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Buyers Shape Health Care Quality

Corporations want to negotiate directly with providers on care quality

First question: How's your bedside manner?

Employers want more than providers' reports as proof of value when they shop for health benefits these days. And in many markets, the force of their discontent comes to rest on hospitals and physicians as business coalitions go directly to the source to negotiate contracts.

According to the National Business Coalition on Health (NBCH) in Washington, DC, at least 30% of the coalitions deal face to face with providers. Coalition rosters include national and local corporations.

One analysis[1] calls the trend a revolution set off by the country's multibillion-dollar Fortune 500 companies. "They set off the insurrection in the 1980s by inducing or requiring their employees to obtain health insurance from managed-care insurers, especially HMOs," write Thomas Bodenheimer, MD, a primary care physician in San Francisco and Kip Sullivan, a consumer advocate in St. Paul, MN. "Whether employers will allow power to remain in the hands of HMOs remains to be seen," they add.

The shift has not escaped the notice of health care quality managers; in fact, it has resulted in revised job descriptions for some. **Rosemary Keeley**, MA, MS, director of Performance Consulting for VHA Central Atlantic in Charlotte, NC, observes that while some employers still fixate on cost as their sole objective, their ranks are thinning.

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- New drug aids in care of dementia patients
- How physicians personalize patient care on-line

Buyers Shape Health Care Quality

"More companies now want quality and cost," she says. "They're saying, 'We don't want our employees to lose so many days from heart attacks and strokes. And we don't want to pay so much for workers' comp claims."

In markets where coalitions represent 10% to 15% of the health coverage purchasers, coalitions wield enormous influence. **Gregg Lehman**, president and CEO of NBCH says employer groups committed to health care quality "will basically reform a marketplace."

According to Lehman, those groups use these three levers to effect value-based purchasing (quality plus outcomes, divided by cost):

1. Unite to share data collection costs.
2. Agree on what constitutes quality.
3. Use collective buying power to implement value-based purchasing. **(See "A look at value-based purchasing in action," p. 41 and "Group fosters cooperation in a competitive market," p. 42.)**

For coalitions committed to value-based purchasing, standard health care quality measures fall short. As far as employers are concerned, the National Committee for Quality Assurance's Health Employer Data and Information Set (HEDIS) guidelines and the Agency for Health Quality and Research's CAHPS (Consumer Assessment of Health Plans) customer satisfaction survey measures don't go far enough, Lehman contends.

Recently, the Washington, DC-based Institute of Medicine's report on medical errors, "To Err is Human: Building a Safer Health System," pointed out the flaws in standard measures. "But employers have talked about them all along," he says. **(For information on CAHPS and the Institute of Medicine's report, see resource box, p. 40.)**

Missing from HEDIS and CAHPS are identifiers of overuse and misuse of services as well as underuse, he explains. NBCH has drawn the federal government into its effort to refine quality measures "in order to keep the government from undoing the innovations of employers. We believe that the marketplace should be the source of health care reform, not the government," Lehman adds.

A recent NBCH survey[2] of coalitions reveals that most have an infrastructure that could facilitate value-based purchasing. Indeed, more than half of the 74 respondents report extensive involvement in collection or analysis of quality data. And some groups, such as the Dallas-Fort

Worth (TX) Business Group on Health (DFW-BGH), go much further. DFWBGH's executive director **Marianne Fazen**, PhD, explains her organization's focus. "We never measure health plans; in fact, we hardly ever deal with health plans. We go for the harder stuff; we're interested in the doctors and hospitals. Patient satisfaction is always important. If they have a lousy bedside manner, it doesn't matter how good the care is." But for the time being, "how good the care is" occupies the lion's share of DFWBGH's attention through its Value Initiative.

Over a four-year period, the DFWBGH has become a familiar presence on quality committees in each of the 39 hospitals, and in physicians' groups as well, throughout the Dallas-Fort Worth area. "Our challenge is to get buy-in from the whole [group]," Fazen explains.

According to **Annette Rowton**, vice president of clinical outcomes at Presbyterian Healthcare System in Dallas, involvement with the coalition has strengthened QI activities. At the same time, it has raised concerns about the validity of the measurement methods, she adds.

At the point of identifying and refining quality measures for obstetrical and cardiology care, for example, the physicians were very willing to pitch in, she says.

"Use of the data is another matter, however," adds Rowton. Clinicians are troubled by the age-old concerns about using administrative data to measure clinical quality. Typical measures required by DFWBGH include length of stay and charges for cesareans and mortality rates for cardiology cases. The group also questions the validity of risk adjustments for outcome comparisons among rural and tertiary care centers, for example. She describes physician reaction to using the measures, as "what we would have expected — some complain about it, others welcome it and use it."

