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Tracer methodology: How it can help you improve quality

Quality pros see opportunity to identify system, process problems

Any time the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) adds a new requirement to the survey process, quality professionals are obligated to become conversant with it to ramp up for their next survey. But if that's all the new tools are used for, they may be missing significant opportunities for improvement, experts argue.

Such is the case with tracer methodology. Likened by some to a safety walk around, a tracer follows a selected patient through the entire continuum of care. It may seem at first glance that little can be learned from a single patient that could be of benefit to the entire organization, or even a unit, but that's not really the case.

"It's a good way of learning where you have opportunities to improve," says **Indun Whetsell**, RN, CPHQ, director of quality management at The Medical Center in Orangeburg, SC. The 86-bed acute-care facility is preparing for a review in 2006, and for Whetsell, as for all quality managers, tracer is "a brand-new methodology."

Although the facility just now is beginning to learn about tracer methodology, Whetsell already sees value in it. "It will push you to a more concurrent review, rather than a retrospective one," she observes.

Key Points

- Tracer methodology follows patient through the entire continuum of care.
- Concurrent, rather than retrospective, approach is seen as a plus.
- Walk around creates opportunities to observe many different activities.

"The tracer methodology used by JCAHO surveyors to evaluate hospital compliance to standards is a valuable internal audit tool," adds **Patrice L. Spath**, RHIT, a consultant with Brown-Spath & Associates in Forest Grove, OR.

"Many organizations are conducting tracers to prepare for an on-site survey; however, the value of this methodology goes well beyond survey preparation. The tracer methodology is similar to other observational hazard identification techniques. The goal is to uncover process or system problems that increase the likelihood of undesirable outcomes," she explains.

When the tracer methodology is used for survey preparation, Spath adds, the goal is to find and eliminate areas that are out of compliance with JCAHO standards.

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"When used for internal auditing purposes, the tracer methodology can help the organization discover a whole host of problematic practices, e.g., fragmented care, communication failures, ineffective hand-offs, documentation deficiencies, and so on," she adds.

What's more, the nature of the process also will point you in a direction that is geared to improvement potential, notes **Judy Homa-Lowry**, RN, MS, president of Homa-Lowry Healthcare Consulting in Canton, MI.

"The selection process will gear you to high-volume, high-risk patients, anyway," she says.

Know your systems, processes

Being up to speed on your hospital's policies and standards, as well as its processes, is a critical part of preparation for tracer, be it for a survey or something much more broad.

"It's overwhelming, initially, because it crosses all boundaries [of patient care]; you have to follow a case all the way through the system," Whetsell explains.

"To be able to do it, there has to be some training involved for your people. You have to know your book of standards, and you also have to know your current hospital policies and procedures. You have to be very knowledgeable to try to implement tracer methodology," she adds.

"If tracer methodology is to be useful for internal auditing purposes, the process must be systematic," Spath advises. "Like any observational survey, the investigation must be conducted consistently and valid results gathered."

A central issue in conducting a tracer is completeness, she continues. "That means assuring all important aspects of patient care and services are evaluated.

"One way to address this completeness is by putting together a multidisciplinary evaluation team. The combined experience of the team will help to assure that no important activities are overlooked. The review process should be formalized and led by a knowledgeable team leader and an experienced review team," Spath explains.

Using the tracer methodology, the team then reviews the care provided to an individual patient systematically, from beginning to end (or to the boundary defined by the scope of the analysis), she says.

"The team leader can guide the analysis in any appropriate, logical way, although the objective is to be as comprehensive as possible, while

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economizing on time and effort. Oversight of the review is important for ensuring that all team members perceive situations in the same way and consistently apply the same criteria," Spath says.

Keep your eyes open

One way to optimize the value of tracer methodology is to observe *everything* that occurs in a unit — and not just those processes directly tied to the specific tracer patient.

