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GOVERNANCE REFORM INITIATIVES IN NOT-FOR-PROFIT HEALTH CARE ORGANIZATIONS

By David A. Bjork, Ph.D.

Governance reform is well underway, according to Clark Consulting's recent survey of governance practices in not-for-profit health care organizations (see sidebar about survey details on page 4). The survey shows that governance practices were already strong in many hospitals and systems. But it also shows that some boards have a long way to go in meeting emerging standards that represent best practices in governance.

The scandals that led to passage of governance reform legislation ("Sarbanes-Oxley") and other governance reform initiatives came largely out of the for-profit sector. One reason is that stock options give executives an incentive to pump up earnings (or earnings statements). Another is that boards of for-profit companies are made up of peers (friends, colleagues or "cronies") of the CEO, folks who are accustomed to considerable independence in leading their own companies, who understand that CEOs resent as interference any second-guessing, skepticism, or probing by outside board members.

For now, the new governance rules apply only to for-profit firms with publicly traded stock. But most observers believe they will eventually be extended to not-for-profits by the courts, legislators, regulators, bond underwriters or liability insurers as the rules come to be viewed as best practices in governance. New York State is considering legislation to do just that and Moody's has said its credit ratings may take governance practices into account. The Coalition for Nonprofit Health Care, the American Governance & Leadership Group, the Governance Institute and the American Health Lawyers Association have all urged boards to take the new rules seriously. The Health Care Compliance Association is even starting to consider good governance a compliance issue.

Boards of not-for-profit hospitals and systems have generally been more independent of management and more focused on their stakeholders than directors of publicly-traded firms have been. CEOs of not-for-profit organizations rarely sit on boards of for-profit businesses or other not-for-profit organizations, so the interlocking boards and compensation committees found in the for-profit sector are almost unheard of in the not-for-profit sector. Boards of not-for-profits aren't paid in stock options, so they have no reason to overlook questions about transactions or accounting treatments that would drive up share price.



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But the not-for-profit sector has seen its own share of scandals revealing weaknesses in governance. The best example of weak governance in health care may well be AHERF. But remember William Aramony and the outcry 12 years ago at the national office of United Way? Now there's a scandal at the United Way of Washington, D.C. Remember the controversy over conversion of Blues plans in Ohio and Maryland? And the recent outcry over excessive compensation at the New York Stock Exchange?

The most important difference between not-for-profit and for-profit boards, we believe, is that directors of not-for-profit organizations feel more accountable for the success of the organizations they govern than directors of for-profits do. They view the organization as belonging to the community; as something that they, as community members, have a major stake in. They rarely view the CEO as the undisputed leader of the organization, because community physicians have a major stake in the organization, too, as do their neighbors who work at the hospital, and their friends and family members who go there for care. They don't view anonymous strangers as the principal stakeholders, as boards of for-profit firms often do.

As a result, boards of hospitals and health systems have generally had a reasonably strong and independent governance process. Many of the reforms called for in the new regulations match practices that not-for-profit boards have been following for years, as our survey results show.

- The best example is that not-for-profit boards almost always separate the roles of board chair and CEO.
- More than half have separate audit, compensation, and governance committees. Most of those have had these committees for more than two years (before the time that governance reform got serious).
- More than two-thirds already have a governance committee charged with periodically reviewing the governance process and evaluating the effectiveness of the board, its committees, and individual members. Most of these have had one in place for more than two years.
- Most (66%) are bringing information on CEO compensation to the board as a whole, and more than half have been doing so for more than two years.
- Almost all (86%) have had a policy addressing directors' conflicts of interest for more than two years.
- Almost as many (70%) have had a policy on business ethics and practices for more than two years.
- Three-quarters of them periodically review total compensation for all executives, not just the CEO, and 64% have been doing so for more than two years.

Still most boards have been taking the call for strengthening governance and corporate accountability seriously. These are some of the initiatives they have taken in the past year.

- Most (83%) have formally reviewed their governance process to evaluate its effectiveness.
- Most (84%) have formally reviewed their corporate bylaws and policies to ensure that they match actual practice.