There's another concern, and perhaps, it's as much a perceptual difference between the business and health care communities as a problem unique to Dallas-Fort Worth. "There are false expectations about how quickly we can clean, adjust, and turn around and use data to make clinical improvements," Rowton observes.

On the other hand, she says, collaboration between DFWBGH and health care providers has generated visions of an interhospital/employer initiative to improve health throughout the Dallas-Fort Worth metropolitan area. Preliminary conversations are under way at this time.

The mission of DFWBGH is twofold:

- to turn employers into value-based purchasers who use a variety of decision-making tools to effect sophisticated buying decisions;
- to promote performance improvement among hospitals and physicians, and to measure that improvement with data.

If the coalition chose to achieve its mission by sheer economic force, it probably could do so. Its members include 50 corporate employers representing 235,000 employees and their families. On the roster are American Airlines, GTE, Frito-Lay Inc., and Exxon Corp. The annual per-employee cost of health benefits is $4,325 — a total of $1.5 billion.

Key Points

- Business coalitions often become active participants in the quality initiatives within delivery systems from which they buy health benefits.
- Dissatisfied with provider-based quality measures, coalitions often introduce different ones.
- In some markets, the standardization of measures and the quality of outcomes improve markedly through business-provider collaboration.
- The changes are typically slow to come, and only after a significant period of trust building.

(See "Facts on health care purchasing coalitions," p. 40; "A look at value-based purchasing in action," p. 41; and "Group fosters cooperation in a competitive market," p. 42.)

In next month's *QI/TQM*

Part 2 of our series continues the examination of the growing employer influence on health care quality. *QI/TQM* will look at how workers' compensation programs have tightened the criteria regarding acceptable loss of work time. It will examine the growing push for wellness programs and the conditions under which health care providers are willing to cooperate. We will also feature a program run by a large employer to reduce the back-to-work time following heart attacks. With the involvement of a cardiologist, the time dropped from 7.5 months to 1.4 months. ■

"That's a big chunk of change floating around in this community," Fazen says. "The health care providers know we don't want to spend it on poor quality, so they need to compete on value, not on cost. Reputation won't cut it anymore; we want to see the numbers."

References

1. Bodenheimer T, Sullivan K. How large employers are shaping the health care marketplace (First of two parts). *N Engl J Med* 1998; 338:1,084-1,087.

2. Fraser I, McNamara P, Lehman GO, et al. The pursuit of quality by business coalitions: A national survey. *Health Aff* 1999; 18:158-165. ■

Need More Information?

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- ❒ **Annette Rowton**, Vice President of Clinical Outcomes, Presbyterian Healthcare System, 8440 Walnut Hill Lane, Dallas, TX 75231-4496. Telephone: (214) 345-4360.
- ❒ **Rosemary Keeley**, Director of Performance Consulting, VHA Central Atlantic, 5955 Carnegie Blvd., Suite 250, Charlotte, NC 28209. Telephone: (704) 557-7214.

For more on the CAHPS customer satisfaction survey, contact:

- ❒ **Agency for Healthcare Research and Quality**, Executive Office Center, Suite 501, 2101 E. Jefferson St., Rockville, MD 20852. Web site: www.ahrq.gov.

For highlights of the Institute of Medicine's report on errors in medicine, "To Err is Human: Building a Safer Health System," contact:

- ❒ **National Research Council**, Institute of Medicine, 2101 Constitution Ave., Washington, DC 20418. Telephone: (202) 334-2000. Web site: www.national-academies.org.

Facts on health care purchasing coalitions

Many corporate buyers of health care coverage are turning from bargain hunters into value seekers. The strength of this shift is underscored by the membership figures of the National Business Coalition on Health (NBCH) in Washington, DC:

- NBCH membership consists of 96 coalitions.
- The coalitions represent more than 8,000 employers and about 34 million employees and their dependents.
- NBCH members are mostly mid- to large-sized employers in the public and private sectors.
- NBCH's membership represents an estimated 90% of all the business coalitions in the country.

