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JCAHO issues roadmap on P4Ps, citing 'few well-articulated goals'

Agency calls currently operating programs relatively untested

Noting that while pay-for-performance (P4P) programs have grown in popularity in recent years, "few are guided by well-articulated goals and principles," the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has issued its own "Principles for the Construct of Pay-for-Performance Programs."

Among the key tenets of the document are the following:

- The goal of P4P programs should be to align reimbursement with the practice of high-quality, safe health care for all consumers.
- Programs should include a mix of financial and nonfinancial incentives (such as differential intensity of oversight, reduction of administrative and regulatory burdens, and public acknowledgment of performance) that are designed to achieve program goals.
- When selecting the areas of clinical focus, programs should strongly consider consistency with national and regional efforts to leverage change and reduce conflicting or competing measurement.
- Programs should be designed to ensure that metrics upon which incentive payments are based are credible, valid, and reliable.

Key Points

- Well-defined programs can help avoid unintended consequences, according to the Joint Commission on Accreditation of Healthcare Organizations.
- Principles stress aligning reimbursement with high quality and patient safety.
- Quality experts see advantages in standardized measures for comparative data.

- Programs must be designed to acknowledge the united approach necessary to effect significant change, and the reality that the provision of safe, high-quality care is a shared responsibility between provider organizations and health care professionals.
- The measurement-and-reward framework should be designed strategically to permit and facilitate broad-scale behavior change and achievement of performance goals within targeted time periods.
- Programs should reward accreditation or have an equivalent mechanism that recognizes health care organizations' continuous attention to all clinical and support systems and processes that relate to patient safety and health care quality.
- Incentive programs should support an interconnected health care system and the implementation of interoperable standards for collecting, transmitting, and reporting information.
- Programs should incorporate periodic, objective assessment into their structure.
- The evaluations should include the system of payment and incentives built into the program design to evaluate its effects on achieving improvements in quality, including any unintended consequences.
- Provisions should be made to invest in subthreshold performers who are committed to improvement and are willing to work themselves or with assistance to develop and carry out improvement plans.

"We saw the proliferation of these programs and felt in reviewing them that they were all well minded, but that there were a lot of [underemphasized] considerations we felt were important. And that our voice could be heard on the quality side, saying, 'Here are some very seminal considerations in the framing of these programs that could help guide their development,'" explains **Margaret VanAmringe**, MHS, JCAHO's vice president for public policy and government relations in Washington, DC.

JCAHO examined about 100 programs, she continues. "People have in their minds implicit criteria about what they want to do and how, but we felt something this important would benefit from *explicit* principles," she notes.

"These are the kind of things sponsors should sit around and think about and discuss, before they put everything together," VanAmringe asserts.

Unintended consequences?

Why the need for such formal principles? For one thing, argues JCAHO, well-designed programs can help avoid unintended consequences.

"For example, if a hospital program picks out some manageable number of measures and will pay differentially on whether or not they meet a threshold, there can be particular attention paid to those measures to the detriment of other [care issues] in the hospital," she explains.

"You don't want to focus so much on those without other day-to-day processes being done well and being rewarded for that," VanAmringe points out.

In other words, if you are the sponsor of a program, you want to make sure the measures you

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use are not contradictory of good practice in other areas, she says.

"That's why we feel there should be national measures," VanAmringe notes. "We're contributing to that now under the ORYX core measures; if you use these, you standardize and will mitigate against conflict."

Problems with payment systems

Another key issue noted in the principles is that payment systems frequently do not recognize nuances of care delivery.

"Right now, most payment systems — especially in the government — are focused on units: how many of these services you provide, how many procedures you do," she says.

"They do not necessarily ask what it takes to really produce high quality of care. For example, certain patients need more education or follow-up, or more time spent on safety, but you don't pay the hospital for that," VanAmringe adds.

"One of the best things about pay for performance, if done well, is that it can help realign the payment system. But to align it with high quality of care may mean we pay differently." she explains.

