is that to make deep-seated change, you can't do it with just classes," Rohe adds.

According to Rohe and Descant, one of their goals is for the department staff to walk away from the program with something practical they can apply in the real world.

"We offer them the tools to get them to change the culture to be customer-friendly — *then* we offer the classes," Rohe explains. "It's the talk about culture that gets them." No punches are pulled as the initiative is explained. "We let them know we are going to change the process side, and that requires teams to support the service they are going to deliver," he says.

"That means a commitment of six months, during which we will be taking people off the floor," Descant adds.

To that end, a change readiness form is completed electronically, which "lets them know what it will feel like being short of staff," Rohe says.

Accordingly, Rohe and Descant required that no other change take place during the initiative.

"We knew that in the next summer, the pharmacy would have to open a new satellite facility," Rohe recalls. "They weren't sure what they wanted to do. They thought about it and came back and said, '[The change process] will be the thing to help kick it off,'" he adds.

"You first have to get the managers to see why they have to change," Descant says, explaining why it is important to establish a sense of urgency. "We use a balanced scorecard; Duke goes through and asks about turnover, productivity, attendance, customer service, finance, and so forth."

"If they don't see a need for change, they don't need to do this," adds Rohe. "At change readiness, we encourage them to talk to a manager who has already gone through this; we don't want them folding in midstream."

Most departments did not have a standing mission statement, Rohe and Descant found.

"If they didn't, we helped them create one," Rohe says. "We had the managers do it because they are the drivers and sponsors of what we are about."

In creating the guiding coalition, the key question asked was, "Who are your stakeholders?" They could be staff, departments downstream, or the patients. As originally conceived, the coalition would include an advisory board as well as a customer service board. In this case, however, since the advisory board is built on a top-down structure, only customer service boards were formed.

The customer service board "can be anyone the staff feels is important to their department," says Descant. "In the information line, we have ex-patients on their board."

"You feel honored to be on this," Rohe adds.

This process is driven by the staff. "We treat staff like stakeholders," he explains. "We let them know what they are about to go through, because not all of them will buy in."

One reflection of just how important buy-in is, is the change master position. "Since we need buy-in from the staff, we ask people to interview for this position," Descant says. "We require each department to have two change masters."

Prior to calling for volunteers, a change master from a previous team is brought in to share his or her experience. Then staff are given two days to read about the position before going through an interview process.

"This is serious stuff," Rohe emphasizes. "It is a two-year requirement with no additional pay — you just obtain more skills.'"

Rohe, Descant, and the managers all interview the candidates, based on a predetermined set of criteria. "We are looking for people who can be

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quick on their feet, who have facilitation skills and presentation skills, and who are team builders, because they will be presenting the customer service modules," Descant explains.

Once the two are selected, they are given a mini-orientation to bring them up to the same level of knowledge as the managers.

The next stage, the customer service board meeting, includes the two change masters, the board, and the managers. "The outcome from there is to look at the managers' mission and to begin crafting the vision," Rohe adds. "Appreciative inquiry is used; we examine the gap between where we are and where we want to be."

In the two-day session, the participants are given a sense of the overall process of how Rohe and Descant work with teams and with customer service modules.

"On the second day we break them off," says Rohe. "The change masters and Paula work on running teams, as well as on doing customer service modules. I take the managers into a session called 'run the bus, change the bus.' This covers how they will change themselves and the staff."

"It's really developing a strategy," Descant explains. "It gets them on the same page. It is also the first step in empowerment; that change master gets to say his or her piece."

Next, an individual team is selected by the change masters and management, also using a set of specific criteria, Rohe says. "The first team's goal is to turn the vision into a real vision statement for the department." He says the ideal team size is six members, but teams have been formed with as few as three members.

The team runs with this assignment for five weeks, then approves a vision statement. Ultimately, the customer service board approves the statement, "but everyone has their fingerprints on it," Rohe notes.

In addition to approving the vision, the board also approves the next project. The idea is to generate short-term wins. "Over the two-year process, a department probably will run 10 teams," he explains. "You have a five-week project, identify the change, then implement it. This way, you get immediate impact," Rohe points out.