"We'll look at medication, environment of care, and infection control," says Homa-Lowry. "We've been cross-trained to look at those issues. If any one of us sees anything out of whack, we'll meet in the morning or after lunch, and ask if anyone else has seen the same activity."

She maintains that if organizations identify their truly unique populations, each discipline service on that unit must look at the processes it provides to that special population.

"You have to make sure on the units that people pay attention, not just to their discipline, but to what other services are doing," Homa-Lowry asserts.

"You can't just say, 'Oh, infection control takes care of that.' People on the unit should have a general understanding of those processes that affect the patient; these things directly impact patients on your unit, and you need to be aware of them — whether you provide the service or someone else does," she says.

Homa-Lowry offers this simple but significant example: "I once asked staff who was responsible for cleaning the ice machine," she recalls. "The nurse thought engineering did it, and dietary and engineering each thought the other did it. They all realized they did not have a policy, and they decided to implement one."

The point, she notes, is that tracer methodology can help point out inconsistent processes.

"This raises the issue of organizational processes," Homa-Lowry says. "You have to make sure that the units are all aligned as well; that's when you get into the issue of having a system for your organization."

The bottom line, Whetsell notes, is that the tracer methodology can have significant value beyond the Joint Commission survey.

"I'm a strong believer in the principle that everything you do should be done to improve care," she says. "That should be your motivating rationale for doing something. Tracer methodology *is* time-consuming, yet through it, you can find opportunities to make some important changes." ■

QI program generates physician involvement

Control of glucose, cholesterol, BP levels improve

Generating physician involvement in QI efforts has been an ongoing challenge for quality professionals, but an initiative to increase diabetes awareness among the University of Pittsburgh Medical Center's (UPMC) 220 primary care physician practices, called UPMC Community Medicine Inc. (CMI), has produced impressive results.

The results of the initiative were reported recently in *Clinical Diabetes,* a publication of the American Diabetes Association (ADA),[1] covering a review of 15,687 laboratory tests.

Over a two-year period, the multifaceted approach to improving patient care and education showed the patients' average HbA_{1c} (which

Key Points

- Average HbA_{1c} levels for participants were brought below the national average.
- Participation, voluntary for physicians at the beginning, now is mandatory.
- Education is a cornerstone, with several different vehicles of delivery.

indicates a person's blood sugar control over the past two to three months) was reduced to 6.97%, nearly a normal level and far below the national average of 7.8%. **(See related story on new ADA/NCQA A_{1C} guidelines, at right.)**

There were 4,598 patients tracked with respect to blood pressure and cholesterol management. Some 51% lowered their blood pressure to less than 130/80 mm, and 78% lowered it to less than 140/90 mm. A total of 71% of the patients were put on an ACE inhibitor or beta-blocker for heart disease. About 42.8% lowered their LDL level below 100 mg, and 76.4% lowered LDL to less than 130.

At the beginning of the initiative, it was found that the primary care physicians (PCPs) were not delivering diabetes care uniformly based on evidence-based guidelines.

At the end of the two years, the physicians had made significant improvement not only in outcomes but in their health care practices. Of the 198 participating primary care physicians, 67% helped their patients lower their HbA_{1c}.

In addition, PCP participation in using a tracking form for lipid and blood pressure management has been 95.3%. There also was a rise in the number of interventions used in the treatment of hypertension and lipid management.

Initiative matches need

This was not the first attempt at quality initiatives at UPMC, reports **Francis X. Solano Jr.**, MD, vice president of the physician services division and chief medical officer of CMI.

"A few years ago, we decided to do quality initiatives," he recalls. "We had some committee meetings and sent out guidelines. We let people send in test questions, for which they would get CME [continuing medical education], and we had a 'resounding' 23 people respond."

Following that experience, the committee implemented a new strategy, which would involve not only education but also a prospective look at patients over a period of several months. The message to the physicians was, "This is what we want you to look for and what you should intervene on," Solano explains.

