Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

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Data interpretation hinges on the rationale for benchmarking project

Art of benchmarking requires flexibility, keen judgment

Vast strides are being made in data collection methodology, and access to the same resources will help increase the commonality among benchmarking facilities. Nevertheless, benchmarking professionals argue, the practice of benchmarking is as much art as it is science, and interpreting data is as important as collecting them.

That being the case, once you have the data in hand, how do you determine what to do with them? "The whole issue of benchmarking is, why are you doing it?" notes **Sharon Lau**, a consultant with Medical Management Planning in Los Angeles.

What's your reason for benchmarking?

"Is it to mark you as the best in the area? To improve overall? To slash and burn? — I hope not, but some people do use benchmarking at the 11th hour, so they can know where to cut. You have to have a reason, and hopefully, it is for overall improvement and for giving your managers some targets to shoot for," she says.

Robert G. Gift, MS, president of Omaha, NE-based Systems Management Associates Inc., agrees with that assessment.

"What's the reason you gathered the data in the first place?

Key Points

- The size of the gap between performance and benchmark is a key guidepost.
- Balancing cost, quality, and speed aspects are at the heart of benchmarking.
- Just because data are less than perfect doesn't mean they should be discarded.

You'll never have complete data," he points out. "You have to look at this stuff and try to make sense of it; therein lies the judgment."

What to use — and when

How do you know which of the data to use, and when? "Here is where you have to be strong," Lau says.

"The first thing any manager will tell you when it comes to a benchmarking result is, 'Yes, but we're different.' Sometimes we are, but you have to approach benchmarking as follows: If the gap [between your performance and the benchmark] is not that big, then maybe that's not what I want to go after. Maybe I'll tackle another department where the gap is much larger, and I can get more bang for the buck and come back to this other area when I've solved it. That is part of the art of benchmarking," she explains.

"Part of it also has to do with whether you are looking at outcomes data or process data," Gift says. "If you are looking at outcomes data, that is the ultimate you are trying to achieve, but what will help you see *what* to change in the work you do are the process data."

Lau warns that "yes, but we're different" should not be used as an excuse to disregard certain data. "Yes, we are *all* different, but that doesn't mean we can't learn from the performance of others," she asserts.

The heart of benchmarking

At the heart of all key benchmarking decisions is the need to balance the cost, quality, and speed aspects of performance, Lau says.

"This is true no matter what it is you are measuring," she insists. "You have to balance the cost benchmarks, the quality benchmarks, and the speed-of-service benchmarks. If you just go after productivity, which is a speed benchmark *(i.e.,* lowest hours), that only gives you one view of the benchmark painting. You could be the most productive but have the worst speed and quality; there's always a need for there to be a balance."

That, she says, is another part of the art of benchmarking — when to seek an exact balance and when, for example, to decide that quality/satisfaction is more important than the other factors.

"We had an ED [emergency department] in our [benchmarking] group that was the most productive in the world," Lau recalls. "But their kids were waiting three hours to be seen by the doc, so they had to add staff to bring the wait time down. Then, customer satisfaction went up."

"Which data to use and when is really driven by the objectives you are trying to achieve," Gift says.

He uses an approach similar to Lau's, employing a tool called the "Family of Measures." **(See example, p. 135.)**

"This is a fascinating way of looking at multiple dimensions of performance," Gift says. "The assumption is that there are only three things we can measure — effectiveness, efficiency, and economy — or if you will, quality, time, and cost."

