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Don't let obsession with numbers take your eyes off your goals

Percentile rankings can be moving target; focus on PI instead

At first glance, the proliferation of comparative databases for benchmarking activities may be a good thing, and of course, it always helps to have more data, but benchmarking experts warn there can be too much of a good thing — especially if it causes you to lose perspective.

"I'm finding that there's an obsession with the desire to attain a certain percentile level of performance, without regard to what that might mean for the organization," says **Robert G. Gift**, vice president for strategic planning and business development at Memorial Health System in Chattanooga, TN.

"With the proliferation of all of the different comparative databases, it seems to me people are pursuing being at a certain percentile without really understanding: a) that we have to change our underlying processes that produce those results; and b) that if you push on one performance metric to the exclusion of all others, it will create some organizational dissonance as well as performance dysfunctions. You *must* keep things in context," he adds.

"He's absolutely right on," says **Sharon Lau**, a consultant with Medical Management Planning in Los Angeles. "The thing I find I need to stress when talking to people about benchmarking is that it can't be done in vacuum."

Key Points

- The proliferation of comparative databases doesn't mean rankings have gained in significance.
- Good benchmarking requires achieving a balance that incorporates quality, cost, and speed.
- Measure success by the positive changes you have made and whether you're reaching your goals.

Lau describes the benchmarking process as a three-legged stool, incorporating cost/ productivity/financial; quality, which includes outcomes and customer service; and speed of service — how long it takes to get something done.

To **Philip A. Newbold**, MBA, chief executive officer for Memorial Hospital and Health System in South Bend, IN, it's a case of "déjà vu all over again," harkening back to the early days of quality improvement, when American industries first sought to duplicate the efficiency of Japanese companies and began adopting the philosophies of W. Edwards Deming, et al.

"As it was then, this is the key point: Are you really serious about change and transformation, or do you just want to play with the toys?" he challenges. "You must confront what it *really* means to execute and perform and to change culture, and to make sure that happens every day, all the time."

Gift concurs. "It seems that there is a disconnect — or a lack of understanding — that exists between attaining a level of performance and the changes required in the processes that *produce* that performance," he says.

The consequences of imbalance

Exactly what can happen to your organization if you take your eyes of the QI 'ball'? "If we push on the productivity performance without focusing on patient satisfaction, it may be that we get the productivity we want — on the two patients we have left," Gift warns.

He offers what he calls his favorite example: Your organization has an operational database that reports worked hours per departmental work load unit — i.e., per procedure, per patient day, per test. Now further suppose that the organization has decided to focus on achieving the top 25th percentile for all of the departments across the board.

"Here's what happens: There are nuances in the data that people may not fully understand," Gift explains. "If I'm in the materials management department and I am pressured to achieve at least the 75th percentile, it may be that some other facilities [in the comparative group] may in fact exclude from their departmental performance a key performance, such as sterile processing.

"The flip side also may be true: As director of the OR, I am pushed to the top 25th percentile, whereas other facilities may not do sterile processing or central supply," he notes.

"If you look at materials management and just go after that productivity, you are going to skew your balance — and benchmarking is a balance," Lau adds.

"Sure, you want to be more productive, but if it takes you 12 hours to get a g-tube up to a unit, your speed may be shot to hell. Or you can get it up in two seconds and not meet your other goals. If you tweak one piece [of the three-legged stool], it will impact the other two," she adds.

What you should be looking for, Lau continues, is to try to get the best balance for all three.

"You may not be *the* most productive, but as long as your service levels are in balance for your organization, that's where you want to target," she says.

"We had a [children's] hospital with the best

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Editor: **Steve Lewis**, (770) 442-9805, (steve@wordmaninc.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russell Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Steve Lewis** at (770) 442-9805.

ED productivity in our benchmarking group, but the kids were waiting eight hours. Is that good service? Of course not. They ended up adding staff so they could bring things into balance," Lau points out.

A moving target?

Another reason not to focus exclusively on numbers is that your target can change, Newbold notes.

"Take something like Press Ganey [patient satisfaction scores]; that's a moving target," he adds. "You may hit the 95th percentile one year, then you may do the same exact things the next year and be in the 85th percentile, because everyone else woke up and started paying attention to satisfaction; the bar has now been raised. You must realize that a percentile is a dynamic number, so the question you should be asking is, 'How do we build a core capacity, resilience, and strength, so we can continue to get better and better?'"