The "Focus on Diabetes Initiative" laid the foundation for improvement through the implementation of the ADA Standards of Care. These standards, along with companion flow sheets, were disseminated to the practices.

Education of the physicians was a critical program component. "We tried to make education a cornerstone," Solano says.

"Since we have so many docs, we had regional presentations and the capability to beam them through teleconference to remote sites," he notes. "Also, we used group leaders and champions' meetings to pull people into the room, bringing in an outside speaker to discuss a pertinent topic." Slide shows also were available on UPMC's e-mail system.

Data so compelling, program now mandatory

Initially, participation in the initiative was voluntary. "If you can get 50% of your docs to volunteer for *anything*, that's a huge win, and we had just about that in three voluntary quality initiatives," Solano reports.

However, that was not enough for the chairman of the board. "I presented [our initial] data, and he said, 'Why is this voluntary? This is great stuff; it should be mandatory,'" Solano recalls. "I took it back to our leadership committee, and they agreed."

The program became mandatory about two years ago. "Now, we have language in peoples' contracts stating they have to participate in quality

ADA/NCQA issue new diabetes measures

The National Committee for Quality Assurance (NCQA) and the American Diabetes Association (ADA) have adopted new guidelines for the Diabetes Physician Recognition Program, a voluntary program for individual physicians or physician groups that provide care for people with diabetes.

The new quality measures include a measure of $A_{1C} < 7\%$ for people with diabetes, which is in line with new ADA clinical guidelines. The previous measurement was $A_{1C} < 8\%$.

A_{1C}, also referred to as glycosylated hemoglobin (HbA_{1C}), is a measure of blood glucose levels over a two- to three-month period. In people without diabetes, the normal range for A_{1C} is 4% to 6%.

The government-funded study National Health and Nutrition Examination Survey 1999-2000 showed that only 37% of people with diabetes had achieved an $A_{1C} < 7\%$, demonstrating the number of people with uncontrolled diabetes has increased over the last decade. ■

initiatives," he adds. "If you don't, you get a nasty letter from me."

Solano says he just completed a project on congestive heart failure, and only one physician did not participate.

More recently, he says, the education programs have been made mandatory as well. "If you can't make a meeting, you get a PowerPoint presentation and questions you have to answer," Solano says.

UPMC also employs some "carrots" with the physicians, he points out. "Every year, there's a president's dinner reception. The top five to 10 people in our quality initiatives are taken to the dinner, along with their spouse or significant other. They receive a nice plaque, and they also get a write-up in our newsletter," Solano relates.

Data drive participation

As scientists, physicians are impressed by data, and, Solano claims, "If you show them the data and how people have done, it's hard to say you're not going to do this."

What's more, he adds, what his committee asked the physicians to do was not onerous.

"The average doc has maybe 70 to 100 diabetics in his practice," he notes. "If you say, 'We want you to track all your diabetes over three to four months,' that's a small number of patients per month — and perhaps only one or two per day. And it takes 30 seconds of your time."

UPMC took a slightly different tack in terms of this intervention, Solano explains.

"With most interventions, you say, 'Here are your data; now go do it,'" he notes. "We say, 'Put down these four to five key critical indicators, and when you see one or more of them in a patient, *do* something; intervene *now,* at the time of the encounter.' After that, you do prospective tracking."

The committee also focused in on specific areas of the ADA guidelines.

"Reading the ADA recommendations, you can be pretty overwhelmed," Solano concedes. "We have said we want to look at those things that really make a difference. It's clear you must control A_{1c}; blood pressure is most critical, as well as lipids. These influence heart attack and stroke rates. So we emphasize such interventions as eye exams and aspirin; the ADA says *every* Type II should be on aspirin."

Giving the physicians involved in the QI initiative the responsibility for tracking data in a prospective manner was critical to the initiative's success, says Solano.

"Physicians have never looked at their data in populations," he explains. "As professionals, we felt we did right and good things; this is very eye-opening, when you look at how well or how poorly you are actually doing in terms of meeting guidelines."

