Healthcare Benchmarks and Quality Improvement

The Newsletter of Best Practices

THOMSON AMERICAN HEALTH CONSULTANTS

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Top quality hospitals have higher survival rates, with sicker patients

Winners say size or budget not necessarily a key to QI success

The latest study from HealthGrades, an independent health care quality company based in Lakewood, CO, shines a bright light on the levels of outcome improvement achieved by the nation's quality leaders. At the same time, their findings and the comments of best performers debunk more than one commonly held perception about what it takes to score near the top on nationwide hospital report cards.

The new study, in which hospitals in the top 5% in the nation in clinical quality were named "Distinguished Hospital for Clinical Excellence" by HealthGrades, showed patients in the highest quality hospitals have 12% to 20% better survival rates for common procedures and diagnoses. What's more, they seem to have found the key to reducing mortality, not in one or two areas, but across the board. More specifically, the study found:

- If all patients went to a Distinguished Hospital for four of the highest volume procedures and diagnoses — coronary bypass, angioplasty, stroke, and community-acquired pneumonia — 52,949 lives could have been saved from 2001 to 2003.

Don't miss infection rate audio conference

State after state considering legislation

Is your state next? Laws requiring disclosure of individual hospital infection rates are sweeping the nation. Four states — Pennsylvania, Illinois, Florida, and Missouri — have passed infection rate disclosure laws, and 20 others have introduced bills.

Driven by consumer demands for patient safety, infection rate disclosure laws are expected to be passed eventually in most states or

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- A Medicare patient who underwent heart bypass surgery at a Distinguished Hospital on average had a 15.3% better chance of surviving than a patient who received treatment at an average hospital.
- The improved survival rates at Distinguished Hospitals were 15.4% for stroke, 12.62% for heart attack (in hospitals where angioplasty and stent treatments were available), and 19.55% for community-acquired pneumonia.

Of particular interest was the fact that the Distinguished Hospitals for Clinical Excellence had better patient outcomes despite the fact that they treated more and sicker patients.

This appears to contradict conventional wisdom that larger academic facilities are at a disadvantage in such rankings — precisely *because* they tend to treat patients with more serious conditions. And, say winners interviewed by *Healthcare Benchmarks and Quality Improvement,* many key QI strategies can be performed by nearly any hospital — regardless of size or budget.

Key Points

- Patients in the highest quality hospitals have 12% to 20% better survival rates.
- Many improvements were made, but there's a long road ahead to reach ultimate quality goals.
- Benchmarking called the first step to achieving high ranking in hospital report cards.

The hospitals — 229 out of nearly 5,000 — were ranked at the top of the list based on the death and complication rates of Medicare patients in 28 common procedures and diagnoses, from hip replacement to bypass surgery, over the years 2001, 2002, and 2003.

"These in-hospital survival differences are significant — they cannot and should not be ignored," says **Samantha Collier**, MD, HealthGrades' vice president of medical affairs.

"I think the major implication [of the study] is we are making improvements, but we have a long road ahead of us," she continues. "The real implications for the quality manager is we can still do more — and with what we have. In every hospital every day, there's a lot of available knowledge and technological know-how to make the needed improvements."

That is what sets the winners apart, Collier says. "You can't be satisfied with the status quo, and that's exactly the culture they display. They are just never satisfied."

Another characteristic of the winners is consistency, she adds. "We see a lot of consistency from year to year, and we are pleased with that. For one thing, we are using three years of data, which stabilizes the results. Also, it demonstrates this is not a fluke thing — the [multiyear winners] are using best practices and maintaining that over time," Collier explains.

Making quality a focus

"We've made quality a focus of our operations and our strategic plan — part of the expectations we put out for leaders," notes **David Spivey**, president and CEO of St. Mary Mercy Hospital in Livonia, MI, one of only 30 hospitals to have received Distinguished Hospital awards for both

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clinical excellence and patient safety. "It obviously helps to have a focus on QI in the organization, and leadership has bought into that — not only administrative, but medical staff as well," he notes. After 40 years as an independent facility, St. Mary Mercy joined Trinity Health in 2000.

The emphasis on quality has begun to manifest itself in a variety of departments, Spivey adds. One of those manifestations is a leadership development program, which is about 3 years old. "We hold two-day retreats quarterly and address issues of quality, finance, and growth," he says.