A 1998 NBCH survey[1] reflects the extent to which the value orientation has taken hold. Findings are based on a 78% response rate:

- Most coalitions have mechanisms in place that could be deployed to advance a combination of quality, service, and cost objectives.
- More than half collect data on quality of care, write financial incentives for performance into purchasing contracts, and collaborate with health plans or providers on continuous quality improvement (CQI) initiatives.
- 90% collect and analyze quality data; nearly 66% of that group describe their involvement as extensive.
- 52% use the National Committee for Quality Assurance's Health Employer Data and Information Set (HEDIS) guidelines as an information source. For those who do not use HEDIS, the report says, "one explanation may be a perceived mismatch in some markets between what HEDIS provides and what the coalitions seek to know. For example, HEDIS aggregates data at the health plan level, masking what several of our interviewees flagged as important details about the quality of care at the provider level."
- 51% conduct consumer satisfaction surveys.
- Some use provider-level information: UB-2 hospital discharge data for Medicare recipients, 39%; Health Care Financing Administration 1500 physician data, 23%; and medical charts, 16%.
- 81% group purchase one or more health benefits for their members. In some cases, those benefits

represent segments of an overall health care package such as pharmacy, vision, or psychiatric benefits. But 35% of coalitions bypass third-party carriers to negotiate the whole package of health care directly with providers in preferred provider organizations and integrated delivery systems.

• 59% report that group-purchasing contracts incorporate financial incentives for performance, namely bonuses, payment withholds, or premium rebates.

One group, Buyers Health Care Action Group (BHCAG) of Minneapolis, awards cash bonuses totaling $250,000 annually to care systems that excel in patient satisfaction, disease prevention, and improved outcomes. **(See *QI/TQM*, November 1999, Quality Talk, p. 132, for a column featuring Patricia Drury, senior consultant for BHCAG.)**

• 84% report involvement in CQI activities; approximately 40% of that group rate their involvement as extensive.

• Some coalitions "vote with their feet" to promote quality improvement. For example, when local physicians refused to participate in QI activities, members of the Southeast Missouri Business Group on Health, in Cape Girardeau, sent employees needing certain surgical procedures 100 miles away to St. Louis hospitals.

Two remaining questions

Two questions remain for future study, according to the researchers:

• To what extent do coalitions exercise their market clout — to improve quality, to temper premium increases, or both?

• Of the strategies that coalitions use to promote quality, which hold the most promise and under what circumstances?

Also, if health care costs continue to rise, how will coalitions and their members leverage their market power to promote quality while containing costs? Will they revert to bargain hunting and shelve value-based purchasing? Either way, health care providers will feel it.

Reference

1. Fraser I, McNamara P, Lehman GO, et al. The pursuit of quality by business coalitions: A national survey. *Health Aff* 1999; 18:158-165. ■

A look at value-based purchasing in action

It took four years for the Dallas-Fort Worth (TX) Business Group on Health (DFWBGH) to become a familiar and sought-after partner in the area's health care community. Its calling card was giving its corporate members value in return for their health benefits dollars. **(See cover story, "Cost and quality share top spot on corporate shopping lists" for additional details on this cooperative venture.)**

Marianne Fazen, PhD, executive director of DFWBGH describes the evolution this way:

Year 1 — Relationship-building with the administrative and medical leadership of each hospital, the medical society, and individual physician groups.

Year 2 — Refining definitions of quality outcomes on which to base standardized data reports.

Year 3 — Trial runs of quality data.

Year 4 — Data reporting.

"We've gotten the hospitals and doctors to sit up and listen to us and to realize that we're trying to improve quality through collaboration instead of a punitive approach," she says. "They are much more understanding of employers' interests and more open than ever before."

The hospitals have agreed on quality and outcomes measures for two areas of care:

1. Maternity and neonatal

Indicators — vaginal birth after cesarean, length of stay, and cesarean rates.

2. Cardiovascular

Indicators — admission rates, infections, readmissions, and beta-blocker use.

Data collection and reporting highlights

• Participating hospitals (39) pay for extra data handling and reporting. Expenses include centralized data scrubbing and warehousing.

• Hospitals have these reporting requirements: Each field on the form is filled accurately according to the standardized style. Data are collected within a specified time window and submitted on time.

• Each hospital receives its own data unblinded, as well as blinded comparative data

from other hospitals in the marketplace.

• DFWBGH has received one blinded report to date and anticipates the receipt of unblinded versions of that report in the near future.

• The burden of data collection and reporting is mitigated by cooperation between area hospitals and the state's hospital council.

Annette Rowton, vice president of clinical outcomes at Presbyterian Healthcare System in Dallas, explains that for a single fee, the council manages data for several reporting requirements. It's worth the expense, she says, given the extensive use of the data. In addition to DFWBGH reports, the fee covers reports for the Oakbrook Terrace, IL-based Joint Commission on Accredita-tion of Healthcare Organizations, as well as others. "We have been analyzing and utilizing the reports internally with our ongoing quality groups," she says. "Also, it's a source of local comparative data from other hospitals in the marketplace."

Additional outcomes from the four-year effort:

• Increased collaboration among area hospitals and physician groups. The DFWBGH is a regular participant on projects, notes Fazen. In fact, "They're asking our blessing on more and more programs."