Which leads to JCAHO's assertion that P4P programs should include nonfinancial incentives as well as financial incentives.

"We think a lot of nonfinancial incentives are important drivers of behavior, though they might not seem to be as strong as money," she points out.

"In the quality arena, we see a lot of hospitals spending lots of time seeing that they have a culture of quality, but they don't get any reward for that.

"They will still have the same number of oversights, the same visits from the government, and maybe from accreditors; where's the reward for fixing a safety problem?" VanAmringe asks.

JCAHO is beginning to offer just such nonfinancial incentives under its new survey process, "But we are only one accreditor, and it costs a lot of money," she notes. "People should not underestimate what a strong driver professionalism is."

The reward structure, VanAmringe continues, also should take into account the unique characteristics of a provider organization's mission.

"There are examples where a hospital may have a very unique status; it may be a safety-net hospital, or a sole community provider," she says

"This can make it a little harder to achieve the performance objectives a program may have," VanAmringe adds.

"So if you only look at the threshold and only pay hospitals that meet 90%, there may be a hospital with a unique mission that has a harder time doing that; do you say that hospital should not be rewarded?" she asks.

What will the impact be?

Beyond the obvious impact of an accrediting body such as JCAHO taking a stand on the P4P issue, and the possibility that these principles may be codified in future survey processes, there is some debate about their practical impact.

While some quality sources criticize the new principles as an effort on JCAHO's part "not to be left behind" in the movement toward P4P programs, they nevertheless recognize the positive impact they could have.

"The thing that's very positive is they are trying to say that if there is to be a reimbursement environment, they should focus on standards of care and performance expectations — more on comparative data —— and that they are also going to partner that with evidence-based information," says **Judy Homa-Lowry**, RN, MS, CPHQ, president of Homa-Lowry Healthcare Consulting in Metamora, MI.

"In other words, they're looking not just at risk-adjusting data, but *what is the standard of care.* We'll be able to look at trends and patterns of care as well as outcomes; so as this would grow, you could base incentives on outcomes that have supported good practices," she continues.

"To me, this looks like a way to standardize not only requirements, but some of the clinical approaches that have been found to do well. If we do that, the incentives will be appropriately placed," Homa-Lowry says.

"It surprises me that they even got involved, unless they felt left out of this," adds **Patrice L. Spath**, of Brown/Spath Associates in Forest Grove, OR.

"There's been a lot of discussion on how to measure and compare, and a lot of these principles have really come out of the whole report card initiative," she says.

And Spath points out that while the principles articulated by JCAHO "are not that different from those that governed quality activities about 10 years ago," when the profession began to measure

comparative performance, "the difference now is, those people who are better performers — it appears — will benefit from that."

A plus for quality

That may be a big difference indeed, not only in who gets rewarded, but in the overall standing of quality efforts within the hospital culture, some observers argue.

"If you look at the health care system, we are kind of Neanderthals in terms of improving quality," VanAmringe argues.

"For example, there's a lot of clinical information available on how to do things right, but it takes lot of time to percolate [through the system]. There's quite a lag from a controlled clinical trial to something being put into practice. Pay-for-performance [programs] can say, 'Here's the latest information.' People will stand up and take notice right away, so in some ways, it can decrease the lag time for all practitioners and providers, and keep the spotlight on quality," she explains.

A twofold issue

"It's really a twofold issue," Homa-Lowry adds. "The Joint Commission is working hard to make patient safety their No. 1 issue, with the adoption of national patient safety goals and actual accredit participation requirements.

"I think the other piece of it is that in the past, a lot of organizations have not really looked at the cost benefits from change processes — not only good patient care, but operating more efficiently and effectively. This will be a way, if we have consistent practices and processes, to more easily study for variation," she continues.

That emphasis on P4P is a definite plus for quality managers, VanAmringe adds.

"I think to the extent that hospitals are, from the leadership on down, trying to imbue a culture of quality and safety within the organization, quality managers are already well positioned," she observes.