To use the "family," you start out with a process

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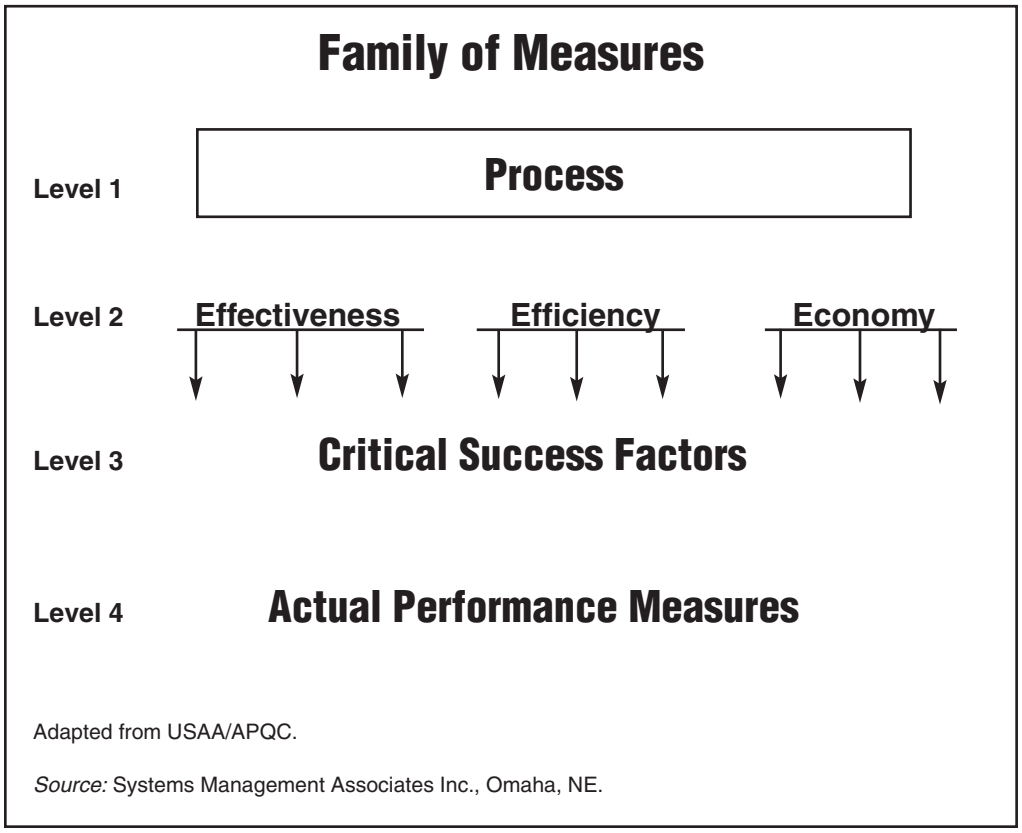

Adapted from USAA/APQC.

Source: Systems Management Associates Inc., Omaha, NE.

and break it down into these three major areas. "Then you identify the critical success factors and what the performance measures are," Gift says.

"If you are thinking about an admissions process, for example, maybe the accuracy of the information you collect is a critical success factor," he adds. "The actual performance measure may be the percentage of patient registrations that are error-free. It's drawing that line of sight between the process you are working on and the actual thing you are measuring."

Many times, people may say they are looking at accounts receivables, for instance, and measuring X, "but what are you trying to get at with X'?" he asks. "The family of measures tries to force some alignment of those things. It also forces you to think of multiple dimensions of performance, so you are not pushing on only one of those three pedals."

Apples and applesauce?

Even with good data definitions and careful data collection, you'll still have some data that will never be apples to apples, Lau notes.

"Apples to applesauce may be the best you can get," she concedes. "But you still need to use the data. How do you do that?"

The first thing you have to do is convince people they are still good data. "If it's apples and rocks, maybe we have a problem," she concedes. "But if its apples and oranges, frankly I can see they are both fruit. You have to be able to interpret when you are close enough; look at the gap in performance and how close you are. If, for example, the benchmark wait time is 20 minutes and I'm at six hours, I don't care if the data are off by 15%; we *still* have a problem, and you've got to use the data. If it's the difference between 20 and 30 minutes, you may not go after it."

"What I tell people is, even if you do the best job you can, the best you can hope for is Golden Delicious to Granny Smith; you'll never get Washington state to Washington state," Gift says. "Variables can include how you gather the data, how much time was spent to clean them, and so on."

The chief contribution, in many cases, is a cause of variation that you can't eliminate — *i.e.,* the nature of the patients who show up at your door, he continues. "You can adjust the data for it, but you will never be able to clean it out completely."

How will you use the results?

In the end, it does all come down to judgment and results. "Benchmarking should be 25% data and 75% best practices — what works and what doesn't," Lau says.

"Maybe if we meet 80% of the benchmark for a certain area, [that is acceptable]; but we need a higher percentage for another," she adds.

Hopefully, the benchmarking results will be used as a carrot. "Our best executives in our benchmarking group have had that approach," Lau observes. "We will report on your performance as it compares to the benchmarks, but it's not like we'll fire you when you don't hit it."