- Most (72%) have changed their bylaws and policies to better match actual governance practices and processes.
- Most (64%) have formally reviewed the new rules set by Sarbanes-Oxley and the SEC.

Boards may be focusing too narrowly on Sarbanes-Oxley, however. The new rules set by Sarbanes-Oxley and the SEC focus primarily on the audit function, not on governance generally. The stock exchanges have developed more comprehensive governance standards, which health care boards should consider. Some of the standards that fit not-for-profit organizations include:

- Holding executive sessions on a regular basis without management present
- Creating audit, compensation and nominating (or governance) committees composed only of independent directors
- Requiring that audit committees have one or more members with expertise in accounting or financial management
- Disclosing audit, compensation and nominating (or governance) committee charters that include the committee's purpose, responsibilities, membership criteria, yearly performance evaluation, and how the committee reports to the full board
- Disclosing board member qualifications and duties, how directors are compensated, processes for orienting and educating trustees, yearly self-evaluation of board and committee performance, succession planning for management, regular review of CEO performance, and the right to have contact with management and outside advisors

The new listing requirements of the stock exchanges are broader, clearer and better prescriptions for governance reform, and they represent a consensus based on many governance reform proposals, including those by the Conference Board, the Business Roundtable, the National Association of Corporate Directors, and the Council of Institutional Investors. Yet, few survey respondents indicate that they have looked at the broader set of recommendations coming from these organizations.

- Only 14% have formally reviewed the new rules proposed by the stock exchanges.
- Only 46% have formally reviewed other proposals for governance reform.

More important is the finding that, even after undertaking a serious review of governance, many boards are not adopting the most important reforms.

- Only 21% have set a new policy calling for regular meetings in executive session.
- Almost none of the boards that do not already have separate audit, compensation, and governance committees are considering establishing them.
- Almost none of the organizations that do not already bring CEO compensation information to the board as a whole are now considering doing so.

Just as important is the finding that boards seem to be taking Sarbanes-Oxley more seriously than intermediate sanctions legislation (Section 4958). This legislation applies directly to not-for-profits and the requirements for minimizing the risk of intermediate sanctions are clear, yet surprisingly few survey respondents are taking the simple steps needed to establish a rebuttable presumption of reasonableness for compensation of their executives and other disqualified individuals.

- Less than half (41%) have formally established a rebuttable presumption of reasonableness for all disqualified individuals.
- Only 31% of them have been doing so for more than two years, despite the fact that the law was passed eight years ago.
- Almost none of those that have not already done so are now considering doing so.

The requirements for establishing a rebuttable presumption of reasonableness are straightforward. Any transaction, such as purchase, joint venture, compensation, or employment agreement, with a "disqualified person" (an "insider" who might have enough leverage to get more than a fair deal) must be approved by an independent board; the board must get and rely upon appropriate comparability data; and it must document its decision, the process followed and the rationale for its decision in timely minutes. Absent an adequate record of having followed this good governance process, the IRS can easily challenge the transaction and impose penalties on both the recipient and on anyone (including board members) who approved the deal.

There is a consensus emerging on what constitutes "best practices" in governance. At least there is a consensus on general principles and on the direction

boards should move to strengthen governance. Because emerging rules and standards have been established mainly to protect investors, however, they will have to be modified to fit not-for-profit healthcare organizations. These modifications need to focus on accountability to the community, to lenders and to donors, instead of to shareholders.

Hospital and health system boards should decide which of these new standards fit their organizations. Since one of the most important new standards involves transparency and full disclosure, they should decide how to communicate with their communities. Boards should determine, for example, whether the annual report should continue to be a glossy promotional publication or a document that discloses material facts, such as JCAHO violations or malpractice litigation, that may have a bearing on the organization's future, much like the information that publicly traded companies are expected to disclose. Boards should also determine what types of responsibilities to take on, such as oversight of executive compensation and succession planning, that may previously have been delegated to the CEO.

