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Hospital-community networks help stretch meager resources

Cooperation solves public health issues, fiscal woes

Hospitals are in trouble. Although one-third enjoy fiscal well-being, another third are merely scraping by, and the rest are failing, according to a report, "Health & Health Care 2010: The Forecast, the Challenge," by the Robert Wood Johnson Foundation of Princeton, NJ. **(See information box at the end of this article.)**

A potential solution for some of the financial

Key Points

- Through partnerships with community institutions, hospitals may find their best hope for surviving financially and for addressing public health issues that consume shrinking health care resources.
- The Health Research and Educational Trust, an affiliate of the Chicago-based American Hospital Association, sponsors a demonstration group of community health networks that will eventually become national models. Already the networks have improved resource utilization and shown remarkable health outcomes.
- For hospitals, participation in partnerships might require redesign of their traditional services.
- Although partnerships might preclude fierce competition among hospitals, some have successfully carved out zones of collaboration along with zones of competition.

(See also "CCN case profile #1: Ethnically diverse, urban mix," p. 100, and "CCN case profile #2: Rural-urban mix," p. 101.)

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Managers' weekend rounds win approval
On weekends, a member of the management team visits each new patient at Brockton (MA) Hospital. The goals are to give patients the opportunity to voice special needs and to show patients that the organization cares. 102

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- The common cold: How to cut treatment costs and boost patient satisfaction
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In next month's *QI/TQM*

Mounting evidence indicates that high volumes of certain procedures mean better outcomes for patients. How is a hospital to react to this phenomenon? As you'll learn in the October issue of *QI/TQM*, the answers are anything but straightforward. Patients' choice and geography come into play. An investigator on a recent study of volume and outcomes will discuss the ethical implications for high-volume and low-volume hospitals. The story will also explain which procedures reflect better outcomes with higher volumes.

troubles may lie in a challenge issued by Carolyn B. Lewis in her acceptance address as chair of the Chicago-based American Hospital Association's (AHA) board of trustees. She urged hospitals to manage resources ethically and prudently, and warned that could require a shift from competition and expensive advertising toward collaborative solutions to local health problems.

To test the mechanics of such a shift, AHA's affiliate, the Health Research and Educational Trust (HRET), began in 1994 to nurture models of cooperative partnerships, called Community Care Networks (CCNs). These groups are dedicated to communitywide health improvements. In more prosperous times, the dogged work required for successful coalition building might have discouraged most hospitals and local agencies. But many have learned that with today's shrinking profit margins and legions of uninsured patients, survival depends on cooperation.

For hospitals, it's a way to keep pace with the changed focus of medicine, from acute care to preventive and ambulatory care. For many communities, partnerships among hospitals and a cross-section of service agencies are the only viable means of delivering health services to indigent populations.

Health care providers have always known that the hospital addresses only a thin slice of the health continuum. Thus, one of the brightest promises of the CCN is a structure that enables providers and hospitals to move outside hospital walls to serve a wider slice of health needs. "People don't go into health care to become rich. They go into it to improve people's health, and this project is putting the emphasis where providers want it," says **Francie Margolin**, director of Community Health Programs for HRET.

The 49 CCNs consist of relationships among community organizations. The membership roster and goals are shaped either by local health needs or by the determination of several organizations to make better use of available resources. Most networks represent the spectrum of community life from health care providers, hospitals, and health departments to government agencies, school districts, and religious organizations. They exist in rural, urban, and suburban settings. Most were up and running before the CCN project was implemented. **(For a thumbnail description of changes implemented through community health networks, see box, p. 99.)**

Besides local funding, 25 of the CCNs received demonstration grants from a pool contributed by

Local Health Reform

Local health reform that is both meaningful and sustainable involves a dynamic process of transformation. Successful transformation requires fundamental change in focus, orientation, operations, and governance. This transformation should occur in individuals, in groups, in organizations and institutions, and in the larger community. The following illustration highlights key elements and mechanisms for transformation.

Key Elements

Patient as passive recipient of services	→ Patient as partner in healing process
Community resident as consumer	→ Community resident as change agent
Hospital institutional expansion	→ Community capacity building
Professional service orientation	→ Community problem-solving orientation
Implement projects	→ Redesign systems
Cohort-focused interventions	→ Sustainable health improvement
Categorical program approach	→ Intersectoral/comprehensive approach
Proprietary model	→ Collaborative model
Treat the symptoms	→ Address the causes

Key Mechanisms

Develop operational principles and decision-making structures that reflect a commitment to shared accountability with community stakeholders

Develop public and private policies that encourage innovation and support sustainability

Develop a strategic approach to resource allocation that leverages institutional reform and builds on existing community assets

Integrate services and activities in multiple sectors in a way that advances the achievement of shared objectives

Develop information systems that validate progress and facilitate continuous quality improvement

the W. K. Kellogg Foundation of Battle Creek, MI; the Duke Endowment in Charlotte, NC; the California Wellness Foundation in Woodland Hills, CA; the Robert Wood Johnson Foundation; and the U.S. Public Health Service.