Your No. 1 focus, he continues, should not be a ranking, but *change*. "It's kind of like [football] training camp," Newbold explains.

"It's about what you have to go through to ensure you'll be there in the playoffs. You begin with the basics, change plays, and strengthen your players, so you'll be ready farther down the road. You're seeking to build a certain capacity within your group so you can do more than hit just one number once, because that number will no doubt change," he notes.

"The benchmarking process is more a process of discovery of the 'hows' than it is an establishments of the 'whats,'" Gift adds. "The big question is how we can change the underlying work processes to produce the desired outcome, rather than just pushing the number."

That, he emphasizes, is the key to benchmarking: Keeping in mind the means and the ends.

"Your goal is the end; the benchmarking process is how we establish the means to that end," Gift explains.

How are we doing?

There are some simple exercises to perform to determine whether you're on the right track in terms of organizational change, Newbold notes.

"With senior leadership, if their job after [PI] implementation is anywhere near what is before, there probably has been no change," he says. "At least half your day should be really, *really* different — an entirely new setup of behaviors, action steps, metrics, and accountability measures. Their day should look radically different — or there has not been any change," he asserts.

Newbold recommends that you perform a calendar audit. "Note what you spend your day on, what you pay attention to, and ask yourself, 'What do I really care about?'" he advises. "The answers should be very different — you can't fake it. You can't say 'I stand for quality,' then only spend 2% of your day on it. If your organization remains trapped in ineffective processes, it will lead to bad outcomes."

To improve those outcomes, you must get back to the fundamentals and basics of benchmarking, says Gift — and that means paying closer attention to Lau's three-legged stool.

"In some cases, your organization may be at the whim of the collective marketplace," he notes.

"For example, a hypothetical organization may be currently operating, per all their comparative data, at better than the 25th percentile and still be losing their shirt because they lack the operating margin they need to sustain themselves over the long haul. In such a case, the top 25th percentile bar isn't high enough. In that marketplace, that facility may need to perform at the top 10th percentile," Gift explains.

"Each organization will be different," adds Lau. "One may have a financial urgency and accept a little less on the other two sides [of the stool], whereas another organization many not have that urgency but does have a pressing need for better speed of service because everyone in

Need More Information?

For more information, contact:

- **Robert G. Gift**, Vice President, Strategic Planning and Business Development, Memorial Health Care System, 2525 de Sales Ave., Chattanooga, TN 37404. Phone: (423) 495-8664. Fax: (423) 495-7226. E-mail: bob_gift@memorial.org.
- **Philip A. Newbold**, MBA, Chief Executive Officer, Memorial Hospital and Health System, 615 N. Michigan St., South Bend, IN 46601. Phone: (574) 284-7115. E-mail: pnewbold@memorialsb.org.
- **Sharon Lau**, Medical Management Planning, Inc. (MMP), 2049 Balmer Drive, Los Angeles, CA 90039. Phone: (323) 644-0056. FAX: (323) 644-0057. E-mail: sharon@mmpcorp.com.

town is advertising a guaranteed maximum wait of 10 minutes."

Benchmarking, she continues, "is a guide for where you are in terms of the ballpark; *then* you make your decisions [as to where you should improve]. It depends entirely on where your organization is internally and externally; make your decisions based on what your goals are, what your culture is, and where you want to be."

"The fundamental requirement is to differentiate the availability of comparative data from the *process* of benchmarking," Gift notes.

"Having data helps you answer the 'what' question — our performance vs. those of others. It says *nothing* about what might be a successful practice, or a really great operating process, or what the core enablers are to allow that process to function properly and let an organization perform at its highest level," he concludes. **(For an example of a facility that felt falling within national benchmark norms was just not good enough to meet its quality goals, see story, p. 30.)** ■

Blood glucose monitoring slashes mortality rates

New protocol also reduces LOS by nearly 11%

A protocol of intensive monitoring and treatment to maintain proper blood glucose levels in all intensive care unit (ICU) patients at The Stamford (CT) Hospital reduced mortality rates by 29% and length of stay in the ICU by nearly 11%. The initiative, headed by **James Krinsley**, MD, medical director of the ICU, also:

- decreased mean glucose from 152.3 mg/dL to 130.7 mg/dL, marked by a 56.3% reduction in the percentage of glucose values greater than 200 mg/dL, without an increase in hypoglycemia;
- gained buy-in of the ICU nurses, integrating their input into the initiative and the target glucose values;
- created a data-driven ICU;
- increased motivation, empowerment, and skill development of the nursing staff;
- demonstrated that close monitoring and rapid treatment of patients using this simple and low-cost intervention can profoundly affect morbidity and mortality of critically ill patients.

