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Benchmarking crucial for small, rural facilities with few resources

Tailor projects to your own community

For a large academic hospital or a major regional health system, using benchmarking as a tool to improve performance and determine strengths and weaknesses is practically second nature. But for small facilities in rural areas, getting on the data bandwagon has been less urgent and much less likely.

But according to **Robert Gift**, president of the consulting firm Systems Management Associates in Omaha, NE, being small isn't a good excuse. "They probably need to do this more than the bigger places," he says. "Those large facilities may have more resources, and it might be hard to do with a three-person administrative staff, but small facilities can benefit more from understanding benchmarking and using it to improve processes, systems, and care." **(For more on the benefits that can accrue for a small health care organization, see article, p. 51.)**

Gift says there are three stages of development for benchmarking:

1. In the first stage, a hospital or health care system will look at task activities, such as buying under group purchasing contracts.

2. In the second stage, the organization looks at processes, such as the logistics system.

3. In the final stage, the hospital or system looks at systemwide issues, such as individual physician patterns of utilization.

Continued from cover page

COMING IN FUTURE ISSUES

- Benchmarking for strokes and heart attacks
- Are you collecting too much data?
- Preventing medication errors
- Do you need help with bed control?
- More on benchmarking in the ED

But just getting to that first stage can be a trial, Gift admits. "One of the barriers to benchmarking is that people want to 'do' benchmarking," he says. "When you work on your car, you don't do a wrench; you solve a problem using a wrench as a tool. [With benchmarking], you improve patient satisfaction by using benchmarking as a tool, or you shorten days outstanding on accounts receivable by improving policies and procedures."

Another obstacle is a lack of enthusiasm among administrators, staff, and physicians to learn about benchmarking. "For it to work, there has to be a willingness to learn," he says. Gift recalls one situation where he was standing in front of a group of people who wanted to reduce cesarean rates in a particular state. "I talked about benchmarking and how it could help, and the person said, 'That might work in Omaha, but not here. We're rural.' My example at the time was from North Dakota."

Once you see an eagerness to learn about the topic, you must take advantage and provide opportunities for staff and managers to learn.

Make it a useful project

Often, those who start benchmarking give up because they don't see it having a positive impact. Gift says that happens when people pick projects that don't really have meaning to the particular organization.

"You have to choose something related to your overall strategic plan." Don't assume that one project will solve all your problems, either, he adds. "No tool can deliver on the hype that surrounds it. You have to view it as one of an arsenal of tools that will help you meet your goals."

For instance, at VHA, an Irving, TX-based group of 1,900 health care organizations, one of the goals is to focus on various critical domains and key aspects of care every year. For 2000, those include stroke and acute myocardial infarction.

VHA started a benchmarking project on those two goals that is already yielding results.

"One thing we have learned is that you can unearth useful information from a diverse group of players," says **Pat Houghton**, RN, BSN, MHA, senior director of performance consulting at VHA, which includes both small rural hospitals and large academic facilities.

Often, administrators and staff at small facilities will complain they don't have the internal resources to start benchmarking. Gift says those organizations should spring for the cost of hiring

Need proof that benchmarking works?

Here are stories to convince you

For skeptics who think they are different from other health care organizations, for those who think that benchmarking is a curse designed to waste precious time and resources, and those who think it all comes to nothing, here are some stories to help convince them otherwise:

- ✔ **Think you're too different?**
  One health care system had a big problem with workers' compensation claims, recalls **Robert Gift**, president of Systems Management Associates, a health care consulting firm based in Omaha, NE. A group of 12 facilities, large and small, covering the whole country, worked together and identified more than 40 procedures that if amended would impact workers' comp claims positively. The facilities ranged in size from 50 to 600 beds, disproving the theory that comparing your facility with an organization that isn't the same size as yours or in the same location can't possibly be relevant.

- ✔ **Think small can't mean good?**
  Gift recalls one group of small hospitals that brought staff together and discussed lab efficiency. Together the group came up with 53 ideas to improve efficiency and cost-effectiveness. While not all of the locations implemented all of the ideas, the collaboration helped all participants. "Ironically, some of the more cost-efficient labs turned out to be from the smallest facilities," he says.