Since most of the new standards are implicit in state statutes governing not-for-profit organizations, they aren't all that different from established patterns of governance in health care—but they do call for more formality, more clarity, and more transparency and disclosure. Boards would be wise to take a proactive approach and adopt as many of them as fit their circumstances, rather than wait until the requirement to do so is thrust upon them by outsiders. They should also let their constituents know what steps they are taking to strengthen their governance practices. Reporting what they have done is one of the best ways for boards to demonstrate accountability to the community. It is also the best way to demonstrate their commitment to ongoing improvement of governance and leadership practices.

ABOUT THE SURVEY

Clark Consulting's survey results were based on responses from 230 health care organizations. Respondent demographics are as follows.

- 92 are hospital systems.
- 123 are independent hospitals.
- 27 are subsidiary hospitals.
- 8 are non-provider organizations.
- Of the participating systems, 44 are integrated delivery systems; 24 of these have major teaching programs. Of the participating hospitals, 24 have major teaching programs and 24 are children's hospitals.
- Almost half of responding organizations have net revenues between \$100 and \$500 million.
- Respondents are regionally distributed throughout the U.S., with the highest percentage (31%) of respondents located in the North Central states.
- Data on 20 single hospital systems were included in both the system and hospital analyses.

Watch for more on the Clark Consulting survey on governance reform initiatives in upcoming publications from *American Governance Leader*. ■

David A. Bjork, Ph.D., is Managing Director at Clark Consulting, a nationally recognized consulting firm with 77 offices, that develops and delivers services and solutions to help companies keep their best people. It provides expert services on executive compensation, retirement plans, public policy and other issues through Pearl Meyer & Partners and its Banking Practice, Executive Benefits Practice, Healthcare Group and Federal Policy Group. The Healthcare Group is the country's leading authority on executive compensation in the health care industry.

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HEALTH CARE GOVERNANCE NEWS

Two Healthcare Organizations Receive Baldrige Quality Award For 2003

For the first time since the program's inception in 1988, two health care organizations were among the recipients of the 2003 Malcolm Baldrige National Quality Award. Baptist Hospital, Inc. in Pensacola, FL and Saint Luke's Hospital of Kansas City were among the seven US organizations honored this year for outstanding quality improvement programs and results.

Baptist Hospital, Inc., a subsidiary of Baptist Health Care, was specifically recognized for overall inpatient and outpatient satisfaction near the 99th percentile, and for patients ranking the sensitivity, attitude, concern, and overall cheerfulness of hospital staff near the 99th percentile for several years running. Specific initiatives of Baptist Hospital that were cited by the examiners included their program for determining key health care process requirements; their reports for integrating clinical quality, customer satisfaction and financial results data; and the Bright Ideas program, which solicits innovative suggestions for improvement from all levels of the organization. In addition, the examiners noted Baptist Hospital's highly successful improvement efforts for improving employee morale and decreasing turnover over a six year period.

Saint Luke's Hospital of Kansas City was also recognized for successful programs addressing employee turnover, and for demonstrating improved financial performance on several key indicators over a four year period. Successful improvement processes highlighted by the examiners included St. Luke's Medical Staff Clinical Indicator Index, used to track 58 critical measures of clinical quality, and its team-based practice of designing and redesigning clinical pathways for high-volume, high-cost diagnoses. In addition, patients have rated Saint Luke's the top provider of quality health care of 21 area facilities every year since 1997.

The 2003 Baldrige Award recipients were selected from among 68 applicants, and rigorously evaluated in seven areas: leadership, strategic planning, customer and market focus, information and analysis, human resource focus, process management, and results. The evaluation process included about 1,000 hours of review as well as on-site visits by teams of examiners. For more on this year's winners, go to http://www.nist.gov/public_affairs/releases/2003baldrige_winners.htm ■

Survey Says Healthcare Inflation Will Slow In 2004 – Slightly

An annual survey of health insurers and pharmacy benefit managers revealed the growth rate for health plan claim costs will likely decrease—ever so slightly—in 2004. Nonetheless, double-digit rates of increase will continue, and the rate of inflation for health care costs will remain between three to five times the general inflation rate, the report predicts.