The meetings have a twofold benefit, Spivey says. "It serves as a way for us to focus leadership around the same goals and objectives," he notes. "Plus, we bring in experts from outside the organization to reinforce our message and to provide education for our leadership group."

The program has been so successful, in fact, that the hospital is launching a "leaders developing leaders" program, so that those who have been through the program already can teach frontline staff.

"They are our everyday true leaders and provide the care that allows you to ultimately be successful," Spivey notes. "So we are growing new leaders and getting people rowing in the right direction; it's all about communication."

Another key to quality improvement has been a management incentive program. "This hardwires the awareness of organizational and departmental objectives." He says incentives range between 7.5% and 15%, depending upon the individual's position. "It has definitely been successful."

Six Sigma plays a part

Six Sigma also has played an important role at St. Mary Mercy. The hospital has five full-time black belts and has had several successful projects. "When I first brought it up, there was some push back," Spivey recalls.

"But it has paid for itself many times over in specific projects that have provided a return, but even more important, it has helped improve the culture. It has helped create a data-driven, evidence-based culture, which forces everyone to upgrade their game," he adds.

DMAIC (define, measure, analyze, improve, and control), a key Six Sigma approach, now is the hospital's process improvement methodology.

Education has been a key to success at another Distinguished Hospital, CHRISTUS Santa Rosa Health Care in San Antonio, which has been named two years in a row.

"We have historically had a heavy commitment to education, and I'm not just talking about nursing and ancillary services but medical education," says **Don A. Beeler**, FACHE, president and CEO.

"For example, in our children's hospital, we are the academic teaching facility for the University of Texas Health Science Center. On the adult side, 10 years ago, we set up our own hospital-based family-practice residency program. They do a lot to influence quality, and a lot of our medical staff choose to be on those teaching services," he points out.

CHRISTUS Santa Rosa is a large Catholic hospital system, part of CHRISTUS Health, with a downtown campus (a large children's hospital and an adjacent facility) and a medical center campus, which is the extension of an adult hospital. Beeler says this emphasis on education and the hospital winning the HealthGrades award are definitely connected.

"Philosophically, we believe that quality and education are linked," he asserts. "When you work in a teaching environment, it keeps everybody a little sharper, and you have people who want to keep up with the latest practices."

Quality and safety, he continues, "are part of who we are."

In fact, in the facility's vision statement, it says that CHRISTUS Santa Rosa wants to be known for compassion, quality, and service. "We put it in our mission statement and goals," Beeler notes. "We have excellent people in our quality department, and they work closely with the medical staff. It's a journey that never ends."

You don't have to be big

For quality managers whose facilities may not have made HealthGrades' top 5% or who would like to do better in other comparative rankings, here's a bit of good news: You don't have to expand your facility dramatically or have a huge budget at your disposal to achieve the improvements you're after.

"I don't think you need a whole lot of money," Spivey says. "We're not the largest facility in the world; we're essentially a 200-bed community hospital."

What's critical is that your programs prove to be good investments. "What I've found is the investments we made in PI come back to us many

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For a list of winners, go to: www.healthgrades.com.

times," he adds. For example, Six Sigma "has been very important for us and has had a lot of return for us." In fact, while Six Sigma may be perceived as an esoteric and thus expensive undertaking, "it's a great one for a small hospital," Spivey insists.

"Certainly, larger volume hospitals may just have more resources to be able to invest in good people and/or good technology, which can cause good outcomes," Collier concedes.

"But for smaller hospitals, the biggest thing is, if you're not benchmarking, you *should* be and with various different databases. You will not know what your issues are unless you see how you're doing and how you are currently performing relative to your peers; that's the first place to start," she points out.

Such comparisons may not exactly be fun at first, Collier notes. "I can't tell you how many hospitals I've talked to who told me that when our ratings came out, it was extremely painful," she says.

"But they also say that looking back, it's the best thing that could have happened because it forced them to look at themselves and identify opportunities to improve. It puts accountability right back on the provider," Collier explains.

What's more, you don't need a lot of high-tech equipment or knowledge to benchmark, she continues. "*All* quality managers and quality departments should be benchmarking themselves, rather than just tracking control charts.