- ✔ **Think it takes too many resources?**
  One home care agency was facing a huge deficit as a result of the many payment changes facing the industry, says Gift. The agency was very small, with an average daily census of just 20 patients. By looking at information that already was published, using the Internet, and using the telephone rather than making site visits, the agency was able to make some operational changes in 10 weeks using only four people to develop and implement the project. The annual savings were $163,000.

- ✔ **Think it doesn't have a positive impact on patients?**
  At Punxsutawney (PA) Area Hospital, a three-year project led to a change in protocols for patients coming into the emergency department with chest pains, says **Ben Hughes**, MS, director of planning, marketing, and development at the 69-bed facility. The project eventually resulted in a decrease in the number of patients who had to be flown to a larger facility for more intensive care. ■

an expert the first time, but make sure the consultant imparts sufficient knowledge during the process so that the same project can be done internally the next time.

"If someone brings me in on a project, part of the specific agreement is that I'm going to be sure when I leave that they know how to do what I did. If they don't, I've failed." Another option is to send one of your staff to a conference or seminar to learn the basics, collaborate with like facilities you can link with in your health system, or work through a professional organization, he explains.

"A small facility may not have all the technological advances and bells and whistles that the bigger hospitals have," Houghton says. "And they may not have progressed with benchmarking because they feel they don't have the resources."

But they can take what they do have and do some simpler projects that are tailored to their community. "Simple isn't a bad thing," she adds. "Start small. Don't try to fix everything about acute myocardial infarction or stroke. Take one key aspect, one evidenced-based item that your institution can buy into, and do it."

You might not choose something clinical initially, such as the door-to-tPA times that VHA chose for its stroke program, Houghton continues. "Maybe choosing a particular process like documentation would work better for your institution. The important thing is not to try to devour the elephant at one sitting. Take a small bite, and don't make it dependent on a hot new computer system."

You can collect data on every fifth or 10th patient as a start, then go on-line and hook up with similar hospitals. "Don't spend money on site visits," she says. "Use the Internet; use the telephone. If you show a willingness to share your numbers, others will share with you."

Ben Hughes, MS, director of planning, marketing, and development at the 69-bed Punxsutawney (PA) Area Hospital was one of those administrators who thought benchmarking was just another dull chore he had to do when his hospital started getting involved in it about five years ago.

"Now it is truly part of our culture." He notes that each of the 40 departments in the hospital has benchmarking projects it is required to complete — whether they are clinical, statistical, or financial. The board of directors of the hospital, which has a primary market of 17,000, looks at the benchmarks and department goals monthly. "This is not something we report; this is something we do that is an inherent part of who we are," says Hughes.

Small facilities, small numbers

One of the obstacles Hughes continually struggles with is the inherent invalidity of the sample sizes. Punxsutawney brought in a statistician from an area university to calculate exactly how much the small sample size affected statistics.

"We also have a challenge relating our numbers to the national figures that are out there," he explains. "If you look at our service area to try to figure out how many radiology technicians we need, we have to compare it to facilities that might serve populations of 100,000. Maybe when you do the math and pare it down, that means we should have two technicians. Because we are small, we cross-train more than most larger facilities, and our techs are usually certified in ultrasound and nuclear medicine. Maybe they are busy doing other things part of the day. Maybe we need four or five technicians, not two. The data out there don't address that."

One solution is to look at regional data, either on a formal or informal basis. Along with data from HCIA-Sachs of Baltimore and various national associations for specialties that Punxsutawney Area Hospital uses for benchmarking data, the facility obtains information from the Pennsylvania Mountain Healthcare Alliance — a three-year-old consortium of rural hospitals in its geographic area that Punxsutawney belongs to.

"We started out looking at safe issues like purchasing," says Hughes. "But based on the successes we had, our trust grew and we have been able to share data on other issues. Something like what we do might be harder in a city, where the hospitals seem to be more competitive."

There are also some data on rural hospitals available from the federal government and the Health Care Financing Administration, but not a lot, he adds.

Finding appropriate data is vital to getting your staff and clinicians to accept a benchmarking program, he points out. "There is a lot of concern that we are small, and our population, which is largely rural, somewhat impoverished, and includes a large Amish population, is different. But if you find good data to compare yourself to, that alone will overcome those objections. And we have used them to validate our efforts. We don't necessarily use [the information] to look for problems or mistakes. We use it to prove how good we are."