"It is the customer service board's responsibility to make sure the short-term wins are continued and produce more change," Descant adds.

These changes are accomplished either through Kaizens or through the customer service training modules, she says. "One team did a new telephone process. When it got done, we did a module on this new process; now it's anchored in the culture."

"The very first team in the outpatient pharmacy revamped the existing flow process for dispensing outpatient drugs," Rohe recalls. "The second personalized the vision statement for their department and developed customer service scripts; a third team took the new customer service skills we learned and a new process and built new performance evaluations around those skills — they re-crafted the evaluation form. At last count, we have had over 30 Kaizens implemented. The staff catalogs and celebrates them."

Perhaps most gratifying, the customer service initiative has become contagious. "As often as not, the departments now approach *us*," he says.

Reference

1. Kotter JT. *Leading Change*. Cambridge, MA: Harvard School of Business; 1996. ■

Stroke centers can cut LOS, boost outcomes

Complicated process needs multidisciplinary team

Stroke centers with specialized stroke teams have the potential to improve outcomes and decrease lengths of stay (LOS) for facilities that previously have relied solely on pre-hospital and emergency department (ED) infrastructure.

This certainly has proven true at the University Hospital of Cincinnati, which was one of the pioneers in establishing a stroke center. "We have been treating [stroke] patients aggressively since the late 1980s, which is very unusual," says

Key Points

- The center is not so much a place as an organized response system.
- Team meets in-hospital on regular basis to discuss patient progress.
- Pathway for acute stroke care is an essential ingredient in the formula for success.

Arthur M. Pancioli, MD, FACEP, associate professor of emergency medicine and vice chairman of the department of emergency medicine at the University of Cincinnati College of Medicine, who came to the facility in 1991.

"It all comes down to the fact that stroke is a very complicated disease process and requires a multidisciplined team," he explains. "It has been shown many times in the literature that a formalized stroke team provides better care."

In many ways, the most appropriate way to treat stroke is no different than the optimal way to treat any complicated disease process, Pancioli continues. "A classic example is trauma, where you have a dedicated center," he notes. "So much of the modeling is similar, although the disease processes are vastly different."

Pancioli notes that over the years, the Cincinnati stroke center has improved outcomes, decreased mortality, and reduced morbidity. "Clearly, organized systems are going to have reduced length of stay relative to acuity. Quite often, major centers have longer lengths of stay than those centers that treat patients of lower severity, but relative to statistics that are adjusted for stroke severity, the patients [treated by stroke centers] do better."

In the mid-1990s, for example, Cincinnati compared its LOS data to its typical benchmarks such as UCLA. "With a typical team, we were able to reduce length of stay relative to our benchmark partners in that particular system," he says.

In many institutions, Pancioli notes, a stroke center is more of a system and a team than it is an identifiable, physical place within the facility.

"Very few places have a geographically located stroke center," he says. "Rather, you have a multidisciplined team, a defined champion, and representatives from all the important disciplines. The organization of the group is vastly more important than [having] four walls."

Bearing that in mind, one of the keys to the success in Cincinnati is that "we have an absolutely marvelous neuroscience department here," says Pancioli. In addition, there is the emphasis on multidiscipline care. At Cincinnati, that includes neurology, emergency medicine, radiology, neurosurgery, PT, and rehab, occupational therapy, speech therapy, nutrition, social work, which is absolutely critical, he says; "and, of course, nursing care has to be dedicated to the cause."

Then there is the actual response protocol. "One thing that's getting an awful lot of attention now is first being capable of taking care of acute patients," Pancioli points out.

This requires complex decision making that must be done rapidly. "For that, we have a long-established acute stroke team so that '24/7' one of our physicians is immediately available by page," he says.

"One number goes to all the team, then there is a signal back that the doc has received the page and responded that he either will treat, or that he is occupied and is a no-go. Also, the whole team knows the call went out and when a response signal has *not* come back. If a second signal comes without response, we all call back. In any event, you need the availability of a primary consultant who can assemble the whole team."