In addition, the development of new renal insufficiency decreased by 75%, as well as the number of patients receiving transfusions of packed red blood cells (by 18.7%).

Stamford Hospital is a not-for-profit, community teaching hospital that has 305 inpatient beds in medicine, surgery, obstetrics/gynecology, psychiatry, and adult and neonatal critical care units.

This initiative involved 800 consecutive patients admitted after institution of the protocol (between Feb. 1, 2003, and Jan. 10, 2004) and 800 patients admitted immediately preceding institution of the protocol (the baseline group, between Feb. 23, 2002, and Jan. 31, 2003). The setting was the 14-bed medical-surgical ICU in a university-affiliated community teaching hospital.

The glycemic management protocol used intensive monitoring and treatment to maintain blood glucose values less than 140 mg/dL. It incorporated frequent FSG (fasting serum glucose) checks; minimal initial monitoring was every three hours — once an hour during IV insulin infusions.

Continuous intravenous insulin was used if glucose values exceeded 200 mg/dL on two successive occasions; subcutaneous regular insulin was used for milder hyperglycemia. After institution of the protocol, the mean glucose value decreased from 152.3 mg/dL to 130.7 mg/dL.

Key Points

- Gaining buy-in of intensive care unit nurses was critical to the success of the initiative.
- Complex diabetes treatment issues required leaving some decisions to bedside nurses.
- Projects success leads to implementation in hospital's special care unit.

Examining the database

After reading a paper on intensive insulin therapy in critically ill patients in the *New England Journal of Medicine*,[1] "The first thing I did was look at our own database [of ICU patients] to see if [there was a similar] relationship between glucose levels and mortality," Krinsley recalls.

What he found was dramatic: Survivors had mean glucose values of 137.9 mg/dL, while nonsurvivors had mean glucose values of 172. The lowest hospital mortality, 9.6%, occurred among patients with mean glucose values between 80 mg/dL and 99 mg/dL.

Hospital mortality increased progressively as glucose values increased, reaching 42.5% among patients with mean glucose values exceeding 300 mg/dL. "The nurse director, with whom I share a wall, must have heard me scream," he says.

This led to the first of two papers Krinsley would publish in the *Mayo Clinic Proceedings*.[2] "At the same time, I started discussions with the nurses [in early 2002], and then we finally put the protocol in place," he says. (The second Mayo paper[3] describes this initiative.)

In his earlier study, Van den Berghe had set a goal of 110 mg/dL, but the nursing staff were uncomfortable with that goal, and the staff were inadequate, Krinsley notes. "So we had further discussions and compromised with a more traditional 140. This was OK with the nurses, and it fit our data."

Krinsley and the staff wrote the protocol together. "We sat down together in a room, hashed it out, then revised and revised," he recalls. "And we are continually tweaking it. In fact, as of two weeks ago, every patient whose blood glucose is over 125 now gets treated, and [insulin] dripped over 180."

The nurses actually initiated this most recent change, Krinsley notes. "They wrote the protocol, and there was no resistance; it shows you how the culture has changed in two years."

The new protocol is even more flexible than the old one, he says, because it allows a greater degree of clinical flexibility at the bedside. "With drips, for example, you specify an initial infusion rate, but the subsequent drip rates are really at the nurse's direction. You can't possibly write a protocol that is as complex and accurate as the integration of data that goes on inside a good nurse's brain."

The protocol itself has been relatively inexpensive, Krinsley adds. No additional staff have been hired; a few extra bedside glucose monitors have been purchased. And while the use of insulin has increased, the cost of the drug is minimal.

A data-driven ICU

One of the keys to the success of the initiative was the creation of a data-driven ICU, he adds. "The use of data permeates the culture of the ICU. I have the databases, and everything we do has data associated with it. I print out colored copies to the nurses, so they know that everything that can be measured is measured."

Glucose is the most complex issue that has been tackled using the database, Krinsley notes. "There are a whole set of treatment issues, and we would not have been able to do this three or four years ago. It requires experience with protocols and a good data management system."