Another reason to jump on the benchmarking bandwagon: It is easier to justify budget and staffing requests with data, rather than with gut reactions. "It is easier to validate what you do with numbers," Hughes says. "It answers the question, 'How are we doing?' in a very concrete way."

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• Ben Hughes, MS, Director of Planning, Marketing, and Development, Punxsutawney (PA) Area Hospital. Telephone: (814) 938-1826.] ■

Measuring success: What one hospital benchmarks

Patient assessment and information technology, infection control and financial management — those are a few of the items Punxsutawney (PA) Area Hospital considers important enough to measure regularly, according to **Ben Hughes**, MS, director of planning, marketing, and development. **(For a complete list, see box, p. 53.)** ■

Punxsutawney Benchmarks

Patient assessment

Focus: Timeliness of communication of essential patient data among the care team
Numerator: Inpatient medical records, which do not reflect a dictated history and physical within 24 hours of admission
Denominator: Total monthly admissions
Reported: Monthly

Focus: Pediatric assessment parameters
Numerator: Pediatric (< 1 year) head and chest circumference; growth and development assessment (< 16 years); initiation of plan of care (< 16 years)
Denominator: All pediatric admissions
Reported: Quarterly

Information management

Focus: Timeliness of communication of pertinent operative findings among the care team
Numerator: Inpatient and short procedure records that do not reflect a dictated operative report within the same operative day
Denominator: Total monthly operative procedures
Reported: Monthly

Focus: Timeliness of record closure
Numerator: Total medical records delinquent at 30 days
Denominator: Total number of discharges for the month
Reported: Monthly

Patient care

Focus: Prenatal patient evaluation, education, and treatment selection
Numerator: Patients treated by cesareans
Denominator: All deliveries
Reported: Monthly

Focus: Patient treatment effectiveness
Numerator: Inpatient mortalities
Denominator: Total number of discharges
Reported: Monthly

Focus: Safety of medication administration
Numerator: Significant medication errors
Denominator: N/A
Reported: Monthly

Continuum of care

Focus: Home care nursing productivity
Numerator: Total skilled nursing visits
Denominator: Total skilled nursing hours
Reported: Monthly

Focus: Monitoring patient compliance
Numerator: Patients completing cardiac rehabilitation
Denominator: Total patients referred
Reported: Monthly

Patient rights and responsibilities

Focus: Restraint reduction initiative
Numerator: Episodes of restraint
Denominator: 1,000 patient days
Reported: Quarterly

Surveillance prevention and control of infection

Focus: Targeted reduction in hospital-acquired infections
Numerator: Surgical site infections
Denominator: Total admissions
Reported: Monthly

Human resource management

Focus: Acuity/staffing variance
Numerator: Monthly average full-time equivalent (FTE) required by acuity
Denominator: Monthly average FTE actual
Reported: Monthly

Focus: Employment stability
Numerator: Employment terminations
Denominator: FTE employment
Reported: Monthly

Financial management

Focus: Ability to pay short-term liabilities
Numerator: Current assets
Denominator: Current liabilities
Reported: Monthly

Focus: Time required to collect patient accounts
Numerator: Ending net accounts receivable
Denominator: Average daily net revenue
Reported: Monthly

Focus: Profitability from health care operations
Numerator: Operating income (loss)
Denominator: Net patient revenue
Reported: Monthly

Monitoring system saves hospital $180,000 a year

It's 10 p.m. Do you know how your patient is?

Wouldn't it be great if a hospital could have a patient monitoring system that would tell health care providers how patients were doing regardless of where they were in the hospital? St. Luke's Hospital in Kansas City, MO, has designed a method to do just that. The result is an enterprisewide system that has saved the hospital $180,000 a year in monitoring technician salaries, has decreased the number of false alarms, and has given patients more time with their caregivers.

Under the old system, technicians in individual units used telemetry systems to monitor patients, explains **David Zechman**, vice president of cardiovascular services at the hospital. The technicians were subject to interruptions for other responsibilities, such as assisting patients, visitors, and other staff. "That made maintaining focus on monitors difficult," he says. "Sometimes it would take a while to detect abnormal rhythms that might not be threatening, but that can serve as a precursor to more serious events."