• The quality commitment has taken on a life of its own, beyond DFWBGH requirements. Hospitals and physicians have become far more involved in measuring quality across the health care continuum.

• Discussions are under way within the DFWBGH board to analyze claims data from the large employers. Although the statistics would not be severity adjusted, they could reveal a pattern of costs for procedures at individual hospitals. For example, the per-day cost of delivering a baby could be linked to pharmaceutical and other clinical charges, he says. "It would not be an apples-to-apples comparison, but it would give us a more complete picture of each hospital's performance. And it might give us a sense of which hospitals are really good at taking care of high-risk maternity cases." The DFWBGH has not budgeted for the project, but Fazen says he might seek a grant to fund it.

• Standardized patient satisfaction measures are still to come. Such measures are currently on hold as the coalition and providers tend to other priorities, he explains. **(For contact information for Fazen and Rowton, see box, p. 40.)** ■

Group fosters cooperation in a competitive market

Business group builds trust where suspicion ruled

When employers in Kalamazoo, MI, formed a health benefits purchasing coalition in 1992, they expected to find meaningful evidence of quality service from the community's three hospitals. "But when we started to look at the data, it was not there. We were looking for consistency and accountability, and what we found were inconsistent standards and measures among the hospitals," says **Marilyn Bell**, president and CEO of the Southwest Michigan Healthcare Coalition (SMHC).

So the coalition asked the hospitals to buy a standard software package to collect and report data from all patient charts. SMHC expected to compare the hospitals, one to the other. Protective of their marketing efforts and competitive positions, however, the hospitals raised strong objections.

Bell says the coalition's objective was "to focus not on who's the best, but on who's improving. If there was no improvement, then we might have

Key Points

Location: Kalamazoo, MI, is the home of three hospitals and the Southwest Michigan Healthcare Coalition (SMHC).

Situation: The hospitals had a history of fierce competition. The coalition, formed in 1992, found that meaningful data on health care outcomes was virtually nonexistent.

Solution: The SMHC engaged in a slow process of building trust for its goals. As the effort progressed, the hospitals also became less wary of each other. After several years, the SMHC has gained trust, and the hospitals are beginning to collaborate with one another. They have a common system of measuring selected outcomes in 30 DRGs. Discussions are bringing to light opportunities for improvement of community services to augment health care.

to drill down to individual providers." The success or failure of the project would depend on the physicians' willingness to change their practice patterns if they were out of line. "We didn't want to do finger-pointing," she emphasizes. Instead, the coalition relied on persuasion through data and painstaking diplomacy.

Negotiations and accommodations

SMHC chose 30 high-cost DRGs for annual severity-adjusted reports. Information would consist of length of stay, total charges, and mortality. Included were congestive heart failure, medically managed back problems, heart attacks, and hysterectomies. It did agree to back away from requiring comparative data among three competing hospitals.

It's not petty for hospitals to haggle over definitions of mortality and severity-adjustment methods, especially when tertiary care is involved, Bell observes. "So it takes a lot of talking through of definitions, and mainly, they come up with the right answers."

Preliminary reports compared each hospital to a national database. "The system doesn't give answers, but the data tell where they need to improve and look at different practice patterns. With data, physicians are empowered," Bell notes.

One or two doctors usually rise as champions and start discussions among their peers. "We can't mandate that doctors use practice guidelines or clinical pathways," she concedes. "The leadership has to come from them." Once physician leaders emerge, SMHC steps in to facilitate the design and use of the tools. Improvements have come from such simple changes as starting antibiotics in the emergency room instead of waiting until patients are admitted, sometimes that amounts to an eight-hour difference.

The diplomatic efforts did not stop with the physicians, however. The coalition embraced the CEOs as well as marketing and financial leaders from each hospital. **(To learn how hospitals can cut door-to-antibiotic times, see *QI/TQM*, May 1999, p. 57.)**

While SMHC sought meaningful measures of quality, the hospitals were extremely tense about who would see the quality reports and how they would be used. So SMHC made concessions of its own. "The definitions of charges are not always real numbers, but they were the most consistent measures we could settle on for comparison of our hospitals with national figures. Besides, when we look at financial data, they are always paired with outcome data," says Bell.

Apprehension ran high during preparations for the first quality reports to go public. Planning was slow and deliberate to protect the trust so dearly won by both sides. The result was this three-stage rollout:

1. The company that ran the data presented findings to a closed session of the SMHC board, which consists primarily of CEOs from member corporations. Hospital representatives were not invited.