Krinsley also has noted increased motivation, empowerment, and skill development on the part of the nursing staff.

"A real esprit has developed because they know they are doing something that really matters, and it has given us national recognition [with the Ernest A. Codman Award], so there's a good deal of pride involved."

Protocol extended

One of the other positive results of the initiative is that the protocol has been extended to the hospital's intermediate care unit, called the special care unit.

"We've not gone to 125, because the nursing ratio is not as tight," he says. "However, while there are no formal data yet, we have had a good impact on lowering glucose levels.

"The whole project has been a 'win-win,' Krinsley adds. "My next paper, which I'm working on right now, is about the cost savings associated with glucose management," he reveals.

While he could not share any data before publication, Krinsley did say, "It will be very big number. So, here we have a low-cost intervention that not only has a positive mortality effect, but also a major cost-savings effect."

References

1. Van den Berghe, et al. A low-cost intervention that will become the standard of care in the ICU. *N Engl J Med* 2001; 345:1,359-1,367.
2. Krinsley JS. Association between hyperglycemia and increased hospital mortality in a heterogeneous population of critically ill patients. *Mayo Clin Proc* 2003; 78:1,471-1,478.
3. Krinsley JS. Effect of an intensive glucose management protocol on the mortality of critically ill adult patients. *Mayo Clin Proc* 2004; 79(8):992-1,000. ■

Need More Information?

For more information, contact:

- **James Krinsley**, MD, Medical Director, Intensive Care, Stamford Hospital, 30 Shelburne Road, Stamford, CT 06904-9317. Phone: (203) 276-5506. E-mail: JKrinsley @stamhealth.org.

Universal protocol cuts hip surgery fatalities

Sentinel event leads to innovation solutions

The determination that "good" is not good enough has spurred Staten Island (NY) University's medical staff to develop a new, universal protocol to reduce the mortality rate for high-risk patients undergoing hip fracture repairs. As a result, mortality rates decreased 80% over three years — from 4.9% to 1%.

Staten Island University Hospital is a 785-bed, tertiary care, teaching hospital and part of the North Shore-Long Island Jewish Health System.

Staten Island's initiative focused on the frail elderly, who are at high risk for hip fracture. This group comprises more than 15% of Staten Island's population and is the second fastest-growing segment of the community's population.

By establishing a defined process for preoperative assessment of high-risk surgical patients, Staten Island's project reduced process variation, defined performance standards, and focused on outcomes for hip fractures, which account for the largest portion of injury-related hospitalizations nationally.

It began with a sentinel event in 2000. A 78-year-old woman was admitted with a hip fracture, as well as a number of medical/surgical comorbidities.

"The medical clearance was identified as 'no contraindication for surgery,' recalls **Joseph Conte**, MPA, vice president of quality. "The anesthesiologist disagreed because of her history of laryngeal cancer and some pulmonary issues." The disagreement went unresolved, however; the patient went to the surgical suite and, at the time of induction, had a cardiac arrest and died.

A root-cause analysis was conducted, and as part of the research, it was revealed that the hospital's mortality rates for hip fracture patients were well within the state norm, "and even in terms of the national norm, we were right in the ballpark," he says.

Nevertheless, "We felt a benchmark was just a measurement — not a solid line drawn that said we hit it. Anything else but zero is really experience-driven, and when we looked at the literature, we saw that some people were doing better than 5%, so [a new protocol] was certainly worth developing," Conte notes.

Key Points

- Root-cause analysis employed to determine best way to proceed.
- Medical management department takes lead role in developing new protocol.
- New privileging requirements established for those conducting pre-op assessments.

Key issues addressed

Since the hospital maintains a quality database for issues of concern, staff were able to sort data on surgical morbidity mortality typically related to hip fracture.

"We found other similar cases, in that the initial assessment did not give a robust picture," he points out. "Then, we began to look into the whole philosophy of medical management; while the prevailing attitude was if a patient had a fracture and needed surgery, they should have it as soon as possible, that's not necessarily in the patient's best interest."

One of the real eye-openers in their research was the discovery that, nationally, within a year of hip fracture, 25% of the patients are dead. "That is higher than most cancer diagnoses," Conte says. "But we also saw they did not die from surgery, but rather from pneumonia, pulmonary complications, underlying comorbidities, urinary tract infections, and blood clots."