"One of the overarching principles that come to mind is that comparative data and benchmarks

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should never replace judgment," Gift adds.

"One of the things we find is that people seem to be developing this insatiable desire to have comparative data. I think they're looking at this as a panacea — a silver bullet kind of thing. But data can only point you in a direction," he says. ■

Injuries in hospitals pose threat to patients

Longer LOS, higher number of deaths seen

Medical injuries during hospitalization resulted in longer hospital stays, higher costs, and a higher number of deaths in 2000, according to a study from the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD. The study, *Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization*, was published in the Oct. 8, 2003, *Journal of the American Medical Association*.

Chunliu Zhan, MD, PhD, researcher for AHRQ and the co-investigators found, however, that the impact of medical injuries varies substantially. Postoperative bloodstream infections (BSIs) had the most serious consequences, resulting in hospital stays of almost 11 days longer than normal, added costs of $57,727, and an increased risk of death after surgery of 21.9%.

3,000 deaths per year from post-op BSIs

Based on those data, researchers estimate that 3,000 Americans die each year from postoperative BSIs.

The next most serious event was postoperative reopening of a surgical incision, with 9.4 excess days, $40,323 in added costs, and a 9.6% increase in the risk of death. This equates to an estimated 405 deaths from reopening of surgical incisions annually.

Birth and obstetric trauma, in contrast, resulted in little or no excess length of stay, cost, or increase in the risk of death.

"The media seems to be talking more about the total numbers," notes Zhan, conceding that they are certainly eye-catching. "If you put the 18 types [of injuries studied] together, you will find that at least 32,000 Americans die each year in hospitals due to injuries. They also account for a total of 2.4 million extra days in the hospital and $93 billion."

The study used AHRQ's Patient Safety Indicators and Healthcare Cost and Utilization Project's National Inpatient Sample data to identify medical injures in 7.45 million hospital discharges from 994 acute care hospitals across 28 states in 2000. The study provides, for the first time, specific estimates for excess length of stay, charges, and the risk of death for each of 18 of the 20 AHRQ Patient Safety Indicators, according to the organization.

The results, while disconcerting, did not surprise Zhan. "They basically confirmed what common sense tells us doctors know in the hospital," he says.

Using the information

Zhan points out that the nation's hospitals can use this information to enhance the efforts they already are making to reduce medical errors and improve patient safety.

"This increases our understanding of the most serious injuries — things we need to pay more attention to," he asserts. "Naturally, hospitals should pay attention to all of them, but nosocomial infections is still the biggest one. This tells us, for example, that we need to do even more in terms of hand washing."

The most legitimate next step is to look at the specific risk factors associated with each injury, "because they are all different with each one," Zhan notes. "For example, with foreign materials left in the body after surgery, the double counting of sponges before and after each operation would be one strategy to adopt. There are a lot of things we can do."

The bottom-line take-home message, Zhan

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says, is that "Medical injuries can have a devastating impact on the health care system. We need more research to identify why these injuries occur, and to find ways to prevent them from happening." ■

SSM slashes LOS almost 2 days in just 2 weeks

'Consistence, insistence, and persistence' are keys

Reducing patient length of stay (LOS) from nearly seven days to the regional average of 5.5 days usually takes two years, according to the Health Care Advisory Board in Washington, DC, a nationally recognized organization that provides best practices research and analysis to the health care industry.

But SSM St. Mary's Health Center in St. Louis, a 582-bed community teaching hospital, did it in just two weeks. And while achieving a high level of patient satisfaction, it further reduced its LOS to five days 30 days later — ultimately reaching a record low of 4.7 days by the end of June 2002.

(SSM St. Mary's Health Center is a member of SSM Health Care, which was named winner of the 2003 Malcolm Baldrige National Quality Award — the first ever presented to a health care organization.)

Three-part formula pays off

The keys to success for SSM were "consistence, insistence, and persistence," explains **Mary Overstreet**, RN, BSN, director of case management at SSM St. Mary's.

"We communicate with you; we talk about what needs to happen with the patients in order to have effective quality care — which will automatically improve LOS," she explains.

"We do not go away. Every physician hears the same message, every day of the week. We are insistent, and we will have the literature and best practices to back up what we say. There are no sacred cows," Overstreet explains. "And this is not just a flavor-of-the-month change; this *is* our new process."