> *"Now patients are monitored in the most appropriate care setting. The technology instantly sends patient data from remote facilities to St. Luke's centralized monitoring room."*

Monitoring at satellite facilities was even more challenging because lower staffing levels made it difficult to dedicate trained personnel to the monitoring function, he adds. And in some cases, patients who could have been adequately cared for at a facility close to their home were transferred to the heart institute at St. Luke's, where a cardiac professional could monitor them more effectively, albeit more expensively.

"Another challenge with the conventional approach was that whenever a monitoring technician called in sick, he or she had to be replaced by a staff nurse who in turn was covered by a nurse from a temporary agency at a cost of about twice the rate of the technician," says Zechman.

Cardiovascular service managers decided to update the hospital's monitoring systems and considered the options that were available, says Zechman. "One approach would have simply been to replace the existing setup with more advanced stand-alone equipment. But we wanted to explore the option of standardizing monitoring with an enterprise approach throughout the health system."

With an enterprisewide approach, a centralized and dedicated cadre of technicians with a higher level of training would monitor patients at multiple locations 24 hours a day. Information technology managers at St. Luke's researched existing commercial technology and chose VitalCom Inc. of Tustin, CA, to create its system.

The VitalCom system provided enterprisewide monitoring in addition to a real-time information infrastructure that allows patients to be monitored throughout the health care enterprise, Zechman explains, including remote locations. All of this is done from one central unit, allowing St. Luke's to monitor patients throughout the entire integrated health care delivery network as well as potentially provide services to hospitals outside the network on a fee basis.

The quality of patient care quickly improved with the implementation of the new system. Now, instead of requiring unit clerks and even nurses to watch monitors, St. Luke's relies on a group of trained technicians who review all data from every monitor throughout the system, says Zechman.

Round-the-clock surveillance

"They work around the clock, following standardized guidelines and procedures to notify clinicians of critical events," he says. Each technician can monitor up to 48 "channels," and St. Luke's currently has 128. A channel is a signal coming from a monitoring instrument, each of which can produce a number of channels of data.

At the beginning of each shift, technicians note the rhythms from each of their patients. They repeat the process hourly to pick up any changes that might be a signal of something more serious to come. "This level of detail and uninterrupted attention often results in the detection of subtle shifts that are easily overlooked using conventional monitoring methods," he continues. An

integrated paging system alerts caregivers within seconds of an alarm. Technicians are also better able to detect false alarms, and they only notify caregivers when appropriate.

Zechman says the system is very user-friendly. That helped get buy-in from physicians, nurses, and other staff. So far, three facilities outside of St. Luke's have been linked to the system. "Now patients are monitored in the most appropriate care setting. The technology instantly sends patient data from remote facilities to St. Luke's centralized monitoring room."

The new system allows the health system to better share resources and expertise among its facilities, he says. "In addition to increasing patient monitoring care and making it more efficient and consistent across the enterprise, we have been able to reduce technical monitoring staff at St. Luke's Hospital by 4.3 full-time employees and have not needed to increase monitoring staff at the remote facilities."

Other benefits that have yet to be quantified include reducing length of stay and reducing costs for unnecessary patient transfers. "All in all, the implementation of enterprise monitoring has significantly improved patient care, reduced costs, and has helped to increase the reputation of St. Luke's," he adds. ■

Communication eases consolidation conflicts

How to make partners out of perceived enemies

In Halifax, Nova Scotia, Canada, a major government initiative to fold five area hospitals and clinics into one system left turmoil in its wake, alienated staff, and made some workplaces more like places of misery than places of healing. But a group of nurses decided to rebuild relationships from the rubble, forming partnership councils that are reinventing departments and changing the focus from management by directive to working by cooperation and consensus.

The immediate results of the mergers two years ago weren't positive, says **Rona Cathcart**, partnership council coordinator at the QE2 Health Sciences Center, one of the newly renamed facilities that make up the health care system in Halifax. "The physical aspects of merging were easy, but there were emotional issues that were not addressed," she explains. "The practices were different. There were two different emergency departments [EDs] that had different ways of handling people, different triage systems, different everything."