Medical management took the reins of the initiative. "The head of the department championed it, and through his own due diligence, found that perioperative medicine was becoming a field in itself," he recalls. The staff soon realized that pre-op patients were not, for example, being put on beta-blockers, and that there were other work-ups that could be done.

Root-cause analysis also revealed that the physicians who were giving pre-op exams were not specifically privileged.

"We decided initially that we needed to identify a cadre of physicians right off the bat who could continue to do this service," Conte adds. That cadre consisted initially of about 15 intensivists (primarily pulmonologists or cardiac or critical care physicians). They were followed shortly by the hospital's 20 hospitalists.

"The next step was the development of a graduate medical education program four hours in duration, which really took from all the evidence-based

Need More Information?

For more information, contact:

- **Joseph Conte**, MPA, Vice President of Quality, Staten Island University Hospital 375/475 Seaview Ave., Staten Island, NY 10305. Phone: (718) 226-1910.]

information out there," he explains.

"A number of physicians then took that class and immediately got on board with what was required; they then requested privileges, and they were granted," Conte adds.

Through a process of education, physicians were encouraged to focus on the new protocol. One component was beta-blocker usage. "It's becoming a standard of practice," he notes.

"Another thing we did was to liberally use consults as necessary." The team also developed a new assessment tool. "We got less tuned in to the fact that the patient has to go into the OR within 24 hours," Conte summarizes. "And in fact, this was borne out with a paper in *JAMA* [the *Journal of the American Medical Association]* last year on the association of timing of surgery for hip fracture and patient outcomes.

The authors said in their conclusion that 'Early surgery was not associated with improved function or mortality.'[1] This flies in the face of everything we used to think, but now we know that if you have the opportunity to optimize the patient by getting beta-blockers on board, improving their cardiac and pulmonary status, that this is more valuable than racing to surgery."

Time still an issue

One interesting discovery during the process, Conte says, was that even though the staff were no longer wed to timeliness, "One of the important things we realized was that we still needed to be aware of time."

For example, the emergency department was focused on the project from the beginning. "As soon as a patient had been identified with a hip fracture, they immediately got the orthopedic surgeon engaged, and he, in turn, immediately got a medical assessment person on board," he shares.

Another key to success, he continues, was the buy-in of the orthopedic surgeons. "If they felt this [new process] was an impediment, that would have been bad," Conte concedes. "We made sure they were involved as important stakeholders at all stages."

Finally, he says, all the people involved had common training and education.

"We started with a common theme of medical management of these patients, which was extremely important," Conte emphasizes.

"Once you have a lot of variance, you don't have a process anymore. A common methodology, approach, training, and background create the same mindset," he adds.

Reference

1. Orosz GM, Magaziner J, et al. Association of timing of surgery for hip fracture and patient outcomes. *JAMA* 2004; 291:1,738-1,743. ■

33% of fatal med errors involve insulin therapy

Statistics spur conference seeking solutions

Spurred by studies indicating that 33% of the medical errors that caused death within 48 hours of the error involved insulin therapy, the American Association of Clinical Endocrinologists (AACE) and the American College of Endocrinology brought together national and international thought leaders in patient safety in endocrinology and metabolic disorders for a consensus conference on Jan. 9-10, 2005, to develop concrete solutions to avoid systemic errors in patient care, focusing on endocrine disorders such as diabetes, osteoporosis, and thyroid disorders.

The statistics were drawn from the research work of **Richard Hellman**, MD, FACP, FACE, clinical professor of medicine at the University of Missouri-Kansas City School of Medicine, a member of the AACE board of directors and chairman of the conference.

Key Points

- Use of computers seen as critical to successful error reduction initiatives.
- Building teamwork takes time, money, and resources — but it's worth it.
- Educational efforts must be customized to fit the patient's socioeconomic and educational background.

"In 1997, I presented a 14-year study on diabetes outcomes, published in *Diabetes Care*,"[1] Hellman notes. "We've done more research since then, and when we looked at people with diabetes who died of a medical error within 48 hours, one-third of those involved error in insulin administration."

This is in keeping with the Joint Commission on Accreditation of Healthcare Organizations' identification of insulin as one of five high-risk medications, he continues.