In addition, she and her staff promoted case management as a service to the physicians and their patients, as opposed to a punitive component of admitting.

"We want you to see us as a service the hospital is providing for you; because if you wanted your own case manager, it would cost you a fortune," Overstreet adds.

"We'll figure out why your 'echo' is not being done in a timely manner, track it down for you, and be your eyes and ears when you are not at the hospital," she says.

How it started

The process began April 17, 2002. The Medicare LOS for SSM St. Mary's Health Center was 6.8 days for the month. The health center was struggling with inflated costs and poor patient flow.

Hospital president **Ken Lukhard** agreed with his supervisor, Mike Graue, executive vice president of network operations for SSM St. Louis, that changing the hospital culture was necessary to reduce LOS, and that it needed to be a CEO-driven effort.

Not wasting any time, Lukhard called on Overstreet to pull together a plan for getting at the root cause of the problem. He asked her to offer suggestions on how to improve; he gave her two hours to prepare a presentation.

Overstreet, with the help of Alka Kapoor, MD, a physician advisor to case management (CM), redesigned the CM model. They presented the new model to Lukhard that afternoon.

Afterward, Lukhard says he called an emergency meeting of the medical executive committee. He received its full support for the new

Key Points

- Case management is promoted as a service to physicians.
- Inflated costs and poor patient flow stir management to action.
- Two internal teams meet daily to discuss length-of-stay triggers.

model, and it was implemented the next day.

"We went through a lot of the CM literature out there," Overstreet recalls. "One of the sources we primarily used was by Kathleen Russell-Babin, *Scaling the Outlier Brick Wall* [The Center for Case Management; 1999]. It not only looks at what keeps patients in the hospital, but at your own processes that are not functioning properly, which can also keep them in longer," she says.

Internally, two teams were formed. The short-stay action team consisted of Lukhard, Kapoor, Overstreet, and others, including the social work team leader, Senior Care Coordination Center physician and director, case managers, and social workers, and a representative from rehabilitation.

The long-stay action team included representatives from the same groups plus medical staff representing various specialties (department medical directors).

Both teams met daily for an hour discussing LOS triggers within their respective LOS time frames. The short-stay team focused on cases with LOS of three to four days that appeared ready for discharge but had no documented discharge plan.

The long-stay team focused on patients with an LOS of more than 10 days. Once triggers or processes that caused an increase in LOS were identified, they were re-examined and addressed, Overstreet explains.

Many times, team members discovered an oversight that could be fixed easily. For instance, it was learned that some short-stay discharges were delayed pending a cardiologist's reading of an echocardiogram. Once a daily schedule was established for a cardiologist to read echocardiograms of patients to be released, the LOS was reduced.

Identifying the triggers

"The first triggers we identified addressed patients in the hospital for more than 10 days," Overstreet recalls. "We would take each case and look at it and say, 'If you were medically ready to be discharged today, what are the impediments? If you are not medically ready, what can we communicate to your physician to make sure you get the best care possible?'"

Overstreet was put in charge of implementing the plan, with the full support of administration.

Additionally, the physicians were kept well informed and involved throughout the entire implementation process. "Our administration constantly involved the physicians. This was very important," she says.

She explains that Lukhard often visited the physicians' lounge to ask how the medical center could improve operations. Plus, he sent mailings to physicians' homes to keep them in the loop.

Overstreet says she is looking forward to a third physician survey to be conducted soon, having seen the physician approval rating increase from 54% to 80%.

The implementation of the new CM model involved breaking down a lot of barriers, she notes. "There were poor processes, and a lot of the culture needed to be changed. In particular, we had to address communication horizontally and vertically."

For example, she says, many staff were reluctant to approach physicians for fear of bothering them. When asked why, the reply often was something like, "No one ever has for 10 years."

"Our response was, 'Well, let's start," Overstreet adds. "We took a fresh look at everything."

Results are retained

Not only were the initial results impressive, but St. Mary's has kept those gains. They have kept their LOS low for more than a year. Other major benefits also emerged.

Emergency department diversion fell from more than 200 hours per month to fewer than 75 hours; the health center's operating margin improved $1 million in 30 days; the readmission rate remained consistent; and most importantly, patient satisfaction — as well as physician satisfaction — did not decline.

From the point of implementation of the new CM model to significantly reducing LOS, Overstreet has kept a notebook of the plan, the activities, the progress, and the outcomes of their remarkable journey that illustrates the power of teamwork.