The program embodies the AHA's commitment to foster local reform of health care delivery and finance systems. AHA's collaborators include the Catholic Health Association of the United States in St. Louis and VHA Inc. in Irving, TX. The CCN mission includes four objectives:

1. community health focus;
2. community accountability;
3. seamless continuum of care;

CCN case profile #1: Ethnically diverse, urban mix

The closing of a neighborhood health center 12 years ago in an underserved area of Vallejo, CA, portended financial crisis for area hospitals. "The closure was strictly because of money, and it would have meant thousands of dollars in nonreimbursed emergency room care for all of the nearby hospitals," explains **Patrick Hughes**, EdD, director of operations for the Solano Coalition for Better Health in Vallejo.

Institutions in the county headed off a crisis by immediately convening the top leadership of hospitals, health departments, schools, and governmental agencies.

"It became a strong coalition because the people who came to the table are those who can make things happen," says Hughes. Originally, they came to fight it out, he adds, but a spirit of cooperation soon emerged. The result was the Solano Coalition for Better Health.

Six years later, the Solano Coalition inaugurated a partnership with the Health Plan of California, which administers the state's Medicaid funds (known as MediCal in California). The partnership enables the Solano Coalition to serve as the single source of capitated reimbursement for MediCal recipients. "This means that every MediCal patient has a medical home," Hughes explains. Now assured of receiving payments on time, providers who would not have taken MediCal patients in the past now do so. It may seem like a simple change, but it has brought health services within reach of all the area's underserved, ethnically diverse population of 45,000.

The year following the change, area hospitals experienced a 50% decrease in emergency room use. The presence of high-powered leadership gives the coalition the ability to devise creative responses to community health issues. And the responses are as diverse as the population itself. "If we are going to preach that we share health, we have to be present and learn the ways each community works," Hughes says. Indeed, the coalition has become a presence in nearly every aspect of community life:

1. The HMO, Kaiser Permanente, extended its substance abuse service to all MediCal recipients. Not because MediCal covers the program, but because Kaiser understands its value in prevention and management of other health issues.

2. A children's insurance program operates through the schools to enroll eligible children. To date, 3,500 previously uninsured children have become MediCal beneficiaries.

3. A community health outreach system, started by the coalition, has spun off to other agencies. Kaiser targets high-risk pregnant women through neighborhood health care workers. Other organizations assign outreach to cancer patients who live alone. Workers help with shopping, bill paying, social visits, and other needs.

4. African-American beauticians teach their customers to do breast self-exams and encourage them to have regular mammograms.

5. Teams advocate for health issues with each city and county government. They have persuaded city governments to include health elements in their annual planning initiatives. Coalition representatives are active with Solano County's board of supervisors to ensure that funds from the tobacco companies' settlement go to health issues. Health fairs and screening programs occur regularly. Cancer and diabetes support groups are active, especially in the Latino community. ■

4. management within limited resources.

As you'll see later, moving from concept to sustainable community-wide improvements in service delivery and health outcomes can take well over a decade. Phase 1 of the national demonstration involved coalition building and design of service delivery models. Phase 2, currently under way, involves measurement of community health outcomes through the year 2001.

Dramatic changes are already on record:

• Emergency room use by adults age 40-plus in a 12-county region around El Paso, TX, dropped 5% between 1996 and 1998.

• The percentage of low birth weight babies dropped from 4.2% to 1.7% of births in a single year, saving more than $99,000 in Vallejo, CA.

Margolin observes that the CCN project is more than a strategy to further the AHA's mission to advance health for individuals and communities. She notes, "it brings people back to why they went into health care in the first place." **(To learn how CCNs utilize and expand local resources, see "CCN case profile #1," above, and "CCN case profile #2," p. 101.)**

Those who commit to delivering services through community networks soon find themselves knee deep in redefining the role of the hospital and its ambulatory clinics. Sometimes the

CCN case profile #2: Rural-urban mix

The Cancer Consortium of El Paso (TX) Inc. serves women dispersed over huge geographic distances in 12 rural counties. This underserved population is largely Hispanic. Many are migrant workers who have never been in the formal health care system. The consortium, founded in 1989, targets cervical and breast cancer. As an advocacy and fiscal agency, it pulls together disparate providers and funding sources. Before the consortium was formed, area residents went to medical school clinics or health departments for screening. Then, due to the vagaries of governmental funding, they would wait six weeks to six months for cancer treatment.