"These Distinguished Hospitals are setting the standards. Other hospitals should want to know how they can do the same, and they can start by benchmarking against those types of hospitals," she adds. ■

SBAR initiative to improve staff communication

Tool was first developed, used by the military

Abington (PA) Memorial Hospital soon will be rolling out a pilot program for a planned SBAR (situation background assessment and recommendation) initiative the program's proponents say will improve communications and reduce errors at the facility.

The link between poor communication and errors is well recognized in the health care community. In fact, the Joint Commission on Accreditation of Healthcare Organizations recently identified communication as a major cause of adverse events.

"We've had instances where there have been adverse events, and where we did not see proper communication, and it turns into a doctor/nurse 'he said, she said,'" notes **Doron Schneider**, MD, associate program director, internal medicine residency, at Abington.

"People say they were not aware of certain vital signs, or the primary nurse's concern was 'X,' and the physician thought it was 'Z.' We want to make sure that when the physician makes an important call, they have received all the pertinent information," he explains.

As with many quality improvement tools being used in health care today, SBAR had its origins far beyond hospital walls.

"This is a communication tool that was developed in the armed forces quite a while ago," says Schneider. "It's an attempt to try to standardize communication between people, and it has been adapted to health care providers. We've noted 60% to 70% of medication errors are related to communication, so the way we deliver information and anticipate delivery as a receiver of information can go a long way to alleviating some patient safety problems."

Key Points

- Poor communication seen as a root cause of many adverse events.
- A pilot program will be conducted in the critical care unit as part of a totally new overall approach to quality.
- Tool ultimately will become part of permanent patient records.

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Interestingly, Schneider and some of the nursing leadership at Abington both heard about SBAR within a short period of time — at separate industry meetings. "It was initially introduced to me at the National Patient Safety Foundation meeting last year in Boston, and a month later, our nurse leadership went to a conference and also heard about it," he recalls. "It's a tool that is really gaining acceptance nationally."

At the heart of SBAR is a form that is filled out and shared with the other health care professionals treating the patient. It is divided into four sections:

- **Situation**: This includes patient identification information, code status, vitals, and the nurse's concerns.
- **Background**: Information is noted on patient's mental status, skin condition, and whether he or she is on oxygen.
- **Assessment**: Here the nurse indicates what he or she believes to be the problem.
- **Recommendation**: Physician follow-up actions are suggested, including possible tests.

Before a potential rollout to the entire hospital, Schneider says a pilot program will be conducted in the critical care unit (CCU), as part of a totally new overall approach to quality. "The tool is not going to start as a permanent part of our medical record, but it will be on the nurse's flowsheet as a reminder of how to communicate information surrounding unstable changes in clinical status," he explains.

In short, it will serve as a unidirectional form of communication — someone on the ground reporting up the chain of command. "It will communicate something of importance from nursing to the physician," Schneider says. "We will later be looking at how residents communicate with attending physicians."

Education of staff is critical, he continues. "We want to make sure we not only educate nursing about the fact that we expect them to use this tool, but we also will educate the docs, so they know they are supposed to receive this information."

This will start with the residents, who will receive a revamped introduction/orientation to CCU when they rotate, which they do monthly. "They will hear about things they have not heard about before, like goal-setting checklists, a bundle project to decrease CAP [community-acquired pneumonia], insulin drips that are now pretty much protocol — a lot of quality initiatives," Schneider notes.

"As part of that, they will be oriented to SBAR, so that when a nurse talks to them in a way they were not previously used to, they will understand what they are communicating."

Once the nurses have been educated, he adds, "We want to make sure they have reviewed the chart, know the admitting diagnosis, know the right doctors to call, have an updated meds list, and have the latest vital signs — even before they make the call [to the doctor]."

At the end of the pilot program, residents and nurses will be debriefed. "We will be able to look very quickly at their attitudes and experience, to see if the form has validity and if people think it helped," Schneider says. "The real outcome, of course, will be a decrease in adverse events and fewer transitions to a higher level of care — once the tool has been rolled out to the general medical floors."

Eventually, the form will become part of the record. "The nurses will just pull one of these sheets out, and it will almost be like a fill-in-the-blank," he predicts. ■

More than 40% of nurse errors not from medication

Procedural errors, charting errors also significant

A recent study of errors and near errors by hospital staff nurses confirmed some pre-existing beliefs, but also contained some surprises, according to one of its authors.