Could St. Mary's success be modeled by other facilities? Overstreet says yes. "The first thing you need would be CEO support — it's by far

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No. 1. Our hospital president became intimately involved; he had [CM] report directly to him and met with me twice a week."

In fact, people made jokes about her trying to teach him medicine, "But when he talked to the docs, he could sort of talk their language," she says.

The other key factor is consistency. "This cannot just be implemented for a short period of time," Overstreet insists.

"What we're really promoting is quality — not just a decrease in length of stay to save money," she explains. "If you market an initiative as an effort to effectively improve quality, by its very nature, it will reduce LOS." ■

Patient flow product taps hidden capacity

Up to 20% increase in bed capacity possible

Capacity limits and bed shortages lead to difficult decisions for hospital administrators, including whether to cancel surgeries, build new facilities, add staff, or continue to divert patients to other hospitals.

Yet, according to Stockamp & Associates Inc., a Portland, OR-based national provider of performance improvement solutions in health care, a crucial option often remains unexplored: tapping into hidden capacity by streamlining how patients move through a hospital's acute care system. **(See flowchart, p. 140.)**

Initial evaluations by the company indicate that often hospitals could increase their capacity by up to 20% by effectively identifying and addressing root causes of inefficiency. This, says the company, presents significant revenue opportunities, reduced cost per case, and increased coordination in the delivery of care.

A new product specifically developed to address this issue, called Patient Progression, has confirmed the company's hypothesis in early pilot programs.

"We discovered this through a review of the literature and pilot work with our clients," says **Ann Kirby**, MPA, MSN, a director at Stockamp & Associates Inc.

"That has held true as we have gone out to other clients. The bottom line in what we find typically is our clients can realize up to 2% to 4% of net revenues by better utilizing their capacity. The kicker is there needs to be demand in the market to fill the [additional] beds, but most of our clients are not concerned about that in growing markets."

Key Points

- Significant revenue opportunities and reduced cost per case are possible.
- Methodology focuses on creating new measures of effectiveness for key factors.
- People, process, and tools addressed to drive culture change.

Kirby has more than 20 years' experience in the health care industry, including working as a staff nurse for nine years in academic medical centers before moving into hospital management and once was a Stockamp & Associates client.

She has led consulting teams in the assessment, redesign, and implementation of revenue cycle workflow and customer service processes, and oversees the design and delivery of Stockamp's clinical service lines.

A common philosophy

The Patient Progression methodology focuses on creating new measures of effectiveness for these key factors:

- demand;
- bed management/turnaround performance;
- discharge planning delays;
- the ability to accurately predict discharges;
- performance against established standards of care.

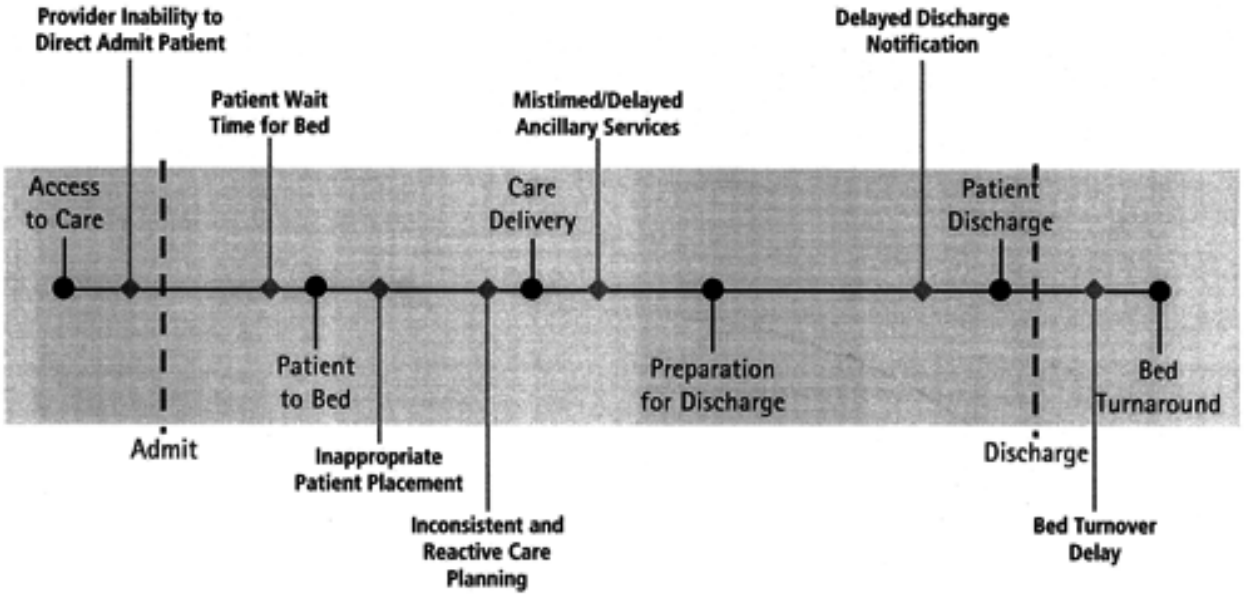
It is a mix of an in-depth review of a hospital's current operations and systems, the creation of detailed operational benchmarks, and the implementation of data management and reporting systems, according to Stockamp.