Per capita claims costs for HMO plans covering prescriptions will rise 13.7% in 2004, according to the survey by Segal Co., a New York benefits consulting group. The forecasted rate of cost inflation for these HMOs was slightly higher for 2003—14.4%—while the actual increase in claim costs for all HMOs in 2002 was only 12.8 percent. Claim costs facing PPOs with prescription coverage are expected to rise 14.4% in 2004, just under last year's predicted increase of 14.5%. The actual growth rate for all PPO plans, with or without drug coverage, was 13.9 percent in 2002.

Prescription drug costs, which are expected to grow 18.1% in 2004, continue to be the fastest-growing component of health plan expenses. The 2004 forecast, however, is notably lower than the 19.5% predicted inflation rate for 2003, and slightly lower than the 18.4% increase in plan drug costs that did occur in 2002. As a measure of forecast accuracy, the survey report indicates that respondents overestimated the amount by which drug

costs would rise in 2002 by 1 percentage point for all enrollees, and 3.5 points for seniors.

The report suggests that in addition to price inflation and an aging workforce, factors serving to drive up claim costs include the health care labor shortage, rising malpractice premiums, and increased direct-to-consumer drug marketing which encourages increased utilization of health benefits. Moreover, consolidation of for-profit health care providers and their increasing sophistication in contract negotiations has made it difficult for plans to contain costs. At the same time, fixed-dollar copayments erode in value as the prices of medical services rise, thus decreasing the relative cost to patients and encouraging increased use of services.

Another recent survey by Mercer Human Resources Consulting explored anticipated changes in employee health plan costs, and predicted they will rise even more in 2004 (13%) than in 2003 (10.1%). The annual survey of nearly 3,000 employers also confirmed that more health benefit costs were shifted to employees in 2003, with employee average contributions rising 31-35% and family contributions rising 50-57%. For more on the survey, go to <http://www.mercerhr.com>. For the full report on the Segal Co. survey, visit <http://www.segalco.com/publications/surveysandstudies/2004trendsreport.pdf> ■

Reports Reveal Discouraging Trends In HIV Awareness, New Cases

According to a release by the Centers for Disease Control on World Aids Day, the number of new HIV cases in the US grew 5.1 percent between 1999 and 2000. The CDC estimates that between 850,000 and 950,000 Americans are now living with HIV—the greatest number since the epidemic began more than two decades ago.

The new analysis of 102,590 people diagnosed with HIV in the 29 states between 1999 and 2002 shows that

African-Americans continued to account for more than half (55%) of the new diagnoses. Additionally, significant increases in new HIV diagnoses were observed among Latinos (26% increase) and non-Hispanic whites (8% increase). HIV diagnoses increased 17 percent among gay and bisexual men, and 7 percent among men overall.

The CDC believes that the growth in diagnoses is probably attributable to actual new infections rather than more widespread testing, even though a new HIV test delivers preliminary results in as little as 20 minutes. A survey released November 25 by Harris Interactive seems to support the CDC's assumption, as well as its assertion that more prevention and HIV awareness efforts are necessary.

According to the Harris poll, 60 percent of heterosexual adults have never been tested for HIV/AIDS, with 85 percent of respondents in this group saying they haven't been tested because they don't consider themselves at risk. The authors of the Harris poll say this attitude indicates a misperception about the risk factors associated with contraction of the HIV virus, and reveals that complacency about AIDS is still widespread in America. Testing rates were better among the gay, lesbian, bi-sexual and transgender population, with only 35 percent saying they had never been tested.

According to CDC estimates, about one fourth of the people living with HIV, or between 180,000 to 280,000 people, remain unaware of their infections. An estimated 40,000 new HIV infections continue to occur in the US each year. For more on the CDC's study, visit <http://www.cdc.gov>. For results of the Harris Interactive survey, go to <http://www.harrisinteractive.com> ■

JCAHO To Develop New Hospital Leadership Standards

The Joint Commission on Accreditation of Healthcare Organizations plans to develop a revised set of standards addressing leadership accountability, and the responsibilities of hospital administra-

tion, the governing body and the medical staff, according to *AHA News Now's* November 18 issue. The new standards framework will be crafted with input from leadership groups, professional societies and associations, JCAHO said.