Pat Graham-Casey, the consortium's executive director, began her work by building partnerships with private sector providers and hospitals. Since, eventually, the patients would end up there for non-reimbursed treatment, she reasoned that the organizations could benefit from an initiative to deliver care at the earliest stage possible.

On visits with providers, Graham-Casey asked what they expected of the consortium. "They told us that while breast and cervical cancer screening were important, screening was actually causing problems if people couldn't get timely follow-up care. The physicians who screened and diagnosed cancer patients were potentially liable because they had no means of doing the follow up," she explains. From that point forward, the Cancer Consortium's role was clear.

"Flexible funding" is the way Graham-Casey describes the fiscal quilt that covers the area's indigent women. Sources include the federal and local governments, private foundations, and community fundraising events. Funds are administered and coordinated by the consortium.

The bulk of reimbursement dollars go for services instead of reporting and record keeping for the funding sources. Unlike pre-consortium days, private sector providers receive at least some payment for care. And of course, early-stage treatment represents a better value for health dollars than late-stage treatment. For patients, this means a higher survival rate and less invasive therapy:

- Five years ago, breast and cervical cancer screenings consistently turned up Stage 3 and 4 cancers.
- Today, the overall average is Stage 1 and 2.
- Today, all cervical cancers are diagnosed at Stage 1 and 2.

The consortium tailors a reimbursement package for each recipient depending on her circumstances. "Patients are assured their care is covered even if their insurance runs out," Graham-Casey observes. Compliance is high because the consortium trains community residents as outreach workers to help women navigate the medical system. "It gives us better access to the community because the workers are friends of the patients."

The outreach workers come prepared with inside knowledge of the social structure, as well as credibility among their peers. Their stipends are lower than the salaries social workers would require, so they help stretch resources. The high rates of early diagnosis, follow-up, and treatment are partially due to their work:

- **Cervical cancer, 1992 through July 2000**
  - — Cervical cancer screenings: around 18,000
  - — Treatment not needed following suspicious Pap smear: 277 cases
  - — Treatment initiated or completed: 171 cases
  - — Treatment refused: five cases
  - — Lost to follow-up: four cases
  - — Pending: two cases
- **Breast cancer, 1992 through July 2000**
  - — Breast cancer screenings: around 12,400
  - — Treatment initiated or completed: 99 cases
  - — Treatment refused, lost to follow-up or pending: no cases

The Cancer Consortium parlayed a $40,000 grant into $300,000 from various sources and distributed the funds to 13 clinics, five rural hospital systems, and a few private physician practices. This means that patients now can receive care from 22 sites instead of one. The best news is that the consortium's financing covers screening as well as treatment.

One question that invariably arises with grant-funded programs is how long they will last. In this case, funding is in its 10th consecutive year. That track record, as well as the consortium's policy of weaving together diverse revenue sources, offers about as much security as can be expected in this period of uncertain health care financing. ■

payoffs come slowly — and sometimes they mean organizational survival. "A lot of us have looked at hospital care as primary service. But after we have participated in a partnership, we've learned to look at ourselves as partners to other community organizations who could build prevention initiatives. This stretches hospital resources and doesn't kill your bottom line because it saves write-offs down the road," says **Pat Graham-Casey**, executive director of the Cancer Consortium of El Paso (TX) Inc., recipient of a CCN demonstration grant.

The Cancer Consortium's partnerships with private sector providers transformed services for

Need More Information?

For dos and don'ts of building community health partnerships, contact:

- ❒ **Francie Margolin**, Director, Community Health Programs, Health Research and Educational Trust, Chicago. E-mail: FMargol1@aha.org.
- ❒ **Pat Graham-Casey**, Executive Director, Cancer Consortium of El Paso Inc., 6024 Gateway E., Suite 2A, El Paso, TX 79905. Telephone: (915) 771-6305. E-mail: pgc@cancerconsortiumofelpaso-wtccc.org.
- ❒ **Patrick S. Hughes**, Director, Operations, Solano Coalition for Better Health, 975 Sereno Drive, Vallejo, CA 94589. Telephone: (707) 651-3681. E-mail: Patrick.S.Hughes@kp.org.