Although it is new, it is based on the same approach used to develop earlier products, Kirby explains.

"We address people, process, and tools to drive culture change. In this case, the change is around how patients flow through the hospital. For example, we might look at the role of house supervisor. We have almost universally found they are not empowered and receive poor communication from the rest of the staff," she says.

Unfortunately, a lot of things typically are broken in the patient flow area, Kirby continues.

Opportunities to Improve Patient Flow



Source: Stockamp & Associates Inc., Portland, OR.

"There is usually no good way for people who know what is going on with the patient to bring that information to a central area, and this is *very* important," she adds.

"You must know what is going on with all the beds in the hospital — for example, which patients in beds will be discharged in one hour. The people who really know that information must all be connected to the same process so that the information gets to the same place."

Kirby says her firm uses a combination of its own proprietary tools and some tools the clients already are using.

"We might, for example, introduce an automated work driver," she says.

"This helps the discharge planner. It has the work laid out for them in the morning, does a lot of what they do automatically, and prompts and prioritizes and helps them keep tabs on what's done," Kirby explains.

"We try and get at things that are good predictors," adds **Ken Saitow**, Stockamp's IT manager. "Some things we come up with will really put your finger on the pulse [of patient flow]."

If a hospital does not have metrics for some or all of the potential breakdown points in the patient flow process, it is not optimizing its current resources, according to Kirby.

She recalls when working with one client, asking that client to predict which beds would be available the next day. "They were only right 20% of the time. You can imagine what that does to their decision-making ability. Two beds vs. 10 beds is a significant difference, yet I haven't found any client who's measuring that."

Stockamp used this formula:
Number of predicted discharges divided by number of actual discharges.

"Now this client is in the 70% accurate prediction range after we have implemented Patient Progression process and tool changes with them," Kirby says.

This may be the single most important factor involved in improving patient flow — perhaps even more important than having good reporting tools or even good metrics, she notes.

"If you do not measure the *right* things on an ongoing basis, you can lose whatever progress you have made." It is *lasting* change, Kirby says, that is most critical.

Making the change last

Stockamp uses a number of strategies to ensure change that is both effective and lasting. For example, increased capacity is achieved by involving all the key stakeholders in a hospital setting, from housekeeping and case managers to nurses and

physicians, to improve the use of existing beds.

"One of the interventions we use is the discharge coordination meeting," Kirby notes.

"In the morning, we bring together the case manager, the bedside nurse, the nurse manager, and a physician [if available] or a nurse practitioner. Between all of those people, we have a really full picture of what's going on with the patients. But we also talk with them about what *should* be happening, she says.

"For example, if a patient is here for knee surgery and our goal is to send her home in X days, what needs to happen? Maybe there needs to be patient education for the transition to happen in a quality manner. We also target in advance beds that will be opening up; by communicating to someone in the central bed hub area, you get a picture of the whole house," Kirby says.

"Quite often, we don't see clients working across the house, but in silos," Saitow adds.

Kirby concurs. "Sometimes, they collect numbers but just don't use them across the system. They may know, for example, that they admit 20% of the ED patients, which is 30 beds a day, but that information is not used by others in bed placements."

Sometimes, the metrics are missing or the information is fragmented, Kirby says. To overcome this common weakness, "we have developed a reporting database."