The study, published in the November 2004 edition of *Applied Nursing Research,* showed nearly 30% of the hospital staff nurses who participated reported making at least one error during a 28-day period; one-third of the nurses surveyed reported a near error, in which they caught themselves before they were about to make an error. The study was funded by the Agency for Healthcare Research and Quality.

Among the surprises noted by co-author **Ann E. Rogers**, PhD, RN, associate professor at the

Key Points

- Minimizing distractions is seen as an important strategy for reducing nursing errors.
- Errors and near errors for 393-nurse sample extrapolates to nearly 5,000 incidents per year.
- Still relatively few hospitals use computerized physician order entry, keeping transcription errors high.

University of Pennsylvania School of Nursing in Philadelphia, was the variety in the major sources of errors.

"Previous studies had always taken note of medication errors, and there's a good reason to focus on them, but that's only *part* of the picture," she says. "Only 58% of the errors reported in our study were related to medication administration."

The study showed the second most common type of errors were procedural errors (18.4%), followed by charting errors (11.9%).[1]

The authors reviewed logbooks maintained by 393 nurses who answered these questions:

- Did you make any medication or other errors today?
- Did you catch yourself before you were about to make an error today?

If nurses responded yes to these questions, they were asked to describe what happened. Depending on their work schedule, nurse participants were asked to complete a maximum of 40 questions per day, along with questions about sleep/wake patterns, mood, and caffeine intake. On their days off, they only responded to the latter questions.

The nurses in the study reported a total of 199 errors and 213 near errors during the data collection period. The authors point out that when these results are extrapolated to a one-year period, errors and near errors for this sample of nurses would total nearly 5,000 incidents.

Although 61.3% of the nurses reported only one error during the data-gathering period, 45 nurses reported making between two and five errors, and one nurse reported a total of eight errors.

Similarly, 80 nurses reported the interception of at least one of their own errors; however, 37% of the nurses stated that they stopped themselves from making between two and seven errors. One nurse reported intercepting a total of nine of her own errors.

The procedural errors reported in the study referred to situations where nurses actually followed the wrong procedure or did not follow standard practices, Rogers explains.

"One was working in dialysis and made a math error, another forgot to put on a grounding cautery pad, a third forgot to put in a Foley catheter — all things that go against accepted practice," she notes.

Many transcription errors were reported because, as Rogers points out, only a relatively few hospitals currently use computerized physician order entry (CPOE). "There's still a lot of [hand] transcription, and there are lots of ways things can get incorrectly transcribed," Rogers observes. "And computerized charting is supposed to make things expeditious, but one nurse reported she mistyped something but couldn't get it corrected without help. Other times, computers went down."

Errors such as those are not necessarily going to hurt patients, Rogers continues, "but it *does* suggest a level of chaos going on. For example, late meds usually won't hurt the patient, but it can easily happen when one patient gets very sick and the nurse can't get to other patients."

Nevertheless, many errors *do* get caught. For example, Rogers recalls, one nurse prepared an IV incorrectly but noticed it was the wrong color. Another realized she initially had mistaken two "p" containers, Pepcid and Pitocin, but realized it as soon as she grabbed the wrong container.

"That's what you want — an alert, vigilant care provider," Rogers adds. "We're all human."

Minimize distractions

From this and earlier studies, Rogers is convinced that one strategy that could help lower error rates is reducing distractions. "This is critical for people in high-risk occupations," she asserts. "Most other occupations of this kind operate in an environment that is very quiet, with few distractions. Nurses, however, perform in a very chaotic environment."

Some facilities, Rogers says, have made it possible for nurses to prepare meds in the middle of a hallway, away from distractions. In a small study, the nurses who prepared meds were provided with brightly colored vests, and other staff were instructed not to disturb them unless there was an emergency.

"Minimizing the distractions would help a lot in reducing errors. Just think of traffic controllers, or pharmacists mixing meds," she continues. "It's

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very hard to maintain accuracy when you are multitasking; we need to manipulate the environment to make things easier for nurses to do."

In terms of reducing medication errors, purchasing decisions can make a huge difference, Rogers says.