"But this absolutely makes them more important to administration; it will underscore their importance. Ultimately, you need to figure out a way to reward hospitals for having a culture and infrastructure within its walls that constantly seeks to improve the quality it provides, which makes the quality manager *very* important, in my view," VanAmringe notes.

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"It will link the quality manager to the financial success of the company and will either make them more involved in the operations, and/or the operations folks will get more involved in clinical delivery," Homa-Lowry says. "It will tend to draw them closer together."

"These principles, if slightly reworded, should be considered in how you use internal data in your organization," Spath notes.

"If I am a quality manager and use quality data to look at whether Dr. Smith or Dr. Jones overutilizes, we need to make sure we are not encouraging Dr. Jones to only take the patients who are the least sick so he does not look bad," she points out.

"You need to make sure your program goals are transparent or measurable, and you could use this as a model for developing your own principles for use of comparative data," Spath adds. ■

VA gets high marks for preventive, chronic care

Integrated medical record needed but not sufficient

A study published in the Dec. 21, 2004, *Annals of Internal Medicine* showed that patients enrolled in the Department of Veterans Affairs health system (VHA) were more likely than a national sample of similar patients in the general population to receive preventive care and

chronic care recommended by established national guidelines.

The study compared 26 facilities in 12 VHA health care systems and 12 different communities; a total of 596 VHA patients and 992 patients identified through random-digit dialing; all who were involved were men older than 35.

The researchers measured quality over the period between 1997 and 2000, using RAND's Quality Assessment Tools system to evaluate inpatient and outpatient care for 26 conditions.

The VHA scores were based on 294 of 348 indicators (there were no eligible patients for some indicators), and 330 indicators for patients on which to base national scores.

Included were such measures as aspirin for patients presenting with acute myocardial infarction, diet and exercise counseling for diabetes, and screening for colorectal cancer.

Here are the highlights of the findings:

- Patients from the VHA scored significantly higher for adjusted overall quality (67% vs. 51%).
- Patients from the VHA scored higher than the national sample for both chronic care (72% vs. 59%) and preventive care (64% vs. 44%).
- Patients from the VHA did *not* score higher than the national sample for acute care (53% vs. 55%).

"This same team a year and a half ago published a paper in the *New England Journal of Medicine*[1] that looked at quality in this country as a whole and basically concluded it was a flip of the coin as to whether or not you got good care," notes **Steven M. Asch**, MD, MPH, of the West Los Angeles Veterans Affairs Medical Center and lead author of the *Annals* article.

"This spurred us to think about what sorts of systems do a better job, and if so, why. The VA came to top of mind because it has put together an information superhighway, measures performance, and holds providers accountable, so we embarked upon a study to see if indeed it was doing a better job, and we found that they are. In general, VA patients get the care they need two-thirds of the time," he explains.

What's the take-home message?

There are a number of significant take-home messages in the study, but according to Asch, one point stands out when it comes to quality improvement.

"For quality managers especially, what's most significant is that what gets measured gets done," he asserts.

In other words, the VHA advantage was most prominent in processes targeted by VHA performance measurement (66% vs. 43%), and least prominent in areas unrelated to VHA performance measurement (55% vs. 50%).

According to the authors, "Differences were greatest in areas where the VHA has established performance measures and actively monitors performance."[2]

Just as significant, Asch explains, is that there appears to be what he calls a spillover effect for improvement.

"So, for instance, if you look at a particular condition, the VA does best in things it is measuring; it does about the same in things that it does not measure and has no relationship [to the condition]; but in things that are kind of alike but not exact, it *still* has an advantage," he notes.

"So, for example, if the VA is tracking blood pressure control, it may not be tracking whether a patient with high blood pressure gets his creatinine measured," Asch stresses.

"But these patients at the VA *do* get their creatinine measured more often [than the nationwide average], even though it is not one of their performance measures. In other words, the VA also has an advantage in things that are kind of like the things that are being tracked," he continues.