Saitow calls it a dashboard. "Clients can look at it on a weekly basis to understand the trends of certain indicators. As unit coordination meetings and others take place, staff can focus on the performance of metrics to know if emphasis is needed in one area or another," he explains.

"This a management tool that, as far as we can tell, is generally lacking" in hospitals, Kirby says.

Working alongside staff

Equally important to ongoing success: Her team works alongside staff to help them attain efficient bed use on nursing floors, critical care units, and emergency departments (EDs), she notes.

"Typically, consultants will run assessments and leave you with their recommendations. Our approach is to stay with you during the whole period of time and help you implement the change; we are concerned about ongoing return on investment," Kirby continues.

"We do not ask the client to take 12 [full-time employees to implement the program]," Saitow adds. "We work side by side with them as they do their jobs. We begin with a no-charge assessment, to get to understand their processes and to understand the level of opportunity and to let us tailor our solution to their environment."

As an illustration, Stockamp has in place with one client a clinician who works on its project. "Last week, she worked with all the utilization review staff," Kirby says. "She looked at their set of criteria for clinical indicators and level of care required. Side by side, she helped them use the tool to problem solve, to make sure they would know how to do the work when we are gone."

Helping staff understand their roles

Another critical part of creating lasting change is for staff to truly understand their roles, Kirby notes. "For example, when something is not meeting criteria, they need to raise a red flag," she says. "They, along with the physicians, must serve as drivers of care."

But it is the recognition of the need to look at things differently that is "the final point that drives culture change," Saitow says.

"In order to make any of these things work, you need it, or it will go away after a period of time. We work shoulder to shoulder with the clients to internalize and look at this business problem differently than they ever have before. They will get recurring benefits *only* if the culture is changed," he adds.

The resulting new efficiency not only helps hospitals reduce ED diverts and discharge delays and enhances communication between care providers, but it also leads to improved patient and physician satisfaction as well as heightened morale and accountability among staff, according to Stockamp.

Kirby notes that the firm soon will be able to report on some real-world results with one of its pilot clients. "A lot of things we thought would happen with this product line are true." ■

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Fundraising software bolsters efficiency

More effective management of donor database

The RWJ University Hospital Foundation Inc. has improved the efficiency of its fundraising operations by switching to new software that allows more effective management of its donor database.

The foundation is the fundraising organization for Robert Wood Johnson University Hospital in New Brunswick, NJ, one of the nation's leading academic health centers.

The software it now uses allows the foundation to carefully select donors by their areas of interest, giving history, geographic area, and many other parameters.

RWJ University Hospital Foundation uses resultsplus! software from Metafile Information Systems Inc. of Rochester, MN, to track the response of every fundraising activity and generate targeted lists used for direct mailing and teleprospecting.

It has found that these appeals are far more effective than the untargeted kind, because they reach the right people. In addition, by tracking pledges against actual contributions received, the software helps the university hospital send reminders that ensure each pledge gets paid, without bothering those people who already have paid.

Querying the database makes it easy to create tailored invitation lists for the foundation's various events according to the interests and history of the invitee. "Resultsplus! helps us organize nearly every aspect of the fundraising process to the point where our results have been substantially improved," says **Jill Kolakowski**, accounts manager for RWJ University Hospital Foundation.

Database is lifeblood of foundation

Kolakowski says that donations to the foundation come from a wide range of sources — from large pharmaceutical companies and foundations to individuals who are simply grateful for the treatment they received at the hospital. Foundation staff members quickly recognized the importance of moving donor information from the filing cards and spreadsheets typically used by most foundations in the startup phase to a database specifically designed for the fundraising task.

"The donor database is the lifeblood of any fundraising operation. The problem with keeping this information in paper files is that as the files grow, a foundation's staff have to spend a considerable amount of time sorting through them to find files and record information," she explains.

"It's very easy to overlook or misplace a file, which means you will probably forget to contact that donor. The donor, in turn, might very well think that you have lost interest in them. And if a donor calls with a question, you have to tell them you'll get back with them after you have located their file," Kolakowski points out.

"This [paper file] approach also makes it very difficult to generate mailing lists. Selecting specific names from your donor database that would be likely to respond to a certain appeal takes so much time that it is not very practical," she adds.

Foundation managers evaluated a number of different fundraising software packages. They selected resultsplus! primarily because they felt it was easier to use than the other packages they looked at.