"We had a number of heparin-related errors. When I first graduated [from nursing school], we knew to watch heparin closely, because it came in two different strengths — 1,000 units and 10,000 units per cc. It's legitimate to have both, but they are known to be easily mixed up. If the pharmacy can draw it up downstairs, your error rate really drops," she adds. "And if the pharmacy buys the pre-mixed solution, it drops to less than 1%. So if purchasing would buy the pre-mixed, or if the pharmacy did more mixing of IV flush solutions, it would reduce the risk of that error."

At first glance, this approach might seem to be much more costly, she concedes. "But if you factored in the nurse's time for mixing and think about the fact that you don't have enough nurses, it might balance out the cost."

Reference

1. Balas MC, Scott LD, Rogers AE. The prevalence and nature of errors reported by hospital staff nurses. *Appl Nurs Res* 2004; 17(4):224-230. ■

Norton Healthcare report will cover 200+ indicators

New publication to be most extensive of its kind

Norton Healthcare, a Louisville, KY-based organization that comprises four adult hospitals, a children's hospital, and a number of physician groups, soon will start publishing what is said to be the most extensive self-published report card of its kind, posting on its web site about 200 indicators of clinical quality.

Sources of the indicators include:

- from the National Quality Forum (NQF), all indicators and practices on hospital care, cardiac surgery, nursing-sensitive care, and safe practices;
- hospital quality measures from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare & Medicaid Services (CMS) indicators;
- JCAHO's National Patient Safety Goals;
- from the Agency for Healthcare Research and Quality (AHRQ), Patient Safety Indicators and Inpatient Quality Indicators.

"We plan to display our performance compared to a national average whenever available," says **Ben Yandell**, PhD, CQE, division director of clinical information analysis for Norton Healthcare. "Where we can, we will also show the Kentucky average."

Yandell directs a group of analysts that set up and maintain data on clinical issues and then analyze results.

Ongoing quality dialogue

Yandell says he has been working with Norton's quality department for a number of years, "and in the late 1980s, we started to talk about how to help hospitals be more transparent about what they do and inform the public about our quality."

This latest initiative logically follows from those discussions. "As for this current step, one of the reasons is the amount of attention being given nationally on indicators and the onset of public reporting," he notes. "This gave us a starting group of nationally designed indicators."

Norton started paying close attention to the NQF and the work it has been doing endorsing measures about a year ago, Yandell continues.

"They check out other people's indicators and endorse them, so we said, 'Let's start there,'" he recalls. "Everything they've endorsed, if it applies

Key Points

- The publication on the web will include indicators from the National Quality Forum, Joint Commission on the Accreditation of Healthcare Organizations, Agency for Healthcare Research and Quality, and Centers for Medicare & Medicaid Services.
- Only national sets will be used to maintain transparency for consumers and competitors.
- Kentucky hospital contends this new initiative will cause staff to pay greater attention to quality.

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to us, we used it. Then we added JCAHO and CMS measures, which is not unusual, and responded to the National Patient Safety goals. And to liven things up, we included all the AHRQ patient safety indicators and inpatient quality indicators."

In determining which indicators were to be used, some rules were laid down. "It has to be a national set; we don't want any homegrown indicators, because we want to be transparent — no black-box methodologies," Yandell explains.

"With all of these, you know what the rules are. We can run comparisons about our competitors in Kentucky, and they can run them on us. We think that's important — in fact, we like it. Also, choosing national sets means it's evidence-based," he says.

Quality check continues

The Norton quality professionals remain key players in the process, Yandell says. "They've been involved in all the work we've done with JCAHO and CMS, which was our first plunge into public reporting; we were the first large system in Kentucky to voluntarily report," he notes. "As we've done our homework on different pieces — such as AHRQ — we've sent them those, and they gave us feedback."

Not surprisingly, the quality staff agreed with some of the indicators, but not with others.

"However, we do not have to agree exactly with a definition; we will use an indicator even if we think the definition is not exactly right," adds Yandell.

He says he expects many future changes and believes the list of indicators will grow rapidly. "Look at the history of the AHRQ indicators. They put out things that seem to work, then people complain and they refine them. But this only happens if people measure themselves on it — and *care*."