Giving physicians the data and the tools

A lot of physicians have never been asked to measure performance, Solano continues. "We say, 'OK, here's your population, and here's where you fall.' If you go out as an insurance company and present quality data to docs, they will be critical about your population size or say you are only presenting outliers. We put the onus on *them*; there's no third party tracking the data — *they* are tracking the data."

What's more, the committee does random chart audits (10% to 20% of the total) to make sure data are being reported accurately, Solano says. "We had one guy fudge his heart data, and he was embarrassed."

The physicians also are given the tools and data they need to facilitate patient management.

"We give them tracking tools, with the ADA guidelines on one sheet, a flow sheet, and we also give them action plans," Solano says.

Basically, he explains, the physicians are given the tools they need to target their population. Then, in the tracking, it is indicated whether a given patient was put on certain medications, sent to an educator, and so on. This year, Solano notes, lipids and blood pressure will be specific targets.

As with any successful QI project, leadership support was critical to the UPMC effort. "We couldn't have done this without support from the top of the university," says Solano.

"You obviously need a zealot like me." (Solano also heads the UPMC's Institute for Performance Improvement.) "Before we do anything, I do it

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myself to make sure it's reasonable. And because I still practice, I have credibility with the docs."

He concedes that there were some special circumstances involved in the UPMC initiative, and that what the medical center did may not be entirely replicable in all other systems.

"The Pittsburgh Regional Healthcare Initiative has a diabetes project. They called to see if they could meet with me to discuss whether our initiative was scalable. I think a captured audience of owned physicians is key [the physicians are employed by UPMC]. I'm not sure you could sell this to private docs."

Reference

1. Siminerio L, Zgibor J, Solano FX. Implementing the chronic disease model for improvements in diabetes care and education in primary care: The University of Pittsburgh Medical Center experience. *Clinical Diabetes* 2004; 22(2):54-58. ■

New tool adds structure, productivity to meetings

Pre-existing tool adapted to strategic goals

All Saints Healthcare, a multifacility system in Racine, WI, has adapted a pre-existing template for meeting structure to more closely mesh with its strategic goals, creating a more organized meeting process while at the same time reinforcing key mission and vision messages with staff personnel.

The new template builds upon a seven-step meeting process originally developed by All Saints' parent organization — The Wheaton (IL) Franciscan System.

"Some of our leaders were using it, but some were not," recalls **Terry Doherty**, director of customer service and leadership development for All Saints, which includes two hospitals and a number of smaller medical sites.

"When we started on our service excellence journey [about three years ago] and put together our infrastructure, we asked people to use the seven-step meeting process," she says.

"As we evolved and encouraged leaders to become more actively involved, we adapted it to our pillar goals — our strategic goals for the organization," Doherty explains.

About two years ago, she says, All Saints began working with The Studer Group, which advised it to use the template more often.

"It helps employees to understand how the issues they're meeting about relate to the big picture; we now connect every meeting to [at least] one of our pillar goals," Doherty says.

Key Points

- Tool reinforces key mission and vision messages with staff personnel.
- Depending on meeting topic, one or all of the goals may be linked.
- Tool offers more balanced approach to decision making and problem solving.

A team structure

Part of All Saints' infrastructure for service excellence consists of 13 teams focused on some elements of service.

These multidisciplinary teams cover four different areas of patient satisfaction (emergency department, inpatient, medical group, outpatient), as well as support services such as communication, measurement, reward and recognition, and service recovery.

The leader of each team, in turn, is a member of the system's steering team.

"We started working with them and tried to give them tools and information they could utilize to help their work go more smoothly, and this was one of them," Doherty explains.

The seven steps of the meeting process are:

1. Review roles.
2. Review objectives.
3. Review agenda.
4. Work through agenda.
5. Review meeting and record assignments.
6. Identify next steps; plan next meeting.
7. Evaluate meeting.