The revised leadership framework will also establish new expectations regarding conflict resolution, and will omit proposed language that would have barred any language in governing body or medical staff bylaws that would allow unilateral amendment of medical staff bylaws.

According to a letter to JCAHO-accredited hospitals that went out in November, field review of the proposed standards showed that working relationships among the three groups of hospital leaders might benefit from a revised definition of their respective accountabilities and

responsibilities. The Standards and Survey Procedures Committee has instructed JCAHO staff to work through its consensus-building process to create the new leadership framework.

In related JCAHO news, the Standards and Survey Procedures (SSP) Committee approved a new element of performance (EP) for the Medical Staff chapter (standard MS.4.20) for hospitals at its Oct. 16 meeting. The new EP will require a listing within the organization of the privileges of each Physicians Assistant or Advanced Practice Registered Nurse, and makes each licensed independent practitioner responsible for knowing the privileges of those practitioners with whom they collaborate or whom they supervise. For more information, go to www.jcaho.org ■

Leapfrog Proposes New Scheme For Scoring Hospital Safety

The Leapfrog Group has asked for comments on a new rating system for evaluating hospital safety under its national reporting program. The proposed scoring method would give partial credit for showing progress on the 27 patient safety practices the group has identified as critical, and would weight some practices more heavily than others.

For example, the first safety practice, "Creating a healthcare culture of safety," would now have a total point value of 263 points out of a possible 1,000 possible points on the whole survey. Practices deemed less critical would have lower point values assigned to them. The practice called "optimizing medication work spaces" carries only seven possible points under the new framework, while "vaccinating workers against influenza" is assigned a total possible score of 11. For each practice, the total point value can be divided across four dimensions of progress: awareness, accountability, ability and action, and the total number of points a hospital earns across the 27 practices would determine its score.

The Leapfrog Group is a coalition of more than 150 public and private health care organizations involved in a nationwide, voluntary safety reporting project. Care providers who participate will have their safety scores posted on the Leapfrog website. The criteria used by Leapfrog to measure hospitals' performance on patient safety are endorsed by the National Quality Forum and were developed by consensus after going through a rigorous vetting process. To view the proposed survey, go to <http://www.leapfroggroup.org/Survey/PAN.pdf> ■

Better Care Often Results In Lower Medicare Reimbursement, Hospitals Say

Health care organizations committed to improving the quality and efficiency of care are finding that Medicare rarely rewards their efforts. In fact, health care executives say that in many cases, improved care and outcomes result in decreased reimbursements from Medicare, and even negative profit margins on certain types of care, according to a December 5 article in *The New York Times*.

Health care leaders interviewed for the *Times* story called the system "perverse," and offered several examples of how reducing complications and shortening or avoiding hospital stays often results in much lower reimbursements from Medicare, some so low that hospitals sustain a net loss for providing better care. Since sicker patients or those with complications require more services, which in turn generate more Medicare

The number of new HIV cases in the US grew 5.1 percent between 1999 and 2000.

—Centers for Disease Control

reimbursements, the system rewards poor care, the article concludes. For example, hospitals stand to lose money by reducing the number of adverse medication events that occur, since they would be reimbursed for treating them.

Dr. Brent C. James, the director of quality improvement for Intermountain Health Care, told *The New York Times* that improved care protocols for treatment of pneumonia and congestive heart failure have saved around 370 lives and 600 hospital stays per year. Ironically, they have also cost the 21-hospital network an estimated \$5 million per year in potential Medicare payments. While their margin on the treatment of pneumonia used to be around 19%, they now lose several hundred dollars on each case, since they receive either a token payment on primarily outpatient treatment, or a fixed payment that is too small for the very sick patients that they admit.

While Medicare's establishment of fixed payments for specific treatments gave providers incentives to provide more efficient care 20 years ago, the incentive structure has since fallen far behind the tide of quality improvement and cost-saving initiatives. According to experts interviewed for the article, a more reasonable approach would be to tie payments to performance, and to reward hospitals for saving Medicare money by avoiding unnecessary services.