In terms of future changes, Norton has joined NQF "so that we can be one of the voices at the table to say what we like and don't like, and we hope other hospitals will do that, too," he says.

One of the main reasons Norton is doing this, he says, is "it makes us pay even more attention to quality. But it also turns the heat way up on us to measure it right, to put resources to it, to improve if we're not where we ought to be."

That pressure will begin this month, at which point the information should be posted on the Norton web site. "We are doing this in the spirit of accountability, not marketing," Yandell stresses.

It will not require great clinical sophistication on the part of the public, because rankings will be color-coded. "The public can tell red from green, so if your area is highlighted, it will get your attention," he notes.

Will this cause any consternation among staff? "Staff may question if we are using the right indicator or the right data, but to their credit, that phase does not last as long as it did at one time," Yandell says.

"The quality managers are getting used to the idea that we are measured in quantified ways that are not perfect but are at least correlated with the truth, and they will respond." The dominant effect, he says, will be that staff will try to raise their quality scores.

Yandell says he doesn't know of any other organization that is doing what Norton is doing. "We've been in contact with the NQF, and they said they are not aware of anyone doing this as extensively as we are," he reports.

Yandell says he is not entirely happy with his role of being a pioneer.

"It's fun, and it's scary; but we hope we are not at the front of the line for long," he adds. "It's just like having a fax machine; it's only useful when other people have it, too. We do not want to be 'Lone Rangers' for very long." ■

Cooperative uses grant to evaluate quality plan

Joint venture will involve academic researchers

The University of Washington (UW) School of Public Health and Community Medicine in Seattle has received a two-year, $656,000 grant from the Robert Wood Johnson Foundation to evaluate the impact of Group Health Cooperative's recent innovations to improve access and quality of care for its members.

Key Points

- Ease of access as well as extensive electronic sharing of information characterize the program.
- Physicians receive incentives based on measures of productivity, cost, and quality.
- The model covers range of care, from primary care and prevention to palliation/hospice.

Group Health is a Seattle-based, nonprofit integrated health care system including one hospital, a number of outpatient clinics, physicians, and health plans that coordinates care and coverage for nearly 540,000 people in Washington and Idaho.

The study will review what Group Health calls its Access Initiative, a six-point plan to improve quality and access that has been rolled out over the past several years. The plan includes:

- offering patients same-day appointments to primary physicians;
- allowing patients direct access to most specialists, eliminating the need to go through primary care doctors to make appointments for specialty care;
- providing patients access to their own medical histories, appointment schedules, immunization records, and other health care information over a secure member web site;
- encouraging patient-physician e-mail communication via a secure web portal called *MyGroupHealth*;
- providing physicians and other providers with a $40 million clinical information system that offers up-to-the-minute patient health information, such as lab, X-ray, and pharmaceutical data;
- providing physicians with new incentives based on measures of productivity, cost, and quality.

"Our findings will be relevant to all people interested in issues of quality and access, regardless of what model of health care they represent," said **Eric B. Larson**, MD, MPH, director of Group Health's Center for Health Studies (CHS) and a co-investigator of the study, upon the announcement of the grant. "This is a seminal observation opportunity."

The CHS conducts research related to prevention, diagnosis, and treatment of major health problems.

David Grembowski, PhD, professor of health services in the UW School of Public Health and Community Medicine, is the principal investigator. He and his colleagues will use Group Health's automated databases, member and physician satisfaction surveys, patient visit surveys, and in-depth interviews with care providers. Based on the data, they will determine how the access initiative is affecting factors such as cost, utilization of services, quality of care, member enrollment, and patient and provider satisfaction.

"We have a structured set of questions we will be asking," Grembowski explains. "First of all, we will look at what we call the 'take-up' of the initiative: Are they making same-day appointments? Are visits to specialists increasing? The second thing we want to look at is, did access actually increase? In other words, if you put this package out there in a group health system, is there actually an increase in access? Also, we want to see if satisfaction with care has increased as well. The final question we want to look at is, if we *do* find access has increased, is the quality of care better?"

Other UW researchers contributing to study will be Douglas A. Conrad, PhD, and Diane P. Martin, PhD. Other CHS researchers on the project are **Paul Fishman**, PhD, and James Ralston, MD, MPH.