Staff were moved around and put into facilities that functioned very differently than what they were used to, says Cathcart. "[The government] built a new infirmary and closed the old one. The school of nursing was closed at Victoria General and moved to the university. It got so bad that nursing staff in one ED were literally screaming at each other. People felt very bad, and there was a lot of frustration."

What does a healthy workplace look like?

Finally, the nursing staff and vice president of nursing at the QE2 got together to find a way to address the problems. "While a lot of people wanted the administration to 'fix' the situation, the VP wanted us to figure out what the issues were and solve them ourselves." The group decided to draw a picture of what a healthy workplace looked like. "We did some research and found that the United States has about 20 years of information on the issue of partnership councils," says Cathcart. "We were like sponges on the topic."

Much of the best research came from **Bonnie Wesorick**, RN, MSN, the founder of the Clinical Practice Model Resource Center in Grand Rapids, MI. "She says it is hard to do in a unionized environment, but we managed it," Cathcart adds.

Wesorick says partnership councils are more than talking shops where people focus on problems. They are rather places where "the people who work in a department or unit can come together to develop healthy partnering relationships and have meaningful conversation. [This helps them] create the best place in the world for anyone to receive care and the best place in the world for anyone to work."

Cathcart's facility established partnership councils in every department with virtually every staff sector involved. "We have it from A to Z, from our labs, to the pharmacies, to the porters," she says. "Physicians, nurses, managers — everyone is involved."

The goal of the councils is to get people to deal with each other directly and address departmental and organizational problems and issues together, rather than complain about situations

and relationships. "We look at the institution and organization as a whole, our roles in it, and our fit," she says. The councils have also tried to flatten the hierarchical structure of the hospital. "We want less bossing and more coaching and facilitating."

The partnership council in the radiation oncology unit where Cathcart works includes six people — a tenth of the staff on the floor. "Each of the six people is responsible for 10 other staff," she explains. "I regularly communicate with my 10. They bring issues and problems to me to discuss in our council meetings. We do research, get information, and make decisions through consensus."

Other councils are much larger. In the ED, for instance, there are 200 people on the council.

While managers sit on the councils, they are not seen as a power source over the rest of the members any longer, Cathcart says. "Before, if we wanted to do something, they would say yes or no. Now they act more as coaches, telling us if we are heading in the wrong direction and why."

While some decisions seem to take longer to make because of the councils, Cathcart says the decisions made are more deliberate. "We don't shoot from the hip so much anymore. They are more thought through than they used to be."

So far, the experiment seems successful. "There is much less conflict now than there was when the mergers first happened," she says. "We have a nurse manager who comes into the councils when they first start to motivate them, and to revive their interest if they seem to hit a plateau."

Cathcart says more issues are freely discussed, and while there is a lot of change happening, she thinks it is positive change. "This stops major grievances from festering."

[For more information, contact:

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• Bonnie Wesorick, RN, MSN, CPM Resource Center, 2048 Lake Michigan Drive N.W., Grand Rapids, MI 49504. Telephone: (616) 791-6399. Web site: http://www.cpmrc.com.] ■

Climbing hospital stays level off in western U.S.

Three-year upward trend ends in 1999

Hospitals in the western United States have long been known for relatively short patient stays — a result of the heavy managed care insurance coverage in the area. But although the area's hospitals release patients faster than anywhere else in the nation, the average length of stay (LOS) increased steadily between 1996 and 1998, drawing questions about whether this trend would continue and whether hospitals in the rest of the country would follow suit.

Getting some answers

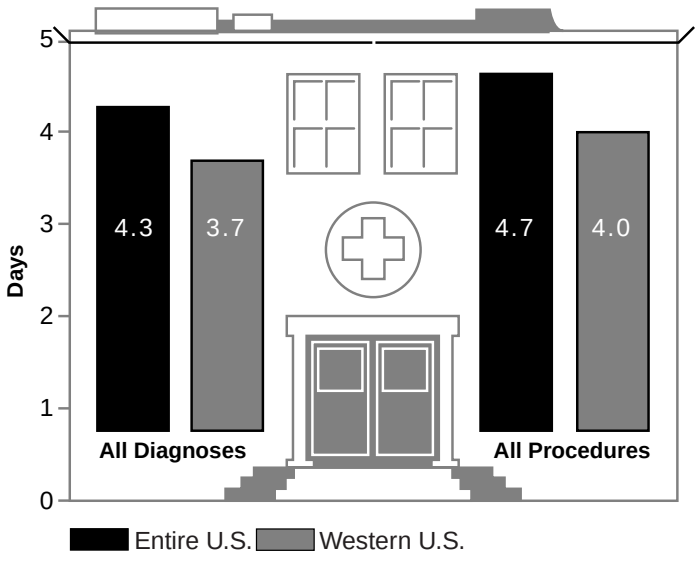
New hospital LOS data from HCIA-Sachs, LLC in Baltimore provide some answers. **(See graph, at right.)** After two years of slight increases, average hospital stays in the West remained flat between 1998 and 1999. However, stays for patients in the remainder of the country are still declining.