2. Representatives of the SMHC membership and the hospitals met for an unveiling of the reports at a large, highly interactive event. A lively exchange of questions and information took place. Bell recalls that at that stage, the health care leaders seemed to realize that SMHC was more committed to quality of care than to defining who was better than the rest.

3. A press conference released the reports to the community at large. Well in advance, Bell and the hospital leaders sat down and delineated precisely what would be disclosed. Their agreement specified that local hospital data be aggregated instead of separated for each hospital. The comparisons were drawn between the expected figures and actual numbers.

However, "the real story at the press conference was that these hospitals got together to improve their quality," she says. In light of the fierce competition among the institutions, it was legitimate news. At the press conference, as at all public events, "our focus is always on how much the hospitals have improved. The main thing is for the public to understand that there are differences in the hospitals, not that one is the best." Now, Bell reports, the hospital leaders usually leave it to her to handle the presentation of information to the media.

Along with copious public praise for quality improvements, Bell continually applies pressure behind the scenes for additional improvement. It's less of an uphill grind now that the physician leadership has hit its stride. A strong infrastructure of

Need More Information?

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- ❑ **Marilyn Bell**, President and CEO, Southwest Michigan Healthcare Coalition, 303 N. Rose St., Suite 424, Kalamazoo, MI 49007. Telephone: (616) 342-5525.

For more on outcomes measurement software, contact:

- ❑ **CIC — MediQual Division**, 500 Nickerson Road, Marlborough, MA 01752. Telephone: (800) 350-6444. Web site: www.mediqual.com.

QI committees and positive experience with guidelines and clinical pathways fuel the movement.

One measure, mortality rates, is the topic of provocative debates. Although down considerably, the rates are not as low as expected. "We discuss each death," Bell explains. They consider the patient's health problems as well as the cause of death. Such analysis is bringing larger issues to light. For example, "Should this patient have been in the hospital, or in a hospice program? If the family insisted on open-heart surgery for an 84-year-old with multiple chronic conditions, should the health care community strengthen its family teaching and advance directives programs? Is pain management and palliative care as good as it could be? Does the community have adequate hospice care?"

Bell says that with the basic trust-building complete, there is more room to explore improvements in community services adjacent to direct health care. ■

Use the power of 'Why?' to improve patient care

Simplify, clarify policies and procedures

The question "Why are we doing this?" could be your best tool for weeding out useless policies and procedures (P&Ps). The possibilities are exciting as long as you dig beneath the rationale "We've always done it that way!" Here, two self-described "why-sayers" explain how they use the question "Why?"

For **Ann Bertoch**, RN, MS, it started with an impending survey by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations. Bertoch, vice president of patient care at the 87-bed Mercy Medical Center in Williston, ND, says she was concerned about her hospital's policy and procedure (P&P) manuals. "There were forms and even photocopied excerpts from books attached to pages in the manuals. We realized they were a mess."

Conflicting policies were not unusual. Some policies, for example, crossed department lines, unbeknownst to all the involved departments. However, when it came time to clean up, Bertoch says, "there was a lot of reluctance, and we had to kill some sacred cows."

The process started in 1995 and took more than a year to complete, using these steps:

- Intradepartmental brain-storming to agree on P&Ps.
- Interdepartmental agreement on P&Ps crossing departmental lines.
- Review of departmental manuals by P&P team.

Bertoch says the team reviewed the material, recommended revisions, and sent them back to the departments. Redundancies were eliminated — for example, job qualification lists reiterating competencies earned through professional training programs. Following the second round of revisions, the P&P team met with each department for finalization. "We kept asking, 'Why do you need this?'" she explains.

- Disassembly and re-creation of key P&P manuals. Global concerns such as patient confidentiality were removed from departmental books and incorporated into the housewide policies.

Vowing never to go through such an ordeal again, Mercy Medical Center converted the P&P team into a standing committee of the same stature as those for infection control or safety. To become official, each new or revised policy must be typed into a template and pass review by the P&P committee as well as other standing committees. "We

Key Points

- Keep policy and procedure manuals relevant by adopting a standard format and maintain a hard-nosed review process.
- Ask "why are we doing this," and think through the intended outcomes to ensure useful, current policies.
- Expect some resistance when the process of elimination begins.

keep asking 'Why?' and 'What is this for?' and 'Of what use is this?' over and over. It breeds thought and rationality," observes Bertoch. "There isn't enough of that in health care these days."

Each time a proposed policy crosses her desk, **Louise Baldwin**, MBA, RN, CAN, asks herself and her staff, "Why are we doing this, and what do we want to get out of it?" She also insists that the outcome be clear before she signs off on a policy. As director of patient care services at Harris Continued Care Hospital (HCCH) in Bedford, TX, she oversees an acute, long-term care service of 36 beds dispersed among three hospitals.