"As a convener of the conference, I thought this was timely because medical errors are one of the causes of poor outcomes in diabetes care, and hospitals are one of the core care areas." Some data also were presented at the conference on osteoporosis, Hellman adds, "And it showed a big problem there as well."

The conference produced a wide range of recommendations on how to prevent patients from becoming sicker or dying as a result of medical errors complicating their illness (see the AACE web site, www.aace.com), but Hellman cites three areas that he says hold particular importance for quality managers:

- the use of computers;
- teamwork;
- education.

"When you use computers to capture more information, it also prevents loss of information, which we identified as a leading cause of errors," he explains. "We strongly recommended CPOE [computerized physician order entry]. In the outpatient setting, we are very strong on wanting electronic health records to be used widely; there's tremendous power there, too, to prevent loss of information."

The health care industry, he notes, still lags behind others when it comes to technology. "You can go into any store anywhere and whip out a credit card, and they can determine if it's valid; but if you go to an ER anywhere, the odds are they can't access your information. This is extraordinary for the second biggest industry in the country," Hellman asserts.

The second key issue is building, valuing, and training teams, he adds. "We must collectively value safety. In order to have teamwork that works, you probably need to have more training, more time, more review of what you're doing, more observing what's been done, and more measuring, — all that, of course, takes more time, more resources, and more money."

It's worth it, however, when you consider what can happen when teamwork breaks down. "Here are two examples," Hellman offers. "In one, a doctor orders insulin; the nurse gives the proper dose; the patient receives it and then is whisked away by transportation for a test, but did not get to eat. Or the patient gets the right dose but then the food tray never arrives."

Situations like these occur all too often, he says. "Two of the more common adverse drug events are due to insulin. Who's talking to whom? [In the previous examples] someone had to communicate to the person coming to take the patient away that they couldn't do that before he was fed. Or, as another example, if you determine the nursing ratio in the ICU has to be at a certain level to keep errors low, then you need to make sure that level is maintained."

In the area of diabetes management, a lot of the educational efforts are not yet evidence-based, Hellman complains. "What that means is, you really can't be assured it's getting the job done," he emphasizes. "In fact, a lot of educational ventures don't seem to change behavior."

The solution, he says, is a more formal approach. "There have been many advances in cognitive psychology, but we do not seem to be using them," Hellman notes.

Finally, he says, education must be tailored to the patient — in terms of their level of education, ethnic background, and so on.

"Particularly when you're dealing with certain ethnic groups, if the information is presented in such way that the patient feels demeaned, it's over," Hellman observes.

"Education is a linchpin [of diabetes management], but how it is given needs to be changed. And we're not just talking doctor or nurse to patient, but doctor to nurse, nurse to nurse, and so on. It all needs to be well-integrated," he adds.

Need More Information?

For more information, contact:

- **Richard Hellman**, MD, FACP, FACE, The American Association of Clinical Endocrinologists, 1000 Riverside Avenue, Suite 205, Jacksonville, FL 32204. Phone: (904) 353-7878.

Reference

1. Hellman R, Regan J, Rosen H. Effect of intensive treatment of diabetes on the risk of death or renal failure in NIDDM and IDDM. *Diabetes Care* 1997; 20(3):258-264. ■

Know differences between kids and adults: Cut errors

Study points out key areas for safety improvement

Kids really are different from adults, and recognizing those differences can help lower the rate of errors for the youngest patients, advises **Donna Woods**, PhD, a postdoctoral fellow at the Institute for Health Services Research and Policy Studies in the Feinberg School of Medicine at Northwestern University in Chicago. Woods is the lead author of a study recently published in the journal *Pediatrics*.[1]

Woods and her colleagues used data from the Colorado and Utah Medical Practice Study to analyze the incidence and types of adverse events in children. The analysis included some 3,700 hospital patients up to 20 years of age and, for comparison purposes, about 7,500 adult patients between the ages of 21 and 65.

Overall, one of every 100 patients in the study suffered an adverse event, and 60% of these were preventable.

Preventable adverse event rates were 0.53% among infants, compared with 0.22% in children 1 to 12 years of age and 0.95% among adolescents 13 to 20. The figure was 1.5% for adults.

In terms of the greatest number of preventable adverse events, they ranked as follows:

- birth-related, 32.2%;
- diagnostic-related, 30.4%;
- system-related, 27.3%.