Full-range access

The leadership of the Group Health Initiative "is attempting to increase consumer access to the full range of preventive, palliative, and health services," Fishman explains. "This includes everything from primary care and prevention to palliation/hospice. And it's not simply to make sure the senior patients have access to their cardiologist, but that the patient has *same-day* access."

This part of the initiative has been in place the longest — since 2001, in fact. "To do it, they had to get rid of the backlog, so there was a short-term crunch," Grembowski notes. "But once you got over that, it was just dealing with the same-day appointments. The caveat is, you may not have the appointment with your personal primary care provider, but Group Health physicians work in clusters of three or four, so the appointment is kept within the cluster."

"I was not convinced as a consumer that this would be a big deal," Fishman adds. "But it really makes a difference — to be sitting there at midnight needing to see a doctor, sending an e-mail and having an appointment the next day."

The extensive electronic contact is significant,

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Grembowski adds. "Patients also have access to their electronic medical records over the web, and they can also do prescription refills.

"They can not only schedule office appointments online, but also obtain visit summaries. And if you are seeing a physician for a specific medical problem, the system will automatically send health care information about that condition to your e-mail address," he notes.

"The web-based initiative is, quite frankly, amazing," Fishman says. "Currently, about 30% to 40% of our patients are registered."

Financial incentives are another unique aspect of the initiative. For example, Grembowski adds, physicians get financial credit for responding to patients' e-mail messages.

"It's part of their compensation. Historically, Group Health physicians have been paid on a salary that was 100% guaranteed. Now, it's 80% guaranteed, and they can earn from 80% to 120% based on productivity, quality of care, and accuracy of coding," he says.

Peer review imprimatur

The reason the Group Health has sought such a study, says Fishman, is quite straightforward: "We are trying to get this initiative to have the imprimatur of peer review," he asserts. "We want this work to be subject to that standard, and then to make sure the heath plan is responsive. When we say, 'Here's what we've learned,' we want them to be responsive to this."

The two-year grant ends November 2006. By that time, the researchers hope to gain understanding in several key areas: for example, whether physicians are responsive to alternative means of compensation and whether consumers are responsive to alternative venues of care, Fishman says.

"The literature shows that when the gatekeeper is eliminated, there aren't significant levels of change in care or in how people choose care. We have the opportunity to study these issues in ways others don't. Typically, these studies have only looked at physician care, but we can track how people move through the entire system." For health care quality professionals, he adds, the study should shed additional light on the relationship between health outcomes and quality measures.

"We will see whether there are relationships between all theses factors; we have a chance to do things others don't," Fishman concludes. ■

NQF publishes report on cardiac surgery measures

The National Quality Forum (NQF) has published a new set of national consensus standards, "National Voluntary Consensus Standards for Cardiac Surgery," which provides a standardized set of measures and framework for improving the quality of cardiac surgery (which accounts for about 14,000 in-hospital deaths each year).

The report details quality standards endorsed by the NQFs more than 250 member organizations through its formal Consensus Development Process. As such, the measures have special legal standing as voluntary consensus standards.

The set includes 21 hospital-level measures that facilitate efforts to achieve higher levels of patient safety and better outcomes for patients. These measures are intended for public reporting.

The measures include:

- participation in a systematic database for cardiac surgery;
- surgical volume for isolated coronary artery bypass graft (CABG) and CABG+valve surgery;
- timing and selection of antibiotic administration for cardiac surgery patients;
- preoperative beta blockade;
- use of internal mammary artery;
- duration of prophylaxis for cardiac surgery patients;
- prolonged intubation;
- deep sternal wound infection rate;
- stroke/cerebrovascular accident;

- renal insufficiency;
- surgical re-exploration;
- antiplatelet and antilipid medications and beta-blocker at discharge;
- risk-adjusted CABG inpatient mortality;
- risk-adjusted operative mortality for CABG;
- risk-adjusted operative mortality for aortic valve replacement (AVR), mitral valve replacement/repair (MVR), AVR+CABG, and MVR+CABG.