For research results and trends in health services delivery, as well as grant funds for demonstration projects, contact:

- ❒ **Robert Wood Johnson Foundation**, P.O. Box 2316, College Road E. and Route 1, Princeton, NJ 08543-2316. Telephone: (609) 452-8701. Web site: www.rwjf.org. The Foundation's report on the fiscal problems of hospitals mentioned above is "Health & Health Care 2010: The Forecast, the Challenge." For the full text, visit the Foundation's Web site and click on Institute for the Future. For a summary, go to www.ahanews.com, click on Article Archive, for AHA News Now. The press release is dated Thursday, June 1, 2000: "Money crunch: One third of U.S. hospitals face financial ruin."

indigent cancer patients. With a system of "flexible funding," providers receive at least some payment, in a timely fashion, for uninsured patients whose care used to be written off as nonreimbursed. The patients are treated at the more curable stages of cancer.

Sometimes partnerships can eke out support for expensive equipment or services that no single organization could handle. In rural areas, CCNs may help resolve the threat of closure of desperately needed hospitals or ambulatory care clinics.

No matter how substantial the gains, life in a coalition is not for the short-sighted or for the stingy. "The biggest issue is financial," notes Margolin. "Hospitals still have to provide their core services. When budgets are tight, preventive health is often the first thing to go — no margin, no mission." Paradoxically, the strongest hope for sustaining the mission of communitywide service could lie in the tussle of complex partnerships:

- Participation could require a restructuring of your service package. For example, a hospital might support the continued existence of an off-site clinic that duplicates primary care services because the clinic is accessible to the underserved or elderly. In the same vein, a group of hospitals might work with the public health department to devise an efficient method for screenings, immunizations, or sports physicals.
- Expenses of participation might include teaching staff how to relate to various ethnic groups, providing interpreters for non-English-speaking clients, or offering child care. Staff attendance at meetings and the related tasks of partnership building represent significant resource investments.
- Politically sensitive issues often require months of negotiation to resolve.

Although coalitions are cooperative by definition, this is not to say that CCN participants shun competition. Margolin describes two models by which they cooperate and compete:

1. Zones of collaboration and competition. Cooperative programs target a disadvantaged population or pre-natal care. Other services such as coronary artery bypass grafts are fair game for competition.

2. Collaboration among certain hospitals, while others choose not to participate. Some tertiary providers stay outside of partnerships but provide specialty services to partnership affiliates. ■

Managers' weekend rounds win approval

Satisfaction rises and falls on the little things

The patients at Brockton (MA) Hospital experience the management's caring in a most unusual way. On weekends, when the patient advocate is off, the hospital's top brass pay a visit to each newly admitted patient. While the managers began weekend rounding in January this year, Brockton's CEO Norman Goodman has been a consistently visible presence in patient rooms throughout his tenure at the hospital.

"We want to make patient satisfaction part of our hospital culture, and now everybody understands what that means," notes **Carol Martin**,

Key Points

Location: Brockton (MA) Hospital, a 288-bed facility in southeastern Massachusetts.
Situation: Brockton's chief administrative officer and the quality improvement coordinator realized that while the patient advocate is off on weekends, the needs of many patients could go unattended.
Solution: Top managers from clinical and nonclinical areas make rounds on weekends, visiting each newly admitted patient. To help managers overcome any uneasiness about relating to patients, the quality improvement coordinator arranged for a comprehensive orientation program. After initial hesitancy, most of the managers have come to appreciate the opportunity to meet patients. Patient satisfaction scores are consistently in the 90th percentile, and admissions are up.

(See the related story, "Should management teams double as patient advocates?" p. 104.)

Brockton's director of Cardiopulmonary / Rehabilitation Services and coordinator of QI initiatives. "Our chief financial officer was one of the first volunteers for weekend rounds." Although Martin does not pinpoint a direct cause-and-effect relationship between managers' rounds and the hospital's financial well-being, she does note that admissions have shown a steady rise in recent years, and the facility finished last year in the black.

Each administrator signs up for visitation one weekend day every three months. Vice presidents are kept apprised of which of their managers participate in the voluntary program, and participation is tied to performance reviews. The managers act primarily as patient advocates. Following are a typical day's duties:

• Pick up admissions sheet at the information desk. It includes an average of 30 patients. In semi-private rooms, the manager checks on the roommate as well.

• First stop on a unit is the nurses' desk to inquire if any patients have conditions, such as confusion, that would make a visit inappropriate.

• After managers introduce themselves, they explain, "I'm interested in your experience here. Is there anything you need or anything we can do to make you comfortable?" They also talk with visitors. If the patient is away from the room, the manager leaves a note and an invitation to leave requests in the patient advocate's voice mail.

• Managers resolve issues personally or through the proper channels. They might check the status of delayed food trays, expedite delivery, and follow up with a complimentary fruit basket. For complaints about noisy roommates, they would look into a room change. More complex matters involving referral to a community service, for instance, are conveyed to the patient advocate.