The article is available for purchase at <http://www.nytimes.com> ■

Nursing Is A Respected And Increasingly Sought-After Profession, Polls Suggest

According to two recent surveys, nursing is not only seen as one of the most ethical professions, but also considered a desirable career by increasing numbers of students entering first-year baccalaureate programs.

Nurses scored the highest in this year's Gallup poll rating the honesty and ethics of 23 professions, with 83% of respondents rating them "very high" or "high" on those two criteria. Nurses have ranked as the professionals most known for honesty and ethics in four of the five years for which nursing was included in the survey. The only year they did not top the list was 2001, when firefighter was judged by Americans to be the most

ethical occupation. In this year's survey, doctors and veterinarians were judged the most honest and ethical professionals by 68 percent of respondents, followed by pharmacists at 67 percent. HMO managers ranked second to last, just ahead of car sales people.

Another survey by The American Association of Colleges of Nursing (AACN) found that enrollments in entry-level nursing programs increased by 15.9% in the fall of 2003, after an 8.1% increase in 2002 and a 3.7% increase the previous year. The recent growth in enrollments follows a six-year period of decline in enrollments, and is expected to continue and perhaps gain momentum over the next ten years. Nonetheless, the AACN report notes that the increase in supply of nurses will still not be adequate to solve the nation's nursing shortage, or even to replace nurses retiring in the coming years. To do that, nursing school enrollments would have to increase 40% annually, experts say.

For more on the nursing survey, go to <http://www.aacn.nche.edu/>. For details on the Gallup poll, visit <http://www.gallup.com> ■

Study: Reducing Medication Errors Should Be Key Patient Safety Goal

U.S. Pharmacopeia's research unit recently analyzed the group's MEDMARX database to determine how relevant the JCAHO's four medication-related safety goals were to medication errors reported by 482 facilities nationwide. The findings appeared to validate the JCAHO's selection of patient safety goals, and also provided some insight on how they might be improved, the report says.

Of the 192,477 medication errors documented by MEDMARX and analyzed in the study, the vast majority were corrected before causing harm to the patient. However, 3,213 errors (1.7 percent) resulted in patient injury, including 514 errors requiring hospitalization, 47 requiring interventions to sustain life, and 20

resulting in a patient's death. Compared with 2001 data, a smaller percentage of reported errors resulted in harm to the patient (1.7 percent in 2002 versus 2.4 percent in 2001).

The analysis confirmed that JCAHO's high-alert medications were an appropriate focus of patient safety efforts, since 8 of the 10 products most often involved in harmful medication errors fell in this category. The top eight high-alert medications were implicated in 31% of errors causing harm to patients. Insulin, morphine, heparin and potassium were the medications that caused the most serious injury to patients. These four medications contributed to 21% of errors resulting in harm to patients.

The report also identified improper performance of tasks and conformance to protocols as leading causes of medication errors, with incorrect administration responsible for the largest number of harmful medication errors (6.2 percent). Examples include not diluting concentrated medications, crushing sustained-released medications, wrong eye application of eye drops, and using incorrect IV tubes for medicine administration. A large number of errors—nearly 1,850—were connected with the improper use of an IV infusion pump. Of these, 8.7% resulted in harm to the patient, including 20 cases where the patient died.

Communication problems among caregivers were the third most common cause of errors in 2002. Sources of communication errors included abbreviations, similar-sounding medication names, and use of nonmetric units such as drams and verbal orders. More than 8,000 errors were reported involving misidentifying patients or giving medication to the wrong patient, ranking seventh most frequent among error types and a factor in 4.7% of overall cases.

The results of the USP's analysis also included some surprises. For example, the report showed that patient identification errors occur throughout the hospital and at all steps involved in delivering

Nursing is not only seen as one of the most ethical professions, but also considered a desirable career by increasing numbers of students entering first-year baccalaureate programs.

medications to patients, and not just at the point of administration, as many safety experts may have assumed. Many identification errors resulted from incorrect entry of data in computer systems, for example by selecting the wrong patient from an onscreen list or mis-keying the patient's room or account number when entering orders or test results.