The executive summary of the report with a list of endorsed performance measures can be found on the NQF web site at www.qualityforum.org/. ■

(Continued from cover page)

required federally under standardized requirements. Thomson American Health Consultants' audio conference, **Law of the Land: Meeting the Challenge of Mandatory Infection Rate Reporting** will help you prepare for these looming regulations. Join us April 7, 2005, from 2:30 to 3:30 p.m. EST to find out more about the Centers for Disease Control and Prevention's (CDC) recently released template for new state laws or a national reporting system.

Crafted by the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), the document recommends three process measures and two outcome measures that could be reported under infection rate disclosure laws.

Our distinguished faculty includes one of the principals behind the new CDC guidance, **Patrick Brennan**, MD. A hospital epidemiologist at the University of Pennsylvania in Philadelphia and HICPAC chairman, Brennan also worked with state officials when the law there was under discussion.

Likewise, our other speaker was heavily involved in the shaping of the infection rate disclosure law in Missouri. **Eddie Hedrick**, BS, MT (ASCP), CIC, has been an infection control professional for 34 years. A veteran of hospital epidemiology, he now is the emerging infections coordinator at the Missouri Department of Health and Senior Services in Jefferson City.

Don't miss this important and timely audio conference, which will serve as an invaluable resource for your entire staff. Your fee of $199 includes presentation materials, additional reading, and free continuing education. For more information, go to www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at ahc.customerservice@thomson.com. When registering, please reference code **T05126-79113**. ■

NEWS BRIEFS

Overworked interns risk car crashes

First-year doctors in training, or medical interns, who work shifts of longer than 24 hours are more than twice as likely to have a car crash leaving the hospital and five times as likely to have a "near miss" incident on the road as medical interns who work shorter shifts, according to an article in the Jan. 13 issue of the *New England Journal of Medicine (NEJM)*.

The article, "Extended work shifts and the risk of motor vehicle crashes among interns," is the third in a series of studies on the impact of extended work hours and fatigue on interns conducted by the Divisions of Sleep Medicine at the Brigham and Women's Hospital and the Harvard Medical School in Boston.

The first two studies were published in the Oct. 28, 2004, issue of *NEJM*. All three were co-funded by the Agency for Healthcare Research and Quality and the National Institute for Occupational Safety and Health.

Laura K. Barger, PhD, research associate in medicine at the Brigham and Women's Hospital and Harvard Medical School, and her colleagues recruited 2,737 interns from medical institutions around the country to fill out detailed monthly

COMING IN FUTURE MONTHS

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surveys recording their work hours, frequency of shifts of more than 24 hours, and driving safety records, including car accidents, near-miss incidents in which property damage was narrowly avoided, and incidents involving falling asleep while driving or while stopped in traffic.

More than 17,000 surveys were collected between April 2002 and May 2003. Researchers also randomly selected 7% of study participants to keep daily work diaries that were verified through direct observation.

The study found that the majority of interns routinely worked more than 30 consecutive hours, and they reported that they were awake 96% of their time in the hospital on average.

Also, during the 12-month study period, interns reported working an average of 80 hours or more during 46% of work weeks and 100 hours or more per week during 11% of work weeks.

Study participants reported a total of 320 accidents during the 12-month study period, including 133 that resulted in treatment in the emergency department, property damage of more than $1,000, or the filing of a police report.

Slightly more than 40% of the 320 crashes occurred on the commute from work. Every extended shift that was scheduled per month increased the monthly rate of accidents on the commute from work by 16% and the monthly rate of any car accident by 9%.

Interns also were more than twice as likely to fall asleep while driving or more than three times as likely to fall asleep while stopped in traffic in months in which they worked five or more extended shifts. ▼

Minnesota Medicaid applies NCQA standards

Health plans in the state of Minnesota accredited by the National Committee for Quality Assurance (NCQA) will gain a new benefit under an agreement reached by the state and NCQA: The Minnesota Department of Human Services, the state's Medicaid agency, will apply NCQA accreditation standards to five major areas of the department's annual quality review required under federal law.

Standards will be applied where they are consistent with federal and state managed care contract requirements in the areas of credentialing, utilization management, grievances, quality improvement and delegation.

This determination will reduce an NCQA-accredited health plan's overall oversight burden.

For more information about federal or state recognition or to inquire about the NCQA accreditation process, contact Patricia Pergal, director of public policy, at (202) 955-3595. A complete listing of states that recognize NCQA accreditation is available at www.ncqa.org. ■