On an ongoing basis, there is a team in-hospital that meets regularly to address the stroke team census, the progress with each patient, and what is going on with the acute stroke population in the hospital. When it comes to recovery, "That's where we have to have significant coordination and communication between the physicians, the nurses, and everything in between," Pancioli says.

The pathway for acute stroke care is an essential ingredient in the formula for success, he says. "In an ideal world, when the patient hits the door, the pathway is put with them."

Pancioli is a firm believer in the need for written protocols. "People who consider pathways or protocols to be 'cookbook medicine' ought to be saying, 'I like to individually forget individual things for individual patients,'" he asserts. "What a protocol provides is a way of not forgetting anything. We are all human — we all forget things. Simply put, a recipe makes sure all the right ingredients end up in the pot."

In treating stroke patients, it is critically important to "do the things that you know affect mortality," says Pancioli. "It's like treating an MI and making sure the patient got an aspirin, and if not, why not," he explains.

So, for example, the stroke team will check such items as whether the patient went home on anticoagulant medicine, whether dysphasia screening was done before the patient started to eat, whether they received some form of DVT/PE prophylaxis,

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and so on. "After all, we know it kills people," Pancioli says. "You look at the things that have a literature basis for improving mortality and reducing morbidity, and you count."

At Cincinnati, tools such as the Paul Coverdale Registry Data collection forms and the Centers for Medicare & Medicaid Services' Fixed Scope of Work are relied on. "These are things benchmarkers should be looking at," he asserts.

Getting a stroke center up and running and making it successful is, unfortunately, easier than it looks, he says. "I've been part of a number of initiatives to take stroke centers 'to the streets,'" Pancioli says.

"It's difficult to do because you have to change a behavioral paradigm. You have to motivate people, explain why a stroke center is beneficial, and ask for resources. If you can find a stroke champion, show the literature, explain the benefits, and find a good protocol [there are many available on the web, he says] and get everybody at the table, you'll win." ■

CAM a special challenge for cardiac care

Many heart patients seek alternative therapies

A study published this spring and follow-up work yet to be released underscore an as-yet unmet challenge presented by many heart patients: An extraordinarily high percentage of these patients turn to CAM (complimentary alternative medicine) therapies in addition to their prescribed meds, often to their detriment.

In a study whose results were released March 19, 2003, at the American College of Cardiology's 51st Annual Scientific Session, researchers at the University of Michigan in Ann Arbor found that, while earlier research showed that nearly half of all Americans use alternative treatments, a full 74% of the heart patients surveyed reported using some sort of CAM therapy. The study involved 145 patients who had been hospitalized for heart attack or angina within the past six months.

Key Points

- Some patients are driven to complementary and alternative medicine because traditional medicine offers no cure.
- Patients and some physicians may be unaware of potential contraindications.
- Bleeding is one of the primary concerns in patients using both modalities.

"If you look in the literature, herbal therapies are used more for chronic illnesses like arthritis, and coronary artery disease is a chronic illness; it's not something you can cure," notes **Eva Kline-Rogers**, RN, MS, an acute care nurse practitioner in interventional cardiology at the University of Michigan Medical Center.

Kline-Rogers coordinated the study under the Michigan Cardiovascular Outcomes Research and Reporting Program. "When somebody has coronary artery disease, they may believe that since some traditional meds will help but will never cure, why not try some herbal remedies?"

In addition, she says, since all of these patients were recently in the hospital and were made aware they had a syndrome that was fairly severe, they might be more likely to look at alternative meds as the way to go.

More worrisome than the reasons these patients tried CAM are the possible health effects. Many heart patients are prescribed aspirin, Coumadin (warfarin), or Plavix (clopidogrel) to thin their blood, prevent clotting, and reduce their risk of heart attack, stroke, or other problems. But dietary supplements such as ginkgo biloba, ginseng, garlic, vitamin E, fish oil, or coenzyme Q10 also cause blood-thinning effects, and doses aren't carefully studied like those for medicines. The potential total anticlotting effect, or other possible interactions, are what worry experts.