• For each patient, the manager charts requests, resolutions, and notes compliments. The data enable tracking of customer satisfaction issues and trends for patient service goal setting.

As you might expect, the overall reception has been positive. Most of the managers embrace the opportunity to visit patients, even those who resisted because of heavy work schedules or unfamiliarity with patient contact. Patients appreciate the attention.

Even those who make no specific requests note on their satisfaction surveys, "Someone came to visit, and I told him that everything was all right." Martin notes that the program reflects Brockton's dedication to correcting problems up front instead of allowing them to fester and surface after it's too late to correct them.

The visits "elevate the patient focus to our managers' and clinicians' awareness," she observes. Now, she adds, the management understands the connection between the full-time patient advocate position and the hospital's high patient satisfaction levels.

Staff nurses are delighted with the program. Managers handle patient requests that otherwise might wait until the patient advocate could check in on Monday morning. By giving administration a first-hand view of the work load employees handle on weekends, the program fosters a realistic consideration of staffing budgets.

While there is no doubt that patient advocacy must run through the weekend, it's still undecided whether the facility will continue to handle it through voluntary visits from managers or add a paid staff position.

"Every patient deserves a visit," Martin contends, "and our CEO thinks every new admit should have the opportunity to see someone from the management team to show them they are important to us and to the clinical staff as well."

If an administrator had any doubts about Brockton's excellence in patient care, they have vanished with the opportunity to witness the

Should management teams double as patient advocates?

The last thing that the manager of billing or medical records might expect to do is to make rounds on patients. But at Brockton (MA) Hospital, that's exactly what they do one Saturday or Sunday every quarter. All of the institution's clinical and nonclinical managers act as patient advocates on weekends when the full-time advocate is off duty.

The program reflects CEO Norman Goodman's passion for showing patients that the hospital is in business to serve them. **(See "Managers' weekend rounds win approval," p. 102.)**

While the program rounds out the patient advocacy function at Brockton, it could not exist without support from the top, cautions **Carol Martin**, the hospital's QI coordinator and director of Cardiopulmonary/Rehabilitation Services. After all, she notes, "management staff typically work 60-hour weeks, and we asked even more of them." Perhaps even more momentous than the time commitment was the plunge into unfamiliar territory.

Some of the administrators, particularly from the support functions, hesitated to volunteer for patient visits. To mitigate their concerns, Martin provided orientation to address all facets of patient contact. In addition to the universal precautions such as hand washing to maintain infection control, "we did not minimize or underestimate nonclinical people's fears of illness. We took into account that we were taking people out of their comfort zones."

Trainees were encouraged to ask questions and express their doubts about what to say to patients and how to handle emotional situations. "After all, a finance specialist didn't go into health care for patient contact," Martin says. "We recognized that nonclinicians would have the same type of fears as clinicians have when they become managers and face budgets and finance reports and trend measurements for the first time."

The first hurdle was the worst. At this point, most of the participants are eager to share their experiences with colleagues.

Martin suggests that managers' rounds might be worth considering under the following conditions:

• If your facility has no patient advocacy program, it would be helpful to initiate managers' rounds during the week. "Our industry needs to make patients the No. 1 focus of our existence," she insists. "How better to do that than start from the top?"

• If a patient advocacy service is not in place on weekends, managers' rounds might fill the gap. Martin explains, "With short lengths of stay, some patients come in on the weekends and they're discharged before the patient advocate can come to see them. If they leave with unresolved issues, the bad feelings might fester and you'll never be able to take care of them. We are a 24-hour industry. So we have to stop thinking Monday through Friday because a lot can happen on weekends." ■

bedside services, Martin says. Other outcomes are equally important:

1. The experience reminded top managers that assumptions about patient service miss the mark. "You don't know what people want until you ask them. And it's usually the smallest things," says Martin, "like moving the table closer to the bed or showing them how to use the phone, or just the comfort of having somebody spend time with them."

People forgive a lot if they're well treated, she observes. For example, Brockton's telemetry unit, located in one of the oldest areas of the facility, consistently rates above the 90th percentile in patient satisfaction. Four patients, the majority with cardiac problems, share each bathroom; sinks are outside the bathrooms. The turnover is high. "It's old but immaculate, and the manager rounds on every patient every day. They clearly see that the staff want to make them comfortable."

2. Brockton consistently garners customer satisfaction ratings in the 96th percentile of Press, Ganey's database of several hundred institutions. Press, Ganey, based in South Bend, IN, specializes in the measurement of health care satisfaction. Martin explains that to