The West's previous slight upswing might be attributable to mandated minimum LOS for childbirth and newborns. Childbirth is the top reason for hospitalization among commercially insured populations.

These mandates have been in place for several years now, so their effects on LOS averages may already have been realized. But only time and

Hospitals' Length of Stays in Western United States

Average Length of Stay, Federal Fiscal Year 1999



Source: HCIA-Sachs, LLC, Baltimore.

careful analysis will tell whether 1999's flattening average is the beginning of a new trend or a one-year anomaly.

HCIA-Sachs' LOS data provide detailed information on hospital stays for the more than 23,000 diagnoses and procedures listed in the current versions of ICD-9-CM and CPT-4 codes. The standards are based on a detailed statistical analysis of all-payer data gathered from more than 12 million actual inpatient discharges annually.

Those data represent one of every three discharges from U.S. hospitals. The standards provide detailed LOS breakdowns by age and sex groups, simple vs. complex patients, and operated vs. nonoperated status.

More information on data from HCIA-Sachs is available from the company Web site at http://www.hcia.com.

(What data do you want to see published? Do you have data to share with your peers? Do you know of a source for data that might be interested in participating in this monthly feature? Contact Lisa Hubbell at thehubbells@earthlink.net.) ■

Who will lose under the outpatient PPS?

Half the big losers are in the West

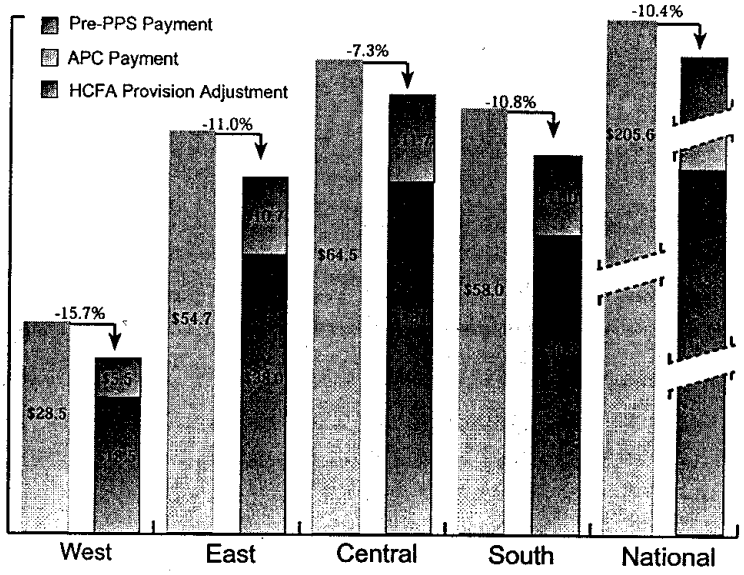
Hospitals are under pressure to improve coding and control resource utilization in order to move from cost-based reimbursement to the new outpatient prospective payment system (PPS).

To lessen the financial impact on hospitals, the Health Care Financing Administration will implement a phase-in plan that provides additional payments that gradually decline over a three-year period. But in a joint study conducted by Market Insights and Superior Consultant Company prior to the release of the final rule on April 7, 2000, overall hospital outpatient reimbursement in year one was forecasted to decrease by 10%.

According to the study, hospitals have to take action now to alleviate the negative impact from PPS on their bottom lines. The consultants advise health care organizations to do the following:

- Perform a retrospective analysis that will apply the new rules to your historical claims data.
- Educate your staff about the new system, and encourage improved efforts in correct coding and claims processing.
- Address outpatient cost competitiveness.