VHA requires accountability

One of the factors that distinguishes the VHA, and is thought to be a contributing factor in the results of the study, is that the VHA, the largest health care delivery system in the United States, began in the early 1990s to institute an electronic medical record system, as well as an approach to quality measurement that assigns accountability to regional managers for processes in both preventive care and chronic condition management.

"The integrated medical record plays an enormous role," says Asch, but he adds that he considers it "necessary but not sufficient."

In other words, he explains, "Lot of folks think that if they just instituted electronic medical access they'd improve, but then they don't track performance or hold people accountable."

The system used by the VA, called CPRS (computerized patient record system), is quite interactive. "As a provider, it helps me remember things," explains Asch, noting that it is a reminding software.

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"When I'm sitting at my desk [and bring up a patient's record], it will say, 'How about giving him a flu shot?' Or if a patient is diabetic, it may note he has not had a hemoglobin A_{1C} in the last four months, and ask if I want to order one. At the VA, there is a terminal in *every* examining room," he notes.

"You can view your X-rays on the screen, or see the results of your colonoscopy; there is no more paper," Asch explains. "The universality is another thing that distinguishes [the VA] from other systems; *everyone* knows how to use it."

The authors argue that "the implications of these data are important to our understanding of quality management.

"The VHA is the largest health care system to have implemented an electronic medical record, routine performance monitoring, and other quality-related system changes, and we found that the VHA had substantially better quality of care than a national sample," they note.

"Our finding that performance and performance measurement are strongly related suggests that the measurement efforts are indeed contributing to the observed differences," they write.

" Performance measurement alone seems unlikely to account for all the differences; the VHA scored better even on HEDIS measures widely applied in managed care settings (but not in other settings) outside the VHA."[2]

What the VA has done is certainly replicable in other large health care systems, Asch notes, although it is extremely expensive. "But can we afford *not* to do it?" he poses. "It's disturbing to me and most providers — and many patients — that we are not getting what we need as often as we need to. If it requires investment to do so, we should do it."

Asch concludes with this thought: "I don't want to leave the impression that information technology is the be-all and end-all of performance improvement; embracing technology all by itself is not enough," he says. "You also have to track performance; tracking performance is the key to improving care."

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Hospitalists, pharmacists partner to cut errors

Shorter lengths of stay, lower med costs result

Hospitalists collaborating with clinical pharmacists at Brookhaven Memorial Hospital Medical Center in East Patchogue, NY, were able to shorten length of stay, lower medication costs, and improve clinical outcomes.

A study conducted by **Saeed Syed**, MD, a hospitalist physician with Cogent Healthcare, a provider of inpatient management programs, compared results between patients treated by voluntary attending physicians and those treated by the hospitalist/clinical pharmacist team.

The hospitalist/clinical pharmacist group had a 23% shorter length of stay, a 21% lower cost of medications, and 1.5 fewer medications per patient than the comparable patient group treated by the voluntary attending model.

The hospitalist-pharmacist group also required less nursing care and had a reduced risk of adverse drug reactions and medication errors.

In addition, the study revealed that the hospitalist/pharmacist team at Brookhaven was able

Key Points

- Pharmacy residents accompany hospitalists on rounds on a rotating basis.
- The study is a logical extension of ongoing physician/pharmacist collaboration.
- Payback extends beyond the program to physicians throughout the organization.

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to reduce length of IV therapy for antibiotics and GI medications by 1.7 and 0.9 days, respectively.

For pneumonia patients, drug costs were reduced by an average of 29% ($507 vs. $360) per case.

Using residency program

Syed, who is the lead physician in the hospitalist program at Brookhaven, wanted to improve specific indicators including pharmaceutical aspects of care — i.e., drug expenditures, and trying to prevent medication errors. Since the hospital had an accredited and approved residency program in pharmacy, "we wanted to see how good the results would be from collaborating with them." The study took place between September 2003 and February 2004.

"What we initially intended was to use one of our in-house pharmacy graduates, but with this program, the residents were assigned to the hospitalist group in training," Syed recalls.