Another revelation of the study had to do with high-alert medications that are one focus of JCAHO's error reduction recommendations. A key goal of the JCAHO initiative was to get concentrated supplies of electrolytes such as potassium chloride off the nursing floors so they could not be used unless properly diluted. But in 2002, insulin was much more likely to be associated with errors, accounting for 3.5% of the total, and 8% of errors causing harm. It was also the drug most frequently associated with a prescribing error, and was most likely to be given to the wrong patient or without authorization. Only heparin and morphine were more often given in the wrong quantity.

The full report, titled Summary of Information Submitted to MEDMARX in the Year 2002: The Quest for Quality, is available upon e-mail request to mediarelations@usp.org ■

Solucient Study Forecasts Demand For Women's Health Services

A recent report by health information company Solucient predicts that women's utilization of several types of health services will grow briskly through the year 2027. Cardiovascular care, physical therapy, diagnostic tests, obstetrics and gynecology were named among outpatient services for which demand is expected to grow most rapidly over the next five years.

The report says that women's demand for cardiovascular and pulmonary services may surpass that for obstetrics and gynecology by the year 2027. This trend will in part be due to the fact that the number of women in the US will surge by 78 percent, or 16.4 million, over the next 25 years. Nonetheless, demand for outpatient gynecology is expected to grow about 50% between 2002 and 2007.

In addition to demographics and utilization trends, the report analyzed

gender disparities in the provision of care for certain diagnoses. For example, men who are diagnosed with heart disease are 34% more likely than women with the same condition to receive a cardiovascular stress test, although it is considered a key tool in managing heart conditions. A smaller disparity exists between the number of men and women receiving electrocardiograms in conjunction with heart disease.

Disparities in treatment patterns for different groups of women with heart disease exist as well. Although single mothers age 45-54 are the most likely to suffer from heart disease, they are 12 percent less likely to receive an EKG and 42 percent less likely to receive a cardiovascular stress test than the general population of women with cardiac diagnoses.

For more on the study's findings, which were based on a survey of 20,000 consumers plus data about demographics and utilization in Solucient's databases, visit <http://www.Solucient.com> ■

Palliative Care Programs On The Rise In Hospitals, With Good Results

Palliative care programs, or those specializing in the relief of pain, symptoms and the stress of illness, have grown in prevalence by more than 20% in the last year, according to the AHA's hospital statistics for 2003. And it's no wonder, writes Diane E. Meier, M.D, in *Hospitals and Health Networks*, since palliative care delivers benefits for patients, clinicians and the bottom line.

Since such programs draw upon resources already available in hospitals, they offer a cost-effective way to improve patients' experiences and satisfaction, and even customer loyalty and the facility's reputation in the community, the article says.

A standard feature of palliative care programs are palliative care consultants, who handle communications with

families, manage changing symptoms and plan for discharge and follow up services. Their efforts save considerable time for busy clinicians, and have the fortunate side effect of improving physician and nurse satisfaction and retention, Dr. Meier reports.

It is easy to see how these outcomes could ultimately translate into better financial performance. But the greatest cost savings comes from a much more important benefit of palliative care programs—improved quality of care. According to Dr. Meier, hospitals have found that providing palliative care to the sickest patients leads to shorter

hospital stays, earlier transitions to appropriate after-care settings, and lower ancillary and pharmacy costs. Dr. Meier cites a study by St. John's Regional Medical Center in Missouri, which found that the cost of treating patients receiving palliative care was \$1,064 less than for those who didn't receive similar care.

Earlier discharges also free hospital bed capacity for other patients, which will be important in the future, since a RAND study released in 2000 estimates that the number of chronically ill people will exceed 160 million by 2025. Given the range of clinical, costs and patient satisfaction benefits, introducing palliative care seems like good strategy for hospitals to begin preparing for this demographic change which is sure to stress the health care system.

Dr. Meier is the Director of the Center to Advance Palliative Care and the Hertzberg Palliative Care institute at the Mount Sinai School of Medicine in New York City. To view her article, go to <http://www.hospitalconnect.com/>, and look for *Hospitals and Health Networks* under "News Sources." ■

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— American Hospital Association