Baldwin subjects her leadership decisions to similar standards. One time, that attitude led to a dramatic change in visiting policies. The social worker asked whether a two-year-old could stay overnight in the intensive care unit with his father. At first, Baldwin stuck by hospital policy and refused. "But as the social worker was leaving, I asked myself whether the policy was for us or for the patient." The patient was from another town. The family had no relatives in the area and no money for baby sitters. The young woman was critically ill; her husband was living in the ICU waiting room. "So I called the social worker back. We discussed it and agreed that the child could stay."

Today, visitors may come to HCCH at any hour. Children are welcome, provided they are accompanied and supervised by adults. Pets are welcome under the same conditions. "We get some flak from the other hospitals about this, but we've never had anyone die from pet infections. The nurses probably pass more infections than the animals," she says. Reflecting on the use of policies and procedures, Baldwin adds, "I realized a long time ago that my role in an organization is to be the person who says, 'Excuse me, but isn't he naked?'" **(For tips on exchanging ideas such as Baldwin and Bertoch share in this article, see "Use on-line listservs to gather improvement ideas," at right.)** ■

Need More Information?

For more on the power of asking "Why?" to rationalize services and procedures, contact:

- ❒ **Ann Bertoch**, RN, MS, Mercy Medical Center, Williston, ND. E-mail: AnnBertoch@CHI-Midwest.org.
- ❒ **Louise Baldwin**, MBA, RN, CNA, Harris Continued Care Hospital, Bedford, TX. E-mail: LouiseBaldwin@hmhs.com.

Use on-line listservs to gather improvement ideas

Are you in a rural community hospital and feel isolated from collaborative opportunities? Do you need background on a specialty such as nurse legal consultants?

If you belong to a listserv, the fix is less than two hours away. Simply defined, a listserv is an on-line discussion group. Members participate only when they have time and if the subject matter interests them. There is no obligation to read through all the comments, to respond, or to introduce discussion topics.

Ann Bertoch, RN, MS, vice president of patient care at Mercy Medical Center in Williston, ND, for example, logs on to a nursing listserv when she gets home from work. She spends 15 to 30 minutes scanning the discussion topics, adding comments as she chooses.

Louise Baldwin, MBA, RN, CNA, director of patient care services at Harris Continued Care Hospital in Bedford, TX, checks in at the office when she has a few minutes.

"You can ask any nursing question and get an answer at the drop of a hat," she says. For example, a colleague asked about employment opportunities for nurse legal consultants. Within two hours, Baldwin had a list of contacts, books, and listservs on the subject.

When Bertoch followed discussions regarding chaperones for intimate exams in the emergency room, it led to unanticipated policy changes in her facility. People were validating the need for chaperones at exams for male as well as female patients.

"With our culture's openness about homosexuality, providers of both sexes need protection against allegations of impropriety," she explains. "As a result of the listserv discussion, we changed policy in our emergency room to include chaperones for all intimate exams."

As with any group, each listserv has its own personality and style:

- moderator-facilitated or free flowing;
- membership fees or free;
- strictly business or business-social interactions.

How can you find relevant listservs? Ask your peers. Many professional societies maintain them. **(For contact information for Louise Baldwin and Ann Bertoch, see resource box, at left.)** ■

Try apple-to-apple benchmarking for ORs

Here's an operating room (OR) benchmarking method that takes a real-time data "snapshot" of your process and compares it with concurrent data from similar facilities.

The methodology designed by OR Benchmarks of Santa Fe, NM, differs from those based on patient records or other hospital reports. All data used by OR Benchmarks comes from the participants who register to benchmark selections from a list of surgical procedures. "Usually they are high-cost procedures and those with high variability," explains **Judy Dahle**, RN, MS, director of OR Benchmarks.

One participant in the cataract extraction group is McKay-Dee Hospital Center in Ogden, UT. McKay-Dee uses OR Benchmarks to provide hospital staff and physicians a common ground on which to set continuous improvement goals. "Primarily, physicians are scientists. When you give them data to react to, it's better than when someone says 'Do this,'" says **Suzanne Richins**, RN, MBA, FACHE, director of patient care at McKay-Dee.

Reports cover performance measures based on the current analyses as well as comparative data collected by OR Benchmarks since its inception in 1996. For instance, total supply costs for cataract extraction have declined steadily, but they still show significant variation.