"They started the day with us around 7:30 in the morning, sat with us [a four-physician group and two nurse practitioners], and went over all the patients. We then went to the floors and started rounds, so the pharmacy residents accompanied us on a rotating basis," he notes.

As a result, Syed explains, the residents saw the actual care as it took place, noticed opportunities to substitute generic drugs; to perhaps move from a more expensive IV drug to an oral one; to be on guard for potential adverse drug reactions; and to help ensure proper dosage and use.

"The pharmacy residents also helped us with chart review for the pharmacy," he notes.

This collaboration came naturally at Brookhaven, adds **Ken Cohen**, PhD, chief of clinical pharmacology and therapeutics.

"We have a history of extreme collaboration with the medical staff," he notes. "We work closely with a number of physicians, reviewing the medications together with physician leaders and determining therapeutic choices, to consistently apply the same models to treat diseases."

The clinical pharmacist residency program was instituted to train academically superior students at the doctorate level in what Brookhaven does in clinical pharmacy and acute care, Cohen says.

"At about the same time, we developed the hospitalist program; they are here all day and are familiar with the collaborative model, so it made sense for the pharmacy residents to enter into interdisciplinary rounds with the hospitalists," he continues.

As part of the increased recent attention to medical errors, "we have heard about medications not being used exactly as they were intended. We wanted to have a pharmacist inserted in the process at the point of order generation. This way, many risks can be eliminated before pen hits paper, so to speak," Cohen explains.

Is a similar program essential?

Both Cohen and Syed agree that a hospital does not have to have a residency program similar to theirs to benefit from a hospitalist/pharmacist collaborative model.

"A residency program is not required," Cohen adds. "The advantage is the same as with medical residents — you get people who have recently emerged, are highly trained and motivated, and current as to what is possible with regard to the latest medical approaches — and frankly, their salaries are lower. But if you do not have such a program, if you can devote the time to allow a clinical pharmacist to go on rounds, there's no reason why this model can't work in nonresident facilities."

"Most hospitals do have a graduate pharmacist in-house," Syed notes. If not, while on the surface it may look as if you are losing some time from your pharmacist, "if you reduce drug costs 20% to 25% or cut lengths of stay by two days, it's certainly worth it."

In addition, by preventing errors, you are avoiding the calls that then have to be made to the pharmacist as part of the follow-up, he explains.

What's more, Cohen adds, "The payback is not just in the hospitalist area, but for *all* physicians who work together with pharmacists in terms of medication management. We've achieved certain efficiencies across all levels of the organization." ■

Kiosks win patient kudos and speed registration

$140 million effort enhances patient-centered care

A series of MediKiosks, designed by Maitland, FL-based Galvanon Inc., have cut patient check-in time at the Baylor Sammons Breast Imaging Center in Dallas from seven or eight minutes down to three, while winning broad approval from patients.

The pilot program, which ultimately may spread to the entire Baylor Health Care System, is part of a $140 million clinical transformation effort at Baylor.

"One of our overriding goals is to consolidate several [electronic] systems into one, to allow a single patient record across all of Baylor," explains **Randy Fusco**, corporate director of Internet development services for the Baylor Health Care System.

"Within this initiative is a specific opportunity to create what we call the 'ideal patient experience.' This entails making the entire patient experience faster, better, and safer," he points out. "Self-service technology is one way to achieve this."

Key Points

- Program is part of systemwide clinical transformation initiative.
- Self-service technology is one way to make patient experience faster, safer, better.
- Incremental revenue from more frequent appointments helps system pay for itself.

Pilot program launched quickly

The pilot program for the kiosks was launched Oct. 15, 2004, but it had its origins in earlier work Fusco had done with Galvanon.

"We were working with this vendor on another software development project inside Baylor," he recalls, "and it turns out, they had some work going on with this device that, with the swipe of a driver's license or a credit card like at some airports, allows a patient to check in. I was intrigued, and since they use similar technology to us, it made it a nice fit both for technology and the ideal patient experience."