[For more information on the study, or for help completing a historical analysis, contact Market Insights at (843) 406-8826.] ■



Source: www.marketinsights.com

Top 10 States with Largest Decrease in Reimbursement

	PRE-PPS PAYMENT	NEW PPS PAYMENT	% Decrease
CA	$1,576,799,318	$1,238,272,340	-21.4%
FL	$1,555,526,525	$1,278,144,843	-17.8%
HI	$54,474,372	$44,924,199	-17.5%
AZ	$197,388,130	$165,466,799	-16.1%
NJ	$641,053,148	$537,757,370	-16.1%
MA	$667,627,774	$569,088,846	-14.7%
DC	$68,667,518	$59,212,181	-13.7%
AK	$21,704,932	$18,889,873	-12.9%
NY	$1,265,162,964	$1,109,687,114	-12.2%
NV	$64,285,748	$56,611,357	-11.9%

Note: New PPS Payment equals APC Payment plus HCFA Adjustment
Source: www.marketinsights.com

NEWS BRIEFS

AHRQ releases Nationwide Inpatient Sample

The U.S. Agency for Healthcare Research and Quality (AHRQ) has released the Nationwide Inpatient Sample (NIS) — the most current publicly available national database of hospital inpatient care use, outcomes, and charges on all patients, regardless of payment source. This newest NIS release includes hospital discharge information from approximately 7 million inpatient stays at more than 1,000 hospitals in 22 states.

"Increasingly, the health services research community is using the NIS to uncover trends that have significant public policy and management implications for inpatient care," says AHRQ director **John M. Eisenberg**, MD. "This data set gives researchers an evidence base to understand patterns of hospitalization by Americans as a whole, or by specific groups such as children and the elderly, and to assess outcomes as well as hospital charges."

The NIS is the only publicly available database that includes charge information from all payers, including Medicare, Medicaid, and private insurers. There are also data on the uninsured included.

As with previous releases, the 1997 NIS contains more than 100 clinical and nonclinical variables including: principal and secondary diagnoses and procedures; patient demographic characteristics such as gender, race, median income; payment source; length of stay; total charges; and discharge status.

The large size of the database permits analysis of rare conditions such as congenital anomalies, and studies of infrequent procedures such as organ transplantation. For researchers who want to analyze trends, NIS data sets are available for 1988 through 1997.

The NIS can be linked with databases containing county-level information, such as the Bureau of Health Professions Area Resource File — a database of the U.S. Health Resources and Services Administration. It also can be linked with descriptive hospital data from the American Hospital Association's Annual Survey of Hospitals.

The data set can be run on desktop computers and comes in ASCII format for ease of use with numerous off-the-shelf products, including SAS and SPSS. NIS also includes weights for producing national and regional estimates and comes with full documentation in Adobe Acrobat. SAS and SPSS users are provided programs for converting ASCII files.

NIS is part of a family of products produced by the Healthcare Cost and Utilization Project (HCUP), a federal-state-industry partnership sponsored by AHRQ.

Information on trends will be released later in the year. Look for a story in an upcoming issue of *Healthcare Benchmarks* that outlines the major changes from the last NIS.

The 1997 NIS is available on CD-ROM with accompanying documentation for $160 from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA, 22161. Telephone: (800) 553-6847 or (703) 605-6000.

Interested users can preview the NIS on-line with HCUPnet at http://www.ahrq.gov/data/hcup/hcupnet/htm. ▼

New benchmark is the largest of its kind

QCSI, Microsoft, and Compaq have created the largest published health care benchmark designed to create a cost-effective and flexible program for large commercial health care plans. The new program uses the Microsoft Windows 2000 operating system, Microsoft SQL Server 7.0, and Compaq's ProLiant hardware.

The makers claim the new program, QMACS, can reduce cost per claim and the time needed to process claims significantly. Tests of the program used data from a large health insurance plan and combined information from the plan's commercial health maintenance organization and Medicaid lines of business.

According to consultants who reviewed the tests of the benchmark data, the results surpassed industry norms and could allow organizations to reduce daily processing times by a minimum of 18%.