The six pillars are as follows:

- **Mission Integration.** Actions, processes, and decisions are rooted in, and consistent with, The Wheaton Franciscan and All Saints Healthcare's Mission, Values, and Vision.
- **Financial Viability.** All Saints Healthcare achieves operating margins and other financial ratios established in the system strategic financial planning process to generate the capital necessary to fund strategic and operational needs.
- **Clinical Excellence.** Clinical quality and clinical outcomes in key service lines will exceed

regionally and/or nationally established standards.

- **Patient Service.** Patients within the communities we serve will experience superior and compassionate service.
- **Health Care Employer of Choice.** All Saints Healthcare values its employees and provides a superior work environment that supports recruitment and retention.
- **Preferred Partner of Physicians.** All Saints Healthcare and physicians choose to work with each other over other market alternatives.

The Studer Group, Doherty notes, advocates five pillars; the other, "Mission Integration," is unique to All Saints. **(The chart, below, illustrates a staff meeting template.)**

Meetings vary

The number of pillars addressed depends on the focus of the meeting, she explains. "You might have only one pillar — or all of them — depending on the issue.

"For example, I head up a project team that helps conduct and serve as a resource around our employee survey, so at every team meeting we have an agenda that incorporates not only the seven steps but is also connected to all the

Staff Meeting Template

ALL SAINTS HEALTHCARE
MEETING AGENDA

Group: Employee Survey Team **Location:** **Date:**

Facilitator: **Reflector/Recorder:** **Timekeeper:**

1. **Review Roles:**
2. **Review Objectives:**
3. **Review Agenda:**
4. **Work Through Agenda:**

PILLAR / GOAL	TOPIC	PRESENTOR	EXPECTED OUTCOME	TIME
Mission Integration	Reflection		Connect to purpose	

Healthcare Employer of Choice	• Review of Assignments from February
	  • Action Plan Stories – Ann, Bob, and Jim
	  • Other
	• Updates & Decisions
	  • Org. Action Plans
	• Abbreviated Survey Debrief
	  • Q & A and issues
	  • What going well?
	  • Response Numbers
	  • Next Steps
			Obtain highlights and opportunities for change or next steps
			Update
			Update & identify & resolve issues	

Stewardship	**5. Review meeting record & assignments** **6. Identify Next Steps** **Plan Next Meeting**		• Carry out our responsibilities to support strategic & financial objectives	
Excellence	**7. Evaluate meeting**		• Improve the way we work	

Source: All Saints Healthcare, Racine, WI.

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pillars," Doherty points out.

She concedes that it is difficult to accurately assess the impact of this tool. "It's hard to say; there's no way to measure it," Doherty says. "However, we re-introduced it to all of our leaders with the pillars, in June 2002, and encouraged them all to use that. In all the meetings I go to, I see it used."

She sees a number of benefits that flow from this tool. "I think that the biggest is that employees have a better understanding of how their daily work connects to our values and goals," Doherty explains.

"Another benefit is that when our leaders start to think more in this way they will be able to make better connections for employees. At staff meetings, information is more balanced if they think about what the meeting is saying in terms of our goals; it's a more balanced approach to decision making, problem solving, and the giving and receiving of information," she adds. ■

Quality, teamwork to be key issues for internists

Task force cites need for compensation restructure

A task force of leading internal medicine physicians is recommending significant changes to their profession and the health care industry so they can better serve patients while stemming chaos in the current health care system.

"The Future of General Internal Medicine: Report and Recommendations from the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine," was published recently by the *Journal of General Internal Medicine.*[1]

The task force was chaired by **Eric B. Larson,** MD, MPH, director of the Seattle-based Group Health Cooperative's Center for Health Studies. It had been tasked by SGIM — a group of physician researchers in the field — to redefine their profession in light of its uncertain future.