Fusco set up a meeting for product demonstration in the summer of 2004. "We got rockin' and rollin' fast, because when we demonstrated it to executive management, they were blown away by it, and said, 'Let's do a pilot,'" he reports.

Although Galvanon does make freestanding kiosks, this pilot program started off with hand-held versions of the technology.

"The hand-held model is a wireless display device with a touch-screen," explains **Jason Whiteside**, manager, business management, Internet development services, who managed the pilot project and interfaced with the staff.

The devices work like this: When patients come to the desk, staff hand them an e-clipboard, on which they fill out the required forms. (A soft keyboard at the bottom of the device allows patients to spell out words when required.)

"There are a total of 14 in the clinic right now," Whiteside says. "We are in the process of determining where the best fit is to do this; our goal is to include the freestanding floor model as well, so we will have experience with that technology, too. This way, as we continue to move forward, we will be in a position to see which of the two models fits specific problems best."

Getting the project up and running required little if any staff training. "The workflow basically emulates the same forms, the same activities," he explains. "All we really had to cover was what to do if the device freezes, and so on."

Streamlining check-in

In introducing the kiosks, Baylor had three major goals: streamline the patient check-in process, reduce administrative costs, and enhance the total patient experience. All three seem to have been achieved.

"Our No. 1 patient complaint had been the cumbersome paperwork," Whiteside notes. "This process is not only faster, but it allows the patient to do it only once; when they come back, we can present them with the information they gave the last time, and they only have to update it."

There were some fears the technology would meet with patient resistance, as many of the patients are 50 or older, but that resistance never materialized.

"When we first launched, we expected a high percentage of the ladies would just decline to use it," Fusco continues. "But to our surprise, they didn't. The response has been tremendous."

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As for administrative costs, Whiteside sees many advantages.

"This practice spends $20,000 a year on paper," he points out. "We have taken a 12- to 14-page paper process down to one piece of paper, so we've seen maybe an 80% to 90% reduction in costs per year, and those savings will be ongoing."

In addition, Whiteside says, a tremendous amount of staff time has been freed up.

"They spent a vast majority of their day doing forms, shuffling paper," he observes.

"Since the pilot began, they have gotten about 50% of that time back — that's over three hours per day per staff member, so that's a total of 18 hours per day back. We want to focus that [regained time] on day-to-day customer support," Whiteside explains.

Budget constraints should not prevent smaller facilities from using such a system, he continues, because it will pay for itself.

"I would say absolutely [it would work at a smaller facility]," he insists. "With the old registration process, appointments were scheduled a month or so out. What we see is that date getting closer, and we're seeing more patients in a day.

"That means a pretty nice increment of patients we've not seen before. If we can do that, the incremental revenue alone will pay for the project," Whiteside adds.

Baylor is now looking at starting pilot programs at its new Plano Regional Medical Center, as well as other facilities.

"The interesting thing is, everyone gets it — they see the potential, and they're scrambling to see how to best fit the technology into their work flow," Fusco explains.

"But, I'd caution against introducing a new technology with old processes. You've got to make sure your forms and so on are in good shape, too," he adds.

"The main thing I want to emphasize," Fusco continues, "is this is not so much an exercise in trying to find technology, but an effort in looking to improve the patient experience. We have come across a lot of technology, but this is the first time we have had patients come unsolicited to administration and say, 'This is the best.' Those things are golden." ■

Simulation center uses real-world training

Findings inform hospital quality program

A futuristic training center where hospital staff and medical students alike can treat realistic mannequins for a wide range of conditions is the first step toward what its proponents hope will be a regional center serving patient safety professionals from many different facilities.

The facility is part of The University of Miami/Jackson Memorial Hospital Center for Patient Safety in Miami.

"Our mission is education, research, and clinical quality improvement," says **Paul Barach**, MD, MPH, director of the center, associate dean for the University of Miami School of Medicine and director of quality efforts at Jackson Memorial Hospital. "It goes to the concept of building a training arm in addition to our quality improvement arm," he explains.