"I came from a nonprofit using a different software package," says **Debra Miller**, special events manager for the foundation.

"When a new person joined the organization, it usually took them a considerable period of time before they became productive. With resultsplus!, on the other hand, all of the most common things you need to do on a daily basis are connected to icons that are always right in front of you on the screen. This makes the program very easy to use," she notes.

While user-accessible and easy to use, the software offers a full range of advanced features. For example, doing an advanced mail merge makes it possible to target mailings to specific individuals within corporations.

And the product allows you to attach gifts and pledges to either an individual for separate giving

Key Points

- Donors can be selected by parameters, including areas of interest and history of giving.
- Appeals become more effective because the right people are approached.
- Database frees up staff time to ensure timely, consistent follow-up.

histories, or to a household or corporation for combined giving histories. Resultsplus! can process any gift, including tributes, split gifts, matching gifts, on-line gifts, and soft credits, as well as in-kind and effective value donations.

All standard reports can be tailored to the needs of an organization or users; staff can start from scratch and create their own reports while accessing all of the information stored in the database.

The foundation configured the software to track donations to nearly 100 separate funds, such as the emergency department, community outreach programs, hematology/oncology, cardiology, nursing education, medical equipment, pediatric programs, and so forth.

"Every gift that comes into the foundation is entered into resultsplus!, making it possible to go to one source to track every contribution and donation that has ever touched our organization," Kolakowski says.

"One of the most important benefits is that we can focus our fundraising efforts on people who have proven interest in the area that we are targeting," she adds.

"Most of our contributors identify with one or several particular diseases or medical specialties and are primarily or exclusively interested in contributing to them. For this reason, nearly all of our appeals are targeted to a specific field of medicine. Resultsplus! lets us very quickly generate lists that target any particular specialty in a matter of minutes," Kolakowski continues.

"I simply query the database for a list of people who meet certain criteria, such as having given a contribution to a particular fund in the past or having given a certain number of contributions or a certain dollar amount," she says.

"The software instantly pulls up a list of everyone in our database who meets my criteria. I can then merge a letter to that list of people or export a file for an outside telemarketing firm to call. The big advantage is that we now spend our resources only on communicating with people who are likely to be interested. At the same time, we protect our contributors from feeling they are being bombarded and ensure that they pay attention to the few targeted appeals they do receive from us," Kolakowski explains.

The foundation also receives lists of prospective donors from affiliated institutions such as the Heart Center of New Jersey, she notes. "The first thing we do is to enter them in resultsplus! and filter them against our existing contributors to make sure we don't contact a donor as if we are talking to them for the first time.

"By the same token, we have the telemarketers send us their pledge lists on a daily basis so we can update our database and make sure we don't

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send a reminder to someone who has just made a contribution. The bottom line is that we avoid annoying our donors by contacting them as few times as possible while also saving money in the process," Kolakowski adds.

Having a detailed record of every contribution also makes it easy to give recognition to your contributors, she observes.

"We generate a report at the end of each year that lists the contributors for our annual report. All we have to do is export the list to a Microsoft Word format and send it to the people who lay out our annual report for us." Kolakowski says.

Miller says the new software is very helpful in planning the foundation's special events.

"We sponsor golf outings and participate in the Auxiliary's Charity Ball. We use resultsplus! queries to generate an invitation list for each of these events. The lists are based on a variety of factors, such as whether or not the person has previously attended the event, their level of giving, and their interest in the specific area. We can be almost certain the names and addresses in the database are correct because they are checked every time we contact each donor. Generating these lists manually would be a nightmare, but with resultsplus! it is a breeze," she adds. ■

NEWS BRIEF

Hospital CAM services are on the rise

The proportion of hospitals offering complementary and alternative medicine (CAM) services increased by 0.8 percentage points in 2002, according to the 2003-2004 edition of the *AHA Guide*. About 16.5% of the 4,756 hospitals that answered the services questionnaire in the 2002 AHA Annual Survey of Hospitals said they provide CAM, up from 15.7% of 4,773 respondents in 2001.

Large hospitals reported the largest rise in CAM services, up 6.7% for hospitals with 300 to 399 beds and 10% for those with 400 to 499 beds. Hospitals with 25 to 49 beds were the only size category to see a decrease in CAM services, down 0.3%. ■

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