It was those concerns that led the research team into further study, this time with 177 patients.

"When coronary syndrome patients are released from the hospital, they are sent home on a minimal dose of aspirin, which can cause some bleeding," she notes. "When they have had an intervention like a stent, they are often put on another med, like Plavix. A small percentage of them are sent home on warfarin, which we do know causes bleeding as a side effect.

"Our thought was that if we send our patients out on these meds and 50% of them take supplements that also cause bleeding, are we also having bleeding problems?" she continues. "We wanted to know what prescription drugs they were taking, and if they were using any other supplements known to cause bleeding, were they indeed having *more* bleeding?"

(Editor's note: While the first study showed that 74% of the patients were using CAM, when the

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patients who only used multivitamins and prayer were subtracted, 60% of all patients were found to use at least one remaining CAM technique.)

While none of the findings have been published, an abstract has been submitted, says Kline-Rogers. "We found bleeding was fairly common — about 25%," she reports. "Most of it was fairly minor, like nose bleeds or easy bruising, but the percentage was fairly high. We also looked at whether any supplements jumped out as a cause of bleeding. The only thing we found that increased the incidence of bleeding was consumption of green tea. In our literature search, we found there is some biological evidence to support this."

The team worked with Sara Warber, MD, co-director of the University's CAM center, who helped them design the surveys and look in the most appropriate directions.

"One thing we found, as a side point in the first study, was that those therapies that have some proven scientific benefit, like folic acid and fish oil, were not used as frequently as, for example, vitamin E, which in several studies has been shown to have no cardiovascular benefit," Kline-Rogers notes.

All of this underscores the need for more and better information — for patients and for health care providers, Kline-Rogers asserts. What are the responsibilities of hospitals, and their quality professionals, in this area?

"My thoughts are that first, everything the patient is taking needs to be assessed on admission," she recommends. "And you need to specifically ask the patient if they take green tea or other teas, as well as other supplements. The health care provider needs to be aware of what is beneficial and what is not. The nurse needs to be able to counsel people appropriately.

"For example, one recent paper indicated that vitamin E in some patients blocks the effects of cholesterol meds trying to raise HDL. Also, you must caution patients about to go home to let their primary care provider or cardiologist know what [CAM] they're taking," Kline-Rogers adds.

One long-term solution is to integrate more herbal medicine into the curricula at medical schools, which currently is happening across the country, she says. "Certainly, for practicing physicians and nurses, inservices and updates would be a good idea."

It also would be extremely helpful, says Kline-Rogers, for staff to have a written guide. "And it must be continually updated." ■

Collaborative patient safety program launched

Venture targets state agencies, hospital partners

The Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, and the Department of Veterans Affairs' (VA) National Center for Patient Safety (NCPS) in Ann Arbor, MI, are collaborating on the Patient Safety Improvement Corps, a training program for state health officials and their selected hospital partners. During the first annual program, 50 participants will complete coursework in three one-week sessions at AHRQ's offices.

Participants will analyze adverse medical events and near misses to identify the root causes of these events and correct and prevent them.

The overarching goal of the Patient Safety Improvement Corps, which is funded by AHRQ at approximately $7 million over four years, is to prevent harm to patients. "The genesis of the corps goes back to some meetings we had with state organizations in which we heard loud and clear the message that they really needed assistance on the front lines of improving patient safety," recalls **Daniel Stryer**, MD, director of the Center for Quality Improvement and Patient Safety at AHRQ. "It's not adequate just to build a research base; people need to develop some skills for addressing threats to patient safety, errors, and harm from errors."

AHRQ felt, frankly, that "no one else could reach this audience," he continues. "We also felt that the

Key Points

- Root-cause analysis of adverse events and near misses are emphasized.
- Participant make-up offers opportunity to hear differing viewpoints.
- VA Center for Patient Safety considered a leader in safety movement.

VA was at the forefront of training in patient safety, so we wanted to build on this experience, combine it with our involvement in research and dissemination, and reach a broader audience." What the initiative is striving to do, Stryer explains, "is reach as many people, organizations, hospitals and, ultimately, patients as possible."