The center, Barach adds, is "tightly integrated with Jackson Memorial."

For about 18 months, the center has used an old operating room to train trainees and nurses on the mannequins in a variety of clinical interventions — from small procedures such as placing IV lines, to resuscitation and crisis management. But Jan. 13 saw the grand opening of a new 8,000 sq. ft. facility for multiple uses — medical/surgical, obstetrical, trauma, acute care, and so on.

Key Points

- Students, hospital staff, and faculty all participate in training sessions.
- Facility provides ability to train and learn without harm to patients.
- Scenarios can be created with specific learning in mind.

"This will give people the ability to train in a realistic setting without harm to the patient or provider, and the ability to turn it into an educational experience," he notes.

In the new center are several full-sized mannequins programmed to react to different scenarios, and treated either by an individual or by a full team of providers. The sessions are recorded for future debriefings. "They can also be stored, so the trainee can revisit them later on," Barach adds.

Providing nontraditional instruction

The traditional approach to learning in medicine, according to Barach, has been the "see one, do one" approach. But this is *not* how many other professionals learn.

"In the sports environment, you have an opportunity to review the videos of your performance, but we have not really had that in health care," he asserts.

The mannequins, which are made by several different manufacturers, range from body parts to whole bodies and are quite realistic, Barach notes.

"They can be programmed with a variety of scenarios. They have electrodes, which allow you to feel pulse arterial pressure; you can put a foley catheter in or place an intravenous line into the great veins of the neck," he points out.

These mannequins provide what engineers call "user haptic feedback," or resistance from the tissue. "If you put a needle in the skin, the tissue has give — it allows you to better replicate true interaction," Barach adds.

In a trauma case, the trainee might work through typical patient characteristics, and then the patient might go into cardiac arrest or ventricular fibrillation. "It's very interactive," he explains, even to the point where the patient can crash.

"It mimics what aviation does by crashing the plane in simulations; we crash the mannequin," Barach says.

"The goal is not to overwhelm them but to see what happens when they overdo. So, for example, if we want to understand what happens when things do not go well, we might pursue it to flat line, take that video, go in the briefing room, and discuss what the trainer or team could have done to prevent things from going that far," Barach notes.

The trainees, he points out, range from high school and college students to med school nurses and residents, to faculty.

"All of the simulations are programmed around a learning objective that is part of the larger curriculum we have created for the students," Barach explains.

The goal also is to train in coordination with the organization's objectives, such as meeting standards set by bodies such as the Joint Commission on Accreditation of Healthcare Organizations and the National Quality Forum, he continues.

You can create scenarios with specific learning in mind, he adds. "For example, if we want to better understand why falls happen, we can create an environment with a bed and a patient falling out of bed, and try understand how best the nurse could interact to prevent that," Barach offers.

Not just any hospital could support such a program, he cautions. "The issue is more than just the mannequins; it's the atmosphere that supports it," Barach notes, putting the estimated cost at somewhere between $500,000 and $800,000 a year.

"I envision us as having regional training centers [across the country], where people can come and train periodically," he says.

In addition, however, many facilities would have the ability to purchase an individual mannequin for about $20,000 to $40,000.

"I imagine that once a year, they could come to a very large center and hook up with their environment, then replicate the scenario with their own mannequin at their hospital," Barach offers. "Or there could be web-based communication using streaming video; we're just starting to explore those ideas."

Finally, he notes, the center will have the ability to translate what it learns into meaningful lessons to be published. After all, "It's incumbent upon us to share what we learn." ■

Need More Information?

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NEWS BRIEFS

New Jersey hospital wins Baldrige award

Until St. Louis's SSM Healthcare broke the barrier in 2002, no health care system had won the coveted Malcolm Baldrige National Quality Award. Now there are four.

Robert Wood Johnson University Hospital in Hamilton, NJ, is the most recent winner. Among the achievements for which it was honored, Robert Wood Johnson University Hospital got its highest marks for customer loyalty; dramatic reductions in emergency department waiting times; surpassing national averages on a number of key quality indicators; and increasing retention rates for registered nurses to 99%.