In 1999, the median cost was $367. However, the range was $199 to $578, a variation of 76%. **(For further details, see "Cost of Supplies & Number of Items," at right.)**

The procedure list for each year's benchmarking is based on client requests. This year, for example, the 16 items include total hip replacement, carpal tunnel, breast biopsy, and colonoscopy. **(To get a complete list, see resource box, p. 47.)**

To register, clients choose the procedures they wish to benchmark. They receive data collection worksheets and instructions, including a time frame in which to complete their data. OR Benchmarks requires a minimum of five sheets, or five cases involving each procedure. The company's OR-trained nurses conduct validation reviews, calling the participants to resolve omissions or apparent inaccuracies. "If a certain piece of equipment is used, for example, we want to know which soft goods [i.e., towels or pads] went with it," says Dahle. OR Benchmarks analyzes the data with specially designed software.

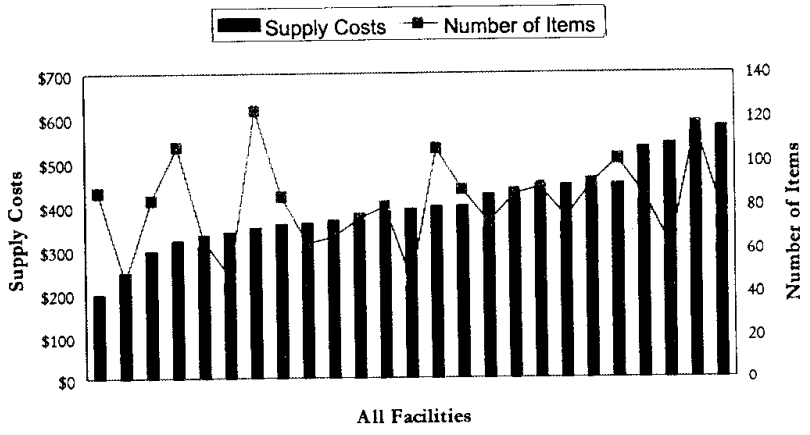
A nagging concern about performance reports is the grouping of sources to adjust for facility size and other variables. OR Benchmarks addresses it in these ways:

- **Peer groupings.** Participants are categorized by type — ambulatory and inpatient, teaching and nonteaching, not-for-profit and for-profit, five OR rooms and 10 OR rooms, and so forth.
- **Real-time data collection.** While it sounds cumbersome to record supplies, turnaround time, or staffing ratios during surgical procedures, Richins describes it as relatively painless. McKay-Dee, like many facilities, has computer software to routinely collect such data for each patient.

In this respect, however, McKay-Dee might differ from other hospitals — the clerical assistant for the surgical suite manages the data collection. "Clinicians could make errors clerically and they would resist doing data collection, anyway," states Richins. "Our clerical assistant is knowledgeable and very accurate. She consults the nurses on clinical points." As a result, the department turns out exceptionally accurate information for surgical billing as well as benchmarking. And staff say they like it because it uses their time and skills to best advantage.

- **Multiple-use reports.** Once a year, OR Benchmarks compiles an operational benchmarking report on salary ranges of management and nonmanagement staff as well as 18 data segments

Costs of Supplies & Number of Items



Source: OR Benchmarks Inc., Santa Fe, NM.

representing the operation of an entire surgical service. The reports are displayed in comparison charts for individual peer groups.

• **Recognition of excellence.** The designations "best performer" and "better performer" go to participants showing the strongest results on each criteria in their peer comparisons. As a best performer in cataract extraction, McKay-Dee Hospital has used the OR Benchmarks method since the company opened for business.

McKay-Dee Hospital is a 350-bed nonteaching, not-for-profit inpatient/outpatient facility with 10 ORs. Its managed care penetration is 23%. It is one of 23 hospitals that comprise the Intermountain Healthcare System based in Salt Lake City. "We've been doing QI forever," says Richins. "We always thought we did well, but when OR Benchmarks came along, we saw the opportunity to substantiate our improvements and to learn more."

The benchmarking experience helped to strengthen collaboration with the community-based physicians who practice at the hospital, she says. "It's easier to change behavior with data than by other means. We have always believed in partnerships instead of adversarial relationships with our physicians. When you get a few of your physicians excited about making changes, then you can count on them to put peer pressure on the rest."

The OR Benchmarks reports also stimulate the push for additional improvement. For example, the orthopedic surgeons tend to use a lot of drapes for infection control, Richins says. "But when we showed them data from other hospitals with lower rates of drape use, our surgeons said, 'All right, show us information about their infection rates for the same procedures.'" She cites exposure to other health care organizations as an important benefit from benchmarking. "As health care providers, we have to network to improve our service." ■

Need More Information?

For more on benchmarking surgical procedures and operations, contact:

❒ **OR Benchmarks**, P.O. Box 5303, Santa Fe, NM 87502-5303. Telephone: (800) 800-9647. Web site: www.orbenchmarks.com.