The team defined an adverse event as an injury caused by medical management rather than disease that led to prolonged hospitalization or disability that persisted at the time the patient left the hospital. They defined a preventable adverse event as an injury that was avoidable using currently accepted practices.

"This study really provides us with an estimate of the magnitude of the problem of adverse and preventable adverse events in this population," notes Woods. "It is equivalent to the estimates that were produced by the IOM [Institute of Medicine] several years ago, and gives us a sense of where we should we focus."

Key Points

- One of every 100 patients has an adverse event; 60% of those were deemed to be preventable.
- Birth-related, diagnosis-related, system-related errors greatest contributors to adverse events.
- Very little pediatric data are available on medical errors; more research is called for.

Customize care for kids

One of the most important things that came out of this study is that patient safety activity for children's medical care must be customized for the child, she asserts. "Children are different from adults, so our hypothesis was that the areas of greatest risk would be different — and they were. Whereas medications and surgeries are the highest risk areas for adults, the areas that need the most patient safety focus for kids are birth and diagnostics."

Using a panel of medical experts, the team determined which "currently accepted practices" could have prevented an injury.

In terms of diagnostics, the errors were not necessarily related to a particular diagnosis, but to the interpretation of diagnostics findings and in the ordering, Woods explains.

"So, for example, a prolonged hospital stay might result if the patient had to remain in the hospital for an extra week or month because of an inappropriate diagnostic test," she offers.

In terms of preventable adverse events, the location most frequently identified was labor and delivery, Woods adds.

Why the emphasis on system-related errors? "This just indicates that many of these things were not skill-related but related to the way information flows and the way procedures move through the medical system," notes Woods. "It's not that [the health care professionals] did not have the skills or knowledge, but rather the systems around them [broke down]."

In summarizing take-home issues for quality managers, she observes:

"One in 100 children experiences an adverse event, and 60 of those are preventable — this is a lot for the population and for hospitals," Woods asserts.

"The direction of our attention must be focused in certain areas — for example, diagnostics is a big and difficult area that no one gets their hands around — and the processes involved in caring for children may be different, so the actual intervention may need to be customized to provide safe medical care for children," she adds.

Finally, there's a paucity of pediatric data

Need More Information?

For more information, contact:

- **Donna Woods**, PhD, Institute for Health Services Research and Policy Studies, Feinberg School of Medicine, Northwestern University, Chicago, IL. Phone: (847) 832-9650. E-mail: woods@northwestern.edu.

available, and more attention must be placed on safety risks for children, Woods says.

"We really need to dig down — to exactly *which* diagnoses, for example, are the sources of the most errors. We need a much bigger [study] population for that — but those kinds of questions are important questions."

Reference

1. Woods D, Thomas E, Holl J, et al. Adverse events and preventable adverse events in children. *Pediatrics* 2005; 115:155-160. ■

Consumer coalition sets performance guidelines

Rapid adoption of PI measures used

A common coalition of more than 25 of the nation's leading consumer, employer, and labor organizations — called the Consumer-Purchaser Disclosure Project — has unveiled guidelines to promote rapid, industrywide adoption of performance measures to help patients compare the relative quality and cost of care provided by the nation's hospitals, physicians, and health care systems.

The Disclosure Project is supported by a grant from the Robert Wood Johnson Foundation and the Leapfrog Group.

"We know care varies significantly from provider to provider, and often these are life-and-death decisions," said **Debra Ness**, president of the National Partnership for Women & Families, and Disclosure Project co-chair, at the announcement.

"A lot of public and private organizations are moving to develop and institute measures of provider performance; these guidelines are intended to get organizations that are developing measures on the same page," she said.

The guidelines call for the following:

- **Scientifically Valid Performance Measures endorsed by the National Quality Forum's (NQF) consensus process:** The NQF performance indicators should serve as primary measures. If the forum has not endorsed a measure for an aspect of health care performance, measures endorsed by national accrediting organizations should be used. If supplemental measures are implemented, they must be scientifically grounded, regularly updated, and reviewed by provider and consumer groups.
- **Transparency of Provider Rating Methods:** Provider rating methods, including detailed measurement specifications and algorithms used to combine scores and/or group providers into performance tiers, should be publicly disclosed.
- **Coordinated Data Collection:** If collection of data about performance creates a significant burden for providers, data collection should be coordinated across health plans and other purchasers who share hospitals and physicians within their contracted networks.