Other previous health care winners include Baptist Hospital Inc. of Pensacola, FL, and St. Luke's Hospital of Kansas City, MO (2003). ▼

Massachusetts launches E-health initiative

The state of Massachusetts is pursuing a new framework for achieving universal adoption of computerized physician order-entry (CPOE) systems by the state's hospitals within a few years.

A report from the Massachusetts Technology Collaborative presents a plan for overcoming cost and other barriers to CPOE implementation, including minimum performance standards and a funding and incentive model.

"The vision is to position every Massachusetts community and teaching hospital on the leading edge of technology to support the highest quality and most cost-effective patient care," said **Ron Hollander**, Massachusetts Hospital Association (MHA) president, at the announcement of the initiative. He noted MHA has been part of the collaborative since its inception and played an integral role in setting its goal of getting every hospital access to current, compatible CPOE within four years. ▼

AHRQ releases new diabetes care guide

The Agency for Healthcare Research and Quality (AHRQ), in partnership with the Council of State Governments, has released *Diabetes Care Quality Improvement: A Resource Guide for State Action* and a companion workbook, both of which are designed to help states assess the quality of diabetes care and develop quality improvement strategies.

"As the lead federal agency supporting research in the quality, cost-effectiveness, and safety of health care, AHRQ is arming health care professionals, policy-makers, and local leaders with evidence-based information designed to facilitate improvements in diabetes care," said AHRQ director **Carolyn M. Clancy**, MD, in announcing the publication.

The guide and workbook provide an overview of the factors that affect quality of care for diabetes, present core elements of health care quality improvement, assist state policy-makers in using the data from AHRQ's 2003 *National Healthcare Quality Report* for planning state-level quality improvement activities, and provide a variety of best practices and policy approaches that national organizations, the federal government, and states have implemented related to diabetes quality improvement.

COMING IN FUTURE MONTHS

- How improvement science spawns quality success stories
- Why integrated electronic medical records can make a big difference in outcomes
- Implementing SBAR to improve nurse/physician communications
- Rural association embarks on five-year effort to improve quality of care
- IHI launches hospital safety campaign and recommends specific steps, standardized care

The workbook includes six modules developed for state leaders as well as officials in state health departments, diabetes prevention and control programs, and Medicaid offices.

Some modules are targeted for senior leaders responsible for making the business case for diabetes quality improvement and taking action, while other modules provide the information necessary for program staff to develop and implement a quality improvement strategy.

The goal is that all groups involved in diabetes care work together as a team to improve the quality of diabetes care.

Diabetes Care Quality Improvement: A Resource Guide for State Action and its companion workbook can be found on-line at www.ahrq.gov/qual/diabqualoc.htm.

Printed copies may be ordered by calling (800) 358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov. ■

Prepare your facility for an unusual flu season

Vaccine shortages may wreak havoc with EDs

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded emergency departments (EDs) and for staff shortages due to record absenteeism. After almost half of the United States' planned vaccine supply was contaminated, high-risk candidates — including the very young, the elderly, those with chronic illnesses, pregnant women, the immunocompromised, and health care workers with direct patient care — have been identified as those to receive the vaccine.

In response to the national shortage, Thomson American Health Consultants has developed an influenza sourcebook to ensure you and your hospital are prepared for what you may face this flu season.

Hospital Influenza Crisis Management will provide you with the information you need to deal with ED overcrowding, potential liability risks, staff shortages, and infection control implications for staff and patients.

This sourcebook will address the real threat of a potential pandemic and the proposed response and preparedness efforts that should be taken in case of such an event. Major guidelines and recommendations for influenza immunization and treatment are included, along with recommendations for health care worker vaccination and the efficacy of and criteria for using the live attenuated influenza vaccine.

Hospital Influenza Crisis Management will offer readers continuing education credits. For information or to reserve your copy at the price of $199, call (800) 688-2421. Please reference code 64462. ■