'Quality accountable physicians'

Among the group's recommendations were the following:

- General internal medicine should remain true to its core values and competencies, though market forces may tempt the field to abandon them while adapting to chaos.
- The domain of the field should remain broad and deep.
- General internal medicine should embrace changes in information systems.
- Postgraduate and continuing medical education should develop mastery.
- General internists usually should work in teams and provide services through their own direct contact with patients.
- Current financing of physician services, especially fee for service, must be abandoned, reformed, or restructured.

The task force also called for internists to be "quality-accountable physicians."

"We think that quality has the same traits that generalists aspire to — a broad concept all the way from timeliness as experienced by the patient, doctor, and nurse leading to the best possible outcomes," Larson adds.

"Along the way [to those outcomes] are satisfaction, reducing errors, care safety, and not using an excess amount of resources," he says. **(See story on environmental stewardship, p. 70.)**

While the general public most likely perceives internists as primary caregivers in an office setting, the report notes that today's internal medicine physicians play a significant role in hospital care — either as hospitalists or as internists dealing with inpatient care issues.

Key Points

- General internal medicine should remain true to its core values and competencies, according to a task force.
- The task force calls upon internists to be "quality-accountable physicians."
- Many internists today have strong hospital connections.

"The general conception of an internist being broad and deep is very important for hospitals; it's what they like about us," Larson notes.

"We take care of a breadth of problems that are both common and unusual, and we are very good at it. Orthopedic surgeons, for example, will want an internist to take care of everything for a patient with a broken hip except the surgery itself," he says.

This vision of the future readily can be seen in the team concept. In general, it envisions the internist leading a multidiscipline team, but as Larson points out, the actual shape of that team will vary from setting to setting.

"We looked at a situation in Dillon, MT, for example," he observes. "The team includes a small rural hospital where the internal medicine physician works with everybody. You can form these teams around the patient first and foremost, but someone has to be willing to take on that organizing principle — the coach/player role.

"We think the internist is the logical person to do this," Larson continues. "You want a person who is interested in this to do it — not to command and control the team, but someone who works by cooperation."

Link pay and quality

Pay structures should be reformed to reflect quality and performance, Larson argues, although he concedes that the task force found pros and cons with many of the alternatives considered. Still, he says, they are preferable to today's fee-for-service model.

"One obvious model is salary plus incentive. Another would be time-based, like an attorney's compensation," he suggests. "A third is a hybrid fee for service plus a management or coordination fee. This gets really important when you talk about chronic disease care."

Quality and compensation were among the frontier issues discussed at the recent meeting of the American College of Physicians (ACP), Larson says.

"There was a lot of interest in coming up with ways to do what we know works for quality in ways that are *rewarded* for quality," Larson reports.

"For example, if a group of docs got together voluntarily to feed in data on their [diabetic] patients, and showed as they did this over time that the hemoglobin A_{1C} readings improved, then incorporating incentives could allow both the patient and the provider to benefit," he says.

Other possible incentive structures might include productivity or efficiency, Larson suggests.

"The new Medicare bill has some provision for studying these issues," he notes.

The bottom line, he says, is that internists and quality professionals are on the same page when it comes to patient care. "Ideally, people would like to do good and do well," he says.

"The ACP has established a performance measurement subcommittee, charged to come up with ways to improve quality without creating distortions in the system. Any good idea needs to be carefully tested, and physician practice groups are close enough to the world of real practice to come up with some of these."

Which brings us to quality managers. "They have a real opportunity to pilot things," Larson says.

"A lot of change will occur in the future by taking things that are out in the intellectual stratospheres, trying them, and charting them," he explains.

In some of these cases, he says, the pilot programs might be underwritten by a government agency or by a private insurance company.

Of one thing Larson is sure; things must change. "One of my colleagues just got word his mother broke her hip," he relates. "He went back from Boston to Seattle, because *he wasn't sure she would get good care*. This means we've really got to make some changes. The whole thrust [of the report] is to not sit back and wait for someone else to do it, but to make changes before the situation gets worse."