In developing the guidelines, the Disclosure Project considered issues that currently challenge standardization of performance assessment: defining uniform performance measures, making ratings useful and accessible to the public, and ensuring efficient collection of provider-level data with minimum burden for providers. These factors are important as hospitals and physicians often are burdened by evaluations from numerous sources that determine performance scores in very different ways.

"A consistent approach to measuring providers is an essential part of employers and health plans' efforts to rein in costs and obtain better value," says **Peter Lee**, president and CEO of the Pacific Business Group on Health and co-chair of the Disclosure Project.

"These guidelines illustrate a shared commitment across groups who don't always see eye-to-eye but are coming together to be a catalyst for performance improvement. Standardized information is the key to fostering provider accountability and to rewarding better performers," he adds.

(Editor's note: For more information, go to: www.healthcaredisclosure.org.) ■

'Quality Plus' gains 39 early participants

The Washington, DC-based National Committee for Quality Assurance (NCQA) says that 39 health plans nationwide, collectively covering more than 11.5 million Americans, have committed to undergo surveys under the first of set of NCQA's new "Quality Plus" standards — Member Connections.

These standards focus on the depth, accuracy, and interactivity of the information health plans provide their members in order to best help them manage their own health.

Member Connections is the first step in NCQA's effort to update its accreditation programs, so that the same standards apply to a broader array of plan types.

The standards assess how effectively an organization interacts with its members via the web and telephone to help them understand benefits, access self-management tools for certain conditions, and check the status of their claims.

Effective engagement of consumers and patients in these ways, coupled with quick, clear responses to inquiries from plan enrollees, can have a dramatic impact on member satisfaction.

The final standards for Member Connections will be released at the end of January; surveys will begin on July 1.

"We want to make it easier for our members to make well-informed decisions about their health care. That includes helping them understand their benefits, and helping them learn how to stay healthy," explains **Dominic Galante**, MD, vice president, medical quality management for Preferred Care of Rochester, NY.

Large employers helped develop the new standards and many are expected to require health plans serving their employees to seek the additional distinction of meeting them.

Among the large employers expressing support for the new standards were NCR Corp., Verizon, and the Pacific Business Group on Health.

The Quality Plus program is a voluntary component of NCQA's Accreditation programs for HMOs, PPOs, and point-of-service plans. Its purpose is to identify those organizations that provide information about the quality of physicians and hospitals, help members make decisions about their own health, take innovative approaches to chronic condition management, and keep their members healthy.

Quality Plus standards are designed to provide consumers and employers with a basis for comparing different types of plans, including HMOs, PPOs, and consumer-directed health plans. Large employers and consumer groups have endorsed the program.

Standards for two other new content areas, Physician and Hospital Quality and Health Improve-ment, will be released for public comment in March.

COMING IN FUTURE MONTHS

- Study: Hospital consolidation may not improve quality of care or efficiency
- Critical care nurses offer recommendations to improve patient safety
- JCAHO seeks to enlist patients' participation to reduce medical errors
- AHA unveils process behind 'most wired' and benchmarking survey; plans' changes in 2005

Plans that meet the standards in any or all of the three Quality Plus content areas will be recognized on NCQA's Health Plan Report Card, available at www.healthchoices.org.

Plans also will receive a seal acknowledging their distinction in the Member Connections program for placement on their web site. ■

Bush seeks $125 million for health IT expansion

President Bush, emphasizing the benefits of health information technology during a recent visit to the Cleveland Clinic, announced that his fiscal year 2006 budget proposal will include $125 million for demonstration projects to test the effectiveness of health IT and allow for widespread adoption in the health care field.

The president said he also will seek another $50 million for health IT initiatives in fiscal year 2005, in addition to the $50 million Congress appropriated last year. ▼

CMS expands Medicare coverage of ICDs

The Centers for Medicare & Medicaid Services (CMS) has decided to expand Medicare coverage of implantable cardioverter defibrillators (ICDs) to prevent sudden death in people with heart disease. It said it expects the decision to increase the number of Medicare beneficiaries eligible for an ICD by one-third, to nearly 500,000, including at least 25,000 additional patients in the first year of coverage.

As part of the coverage decision, CMS will require the submission of specific demographic, clinical, provider and device data into a data registry at the time of the procedure.

The agency said the registry process will ensure patients are receiving high-quality, medically necessary care, and provide valuable new