For more on turning benchmarking data into improvement goals, contact:

❒ **Suzanne Richins**, Director of Patient Care, McKay-Dee Hospital, 3903 Harrison Blvd., #100, Ogden, UT 84403. E-mail: mksrichi@ihc.com.

Men's group faults new HMO criteria

The recently released Health Plan Employer Data and Information Set (HEDIS) guidelines include 12 specifically female-oriented health care measures. **Ed Bartlett**, PhD, senior policy advisor for Men's Health America in Rockville, MD, contends that they represent a serious oversight. "From a quality perspective, health plans are supposed to promote health for populations," he says. "The new measures do not address the factors that contribute to men dying seven years earlier, on average, than women."

Bartlett points out that for each of the top 10 causes of death in this country, men have disproportionately higher mortality rates than women. Heading the list are heart disease and cancer — and not just prostate cancer. The fact that men are less likely than women to seek medical care

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GRASS-ROOTS QI

Restraint use was already low when nursing leaders at the University of Medicine and Dentistry of New Jersey University Hospital (UMDNJ) in Newark launched a safer alternatives initiative in March 1998. The 500-bed facility's average was 3.48% compared to a national average of 5.8%.[1] Within eight months, UMDNJ's average restraint use dropped to 2.2%. Project leaders include **Chris McCallion**, director for patient care services for medicine, psychiatry and emergency; Kathy Ennis, clinical nurse specialist for emergency/trauma service; and Faith Solkoff, director for quality improvement.

✔ IMPROVEMENT OPPORTUNITY

While the psychiatric units' restraint use averaged less than 2%, "we wanted to focus on the differences between the ICU and non-ICU areas," McCallion says. UMDNJ has four ICUs: medical, surgical, cardiac, and neurological. At project launch, ICU restraint use averaged 11.8% (benchmark, 24.3%); non-ICU areas averaged 1.2% (benchmark, 3.4%).

✔ SOLUTIONS

Action plan:

1. Staff education, including a presentation by an employee who was restrained following a trauma injury, as well as actual experience of being restrained.
2. Improved sedation and ventilator weaning protocols.
3. Restraint alternatives such as one-to-one and group observation of patients, splints to prevent bending the elbow, soft hand mitts to reduce dexterity, and chair padding to prevent patients from sliding out.
4. Revised policies and procedures defining safe restraint use as a last resort.

✔ RESULTS

Adult ICU rates dropped from 11.8% to 7.6% (benchmark 24.3%); adult non-ICU 1.2% to 0.6% (benchmark 3.4%); pediatric ICU 3.6% to 1.4% (benchmark 5.2%); pediatric non-ICU 0.3% to .07% (benchmark 5.2%).

✔ KEYS TO SUCCESS

- Support senior leadership.
- Teach staff that "nothing in the literature proves that restraints are safe," notes McCallion.
- Authorize nurses to question physicians and discuss alternatives to restraint orders.
- Enlist family support. McCallion notes that education and staff support can change family beliefs that their loved ones require restraints for safety.

✔ CONTACT

Faith Solkoff, Director, Quality Improvement, UMDNJ-University Hospital, 150 Bergen Street, UH-C437 Newark, NJ, 07103. Telephone: (973) 972-1530. E-mail: solkoffd@umdnj.edu.

Reference

1. Minnick AF, Mion LC, Leipzig R, et al. Prevalence and patterns of physical restraint use in the acute care setting. *J Nurs Adm* 1998; 28:19-24. ■

means they should be the target of more aggressive education initiatives by HMOs, he adds.

The National Committee on Quality Assurance (NCQA) takes the position that many of its measures automatically address gender disparity in disease and mortality rates. **Brian Schilling**, spokesman for the Washington, DC-based agency says the NCQA's goal is to "put in measures that do the most good for the most people. We would be the first to admit that HEDIS needs more measures in more health areas," Schilling says. "But we don't want to put something in place that isn't going to give us good data about health outcomes, and some of the screening guidelines in men's health areas are not tested or refined yet." Implementation of new guidelines are expensive for health plans, he adds. That's why NCQA's policy is to move slowly on the certainty that changes are founded on hard evidence.

[For more information, contact Ed Bartlett, PhD, Senior Policy Advisor, Men's Health America, P.O. Box 1404, Rockville, MD 20849. Telephone: (301) 670-1964. E-mail: eba@intr.net. Contact NCQA at 2000 L St. N.W., Suite 500, Washington, DC 20036. Telephone: (202) 955-3500. Web site: www.ncqa.org.] ■