The primary design criteria for the tests were

data volume and complexity and included 9 million members, 16.5 million claims, more than 25,000 employer groups, more than 1,000 unique benefit packages, and 62,000 providers.

Test highlights include:

• In one hour, the n-tier QMACS enterprise architecture processed more than 3.7 million health care transactions.

• Cost per transaction was about a .001 cents.

• About 33,800 claims were processed per hour.

The complete set of test results can be found at these Web sites:

• http://www.qmacs.com/

• http://www.microsoft.com/industry/health/

• http://www.compaq.com/products/servers/benchmarks/index.html

• http://www.synertechsystems.com/ ▼

New book helps with best practice in home care

Is your home care agency looking for assistance in developing its social work practice? A new book, *Social Work Practice in Home Health Care*, from the Haworth Press of Binghamton, NY, can help you determine best practices, give you assistance in finding benchmarking partners, and even provide sample documents and case studies for comparison.

The book's author, Ruth Ann Goode, PhD, a home health consultant from Cuyshaga Falls, OH, includes chapters on patient care policies, staffing models, and Medicare standards.

Social Work Practice in Home Health Care is available for $24.95 from the publisher by calling (800) 429-6784, or by going to the company Web site at http://www.haworthpressinc.com. ▼

IPRO launches new Web site

IPRO, the New York-based health quality evaluation organization, has retooled its Web site (www.ipro.org) to provide better access to its publications and products.

New features of the site include:

• a directory of services for consumers, business, governmental entities, health care providers, and health plans;

• the group's Medicare quality improvement studies, which are done in collaboration with providers throughout New York state;

• text and graphics for the 1999 New York State HMO Report Card;

• an on-line version of IPRO's *Medicare Rights Guide* and other consumer publications;

• full text of the technical report on the group's performance audit of Medicare HMOs, done under contract with the Health Care Financing Administration;

• newsletters for providers;

• on-line versions of IPRO's consumer brochures

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on mammography, immunization, and other health topics;

• direct links to tools like IPRO's pneumonia management program. ▼

JCAHO offers new manual for hospitals

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has three new publications to help hospitals get through their surveys.

The Comprehensive Accreditation Manual for Hospitals: The Official Handbook, the *Automated Comprehensive Accreditation Manual for Hospitals*, and the *2000 Subscription Update Service* can help give administrators the tools they need to get through their surveys successfully.

The manual was updated, and includes an explanation of the accreditation process and scoring, a description of the standards, and new standards for this year, including the most current sentinel event policy and accreditation watch information.

The automated version provides the same information in an electronic format and allows organizations to incorporate HTML in their intranets. Users can also search by words or phrases. The table of contents is always visible, and hyperlinks make corresponding information easily accessible.

The electronic manual can be purchased as a single license or a site license. Those organizations that purchased the 1999 version can receive the next version by purchasing an update to the existing license.

To remain current with Joint Commission policies and standards throughout the year 2000, the Joint Commission offers the *2000 Subscription Update Service*. This service provides quarterly updates to the *Comprehensive Accreditation Manual for Hospitals: The Official Handbook*.

The service provides hospitals with standards and intent changes, performance measurement requirements, revised policies and procedures, and scoring changes, as well as new examples of compliance.

For more information or to order any of these publications, call the Joint Commission customer service center at (630) 792-5800, between 8:30 a.m. and 5 p.m., Central time, Monday through Friday. ▼

APQC offers health care a passport to success

Organizations can now set their course for success with *Knowledge Management*, the first of several books to be released as part of the American Productivity & Quality Center's (APQC's) *Passport to Success* series. The book includes examples of best practices and tips from professionals. It's available through APQC's online bookstore at www.store.apqc.org. The price is $17.95 for members of APQC's International Benchmarking Clearinghouse and $19.95 for nonmembers. ▼

Hospitals can access medical encyclopedia

A partnership between adam.com, a medical information Web site based in Atlanta and MedSeek, a developer of Web sites and services for health care in Solvang, CA, will bring adam.com's medical encyclopedia to many medical professionals. The proprietary library contains more than 10,000 pages of medical and health content covering more than 1,500 topics, and includes medical illustrations, interactive animations, 3-D models, broadcast-quality video, and fully dissectible male and female bodies. The encyclopedia's content and products are used in the education, broadcast, legal, and print publishing markets. ■