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Reference

1. Larson EB, Finn SD, Kirk LM, et al. The future of general internal medicine: Report and recommendations from the Society of General Internal Medicine (SGIM) Task Force on the Domain of General Internal Medicine. *J Gen Intern Med* 2004; 19:69-77. ■

Staff education about environment starts day 1

Environmental stewardship part of orientation

Key Points

- Part of Dartmouth-Hitchcock Medical Center's core mission is to be a good environmental steward.
- New employees are given a personal tour of waste management center.
- An environmental rep sits in on value and analysis committee meetings.

Employees at Dartmouth-Hitchcock Medical Center (DHMC), an academic facility in Lebanon, NH, that includes a 400-bed tertiary hospital, research and clinical space, work for an organization that places prime importance on sound environmental stewardship — and they become aware of that fact their first day on the job.

That's because environmental education is an integral part of the orientation process, and every individual who joins the facility must participate in that process. "I get 45 minutes with them, whether they are a janitor or an MD," says **John Leigh**, recycling & waste minimization coordinator at DHMC. "It's required, and they all get it — regardless of their background."

No doubt it is this determined attitude, along with an extensive program, that made DHMC one of the four hospitals to receive the annual Environmental Leadership Award from the Hospitals for a Healthy Environment (H2E) program, a joint national effort of the American Hospital Association, the U.S. Environmental Protection Agency, Health Care Without Harm, and the American Nurses Association.

"The health of our patients, staff, and community are directly impacted by the choices we make about what products and practices we use," says Leigh.

"As part of the first-day orientation, I bring up the notion that the stuff that we use absolutely impacts the long-term health of the community — so is it not part and parcel of our core mission to be good environmental stewards as we deliver quality health care?"

DHMC started to look at recycling and environmental stewardship in general in 1991, when it moved to its current facility, Leigh says. "This position, however, did not come around until 1995."

The commitment of top leadership is clear, he adds. "They have been refilling this position and moved it from part-time to full-time," he notes.

It's virtually impossible for a health care facility to not be affected by the pollution of the world outside, Leigh explains. "At any stage of a product's life cycle, unfortunately, a certain amount of pollution goes into the environment and can be translated into health care," he says. "A certain amount of pollution occurs quite legally, yet nitrous oxide and sulfur dioxide, for example, are significant pollutants that come out of power plants and are known to contribute to respiratory illness."

With the amount of stuff we purchase, says Leigh, "if we are wasteful in any way, certain products may have a greater impact. Becoming knowledgeable about the preferability of competing products becomes the kind of thing a health care organization our size should get into. We also have to keep up with which products are determined by [environmental] groups to be preferable."

On orientation day, Leigh is given 45 minutes with the employee. "We bring all of them down to the waste management center and let them see how it is we handle the 6+ tons of discards per day; we show them where they throw their trash, recyclables, and infectious waste, and how it impacts the individuals who are co-workers of theirs. They get to meet the staff who run the center and physically observe their activities. So, waste is no longer some black hole that is forgotten once it hits the trash bin."

In addition, Leigh covers what employees need to do to properly handle infectious waste, and what gets recycled at DHMC. "We want to make sure that what can be recycled *gets* recycled," he explains, "And we teach them how to reduce the amount of waste they generate on a personal basis." For example, he says, they are taught different ways to reduce the amount of paper they use — such as using both sides of a sheet of paper when copying.

"I also give them guidelines on how to recycle the many things they will probably have to recycle," he says. "I give them a characterization of our waste stream and show them a graph of how we've be successful in land-filling less as we've increased our recycling rate over the years."

Need More Information?

For more information, contact:

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Leigh also impresses on the employees the message that everyone is involved in DHMC's environmental programs. "With 4,600 people working here, we depend on them to carry some of the knowledge they've picked up to the veterans with whom they work in their department," Leigh observes. "I hope the 'newbies' can question what they see as they observe certain practices; and where those that are in place are not what I've told them, it might be good food for a conversation either with the vets or with me. If it's something involving the system, then I have to correct it."

The orientation session is just one part of an ongoing process at DHMC. Leigh provides some inservice training by getting on the agenda for sectional or divisional staff meetings.

"For example, the cath lab staff get together once a month early in the morning before they start the day. I'll get 10-15 minutes on the agenda to make sure to try to correct things I see happening, such as people not doing a great job of recycling, or the improper placement of an infectious waste container," he explains.

Leigh also interfaces with quality control, sitting together on a committee headed by the purchasing department that evaluates any new product that comes into the hospital. "Since I've been sitting there, the members of the value and analysis committee have started thinking in terms of whether a given product is disposable or reusable," he notes.

In addition, Leigh gets involved in environment of care or safety team tours. "These involve areas like safety, engineering, or housekeeping on a weekly basis; every area of the hospital is covered in the course of a year," he continues. "I join in on these; it allows me to monitor things like waste containers, to educate the staff on an informal basis, and to basically ask them how it's going." ■

Michigan hospitals track bioterror

Nine Michigan hospitals are participating in a statewide surveillance pilot program to track potential bioterrorist attacks, infectious disease outbreaks, and other public health emergencies. The syndromic surveillance system focuses on assembling information as close to real time as possible from the hospitals, which would allow for early detection and intervention.

If the system detects an outbreak or emergency, an automated response will be sent to epidemiologists at the Michigan Department of Community Health (MDCH), which will analyze the findings and investigate further.

The Michigan Health & Hospital Association is helping to coordinate the effort, which will be expanded later this year to include more hospitals. The system is guided by a steering committee made up of representatives of MDCH, local health departments, regional hospital bioterrorism coordinators, and medical directors, and participating facilities.

The program is funded through a cooperative agreement with the National Bioterrorism Hospital Preparedness Program of the U.S. Department of Health and Human Services' Health Resources and Services Administration, and the Centers for Disease Control and Prevention.

For more information, go to www.hrsa.gov/bioterrorism/. ▼

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Ohio group issues surgical protocol

The Ohio Patient Safety Institute has released a surgical protocol to help Ohio providers prevent the incidence of wrong-site, wrong-patient, and wrong-procedure surgery.

Developed with input from 20 medical and health care organizations, including the Ohio Hospital Association (OHA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the protocol outlines three steps for caregivers to follow prior to surgery: patient verification, marking of the surgical site, and a time-out before incision to conduct a final checklist.

The protocol will give Ohio hospitals a head start on implementing JCAHO's universal protocol for surgical procedures, with which U.S. hospitals must comply by July 1.

The Ohio Patient Safety Institute is a subsidiary of the Ohio Health Council, founded by the OHA and two other health care organizations.

The protocol and related resources are available at: www.ohiopatientsafety.org/Correctsite/correctsite.htm. ▼

NFPA now allows hand-rub dispensers

The standards council of the National Fire Protection Association (NFPA), which sets fire safety standards used in 38 states, has announced amendments to the NFPA Life Safety Code that will permit hospitals and other health care facilities to install alcohol-based hand-rub dispensers in their corridors.

"This decision paves the way for hospitals to install these dispensers to allow caregivers ready access to the hand rubs that are proven to save lives without compromising fire safety," said **Dale Woodin**, deputy executive director of the American Hospital Association's (AHA) American Society of Healthcare Engineers (ASHE).

The AHA and ASHE have been pushing for changes to current fire codes, which have restricted hospitals' use and storage of alcohol-based hand rubs, despite the Centers for Disease Control and Prevention's recommendation that the hand rubs be used to combat hospital-acquired infections.

The NFPA approved the fire code revisions based on a fire modeling study commissioned by ASHE showing the dispensers can be installed safely as long as they hold no more than 1.2 liters and are not installed too closely together or near electrical outlets. "Our next step is to work with other standards-setting organizations and state and federal agencies to ensure consistency in fire safety codes nationally," Woodin said. ■