By going through representatives of state health departments, Stryer says the partnering organizations will provide indirect access to literally hundreds of hospitals and health care organizations, "providing us with leverage to amplify the impact we will have."

Toward that end, the corps has a partnership structure. "What we have done is ask for the representatives of the state to partner with representatives of local hospitals," he says. "They provide different viewpoints, experience, and also ensure that the training they are getting is really going to be applicable to local environments. That one organization will benefit, but the state health departments will also benefit from the partnership. This is a very important program grounded in reality."

Many of the session trainers are from the VA's NCPS, says Stryer. Others will include AHRQ faculty and outside experts.

The training program for Wisconsin, which just recently was completed, appears to have been a success according to **Myra Enloe**, RN, MS, patient safety officer at the University of Wisconsin Hospital and Clinics in Madison.

"Our state's QIO, MetaStar Inc., represented the state [and its Department of Health and Family Services] in the program and chose us as a partner," she says. "I felt it was important; it seemed like a wonderful opportunity to really get some formal education in patient safety from some of the real experts in the field, and that it would benefit our organization in continuing its efforts to promote patient safety."

Having completed the course, she is convinced she made the right decision. "It was great — very worthwhile," Enloe says. "It was five days of education, with people from the VA's [NCPS], who are considered leaders in the movement. It was also an opportunity to get to know other people who are in patient safety."

It was valuable for state organizations and hospitals to be brought together, she adds. "These are folks who don't usually work together in this way." The trainers and participants spent a lot of time on root-cause analysis processes. "This was

Need More Information?

For more information, contact:

- **Agency for Healthcare Research and Quality**, Rockville, MD. Web site: www.ahrq.gov.
- **Myra Enloe**, Patient Safety Officer, University of Wisconsin Hospital and Clinics, Madison. E-mail: mg.enloe@hosp.wisc.edu.

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an opportunity to practice doing them in a little more structured, efficient, and probably more effective way than how we have done them in the past. One of the key things I took home is that they really involved senior leadership in root-cause analysis, and I find that to be a crucial factor."

As for the ultimate benefit of the state/hospital interface, Enloe contends the jury is still out. "I'm still trying to figure out how this will play out. But it will definitely help to raise some of the regulatory problems, as well as clinical issues, and provide a better understanding for both sides." ■

United States Postal Service
Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication No.	3. Filing Date
Healthcare Benchmarks and Quality Improvement	1 5 4 1 - 1 0 5 2	10/1/03
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$519.00

7. Complete Mailing Address of Known Office of Publication *(Not Printer) (Street, city, county, state, and ZIP+4)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305 — Contact Person: Robin Salet — Telephone: 404/262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not Printer)*: 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do Not Leave Blank)*

Publisher *(Name and Complete Mailing Address)*: Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305

Editor *(Name and Complete Mailing Address)*: Steve Lewis, same as above

Managing Editor *(Name and Complete Mailing Address)*: Russ Underwood, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Thomson American Health Consultants	3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☐ None

Full Name	Complete Mailing Address
Thomason Healthcare, Inc.	Five Paragon Drive Montvale, NJ 07645

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526**, September 1998 *See instructions on Reverse)*

13. Publication Name: Healthcare Benchmarks and Quality Improvement — 14. Issue Date for Circulation Data Below: October 2003

15. Extent and Nature of Circulation			Average No. of Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies *(Net Press Run)*			550	500
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	330	302
	(2)	Paid In-County Subscriptions *(Include advertiser's proof and exchange copies)*	2	2
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	3	3
	(4)	Other Classes Mailed Through the USPS	13	17
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2)*			348	324
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	(2)	In-County as Stated on Form 3541	0	0
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g. Total Distribution *(Sum of 15c and 15f)*			394	353
h. Copies Not Distributed			156	147
i. Total *(Sum of 15g, and h.*			550	500
Percent Paid and/or Requested Circulation *(15c divided by 15g times 100)*			88	92

16. Publication of Statement of Ownership
Publication required. Will be printed in the November 2003 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: Publisher — Date: 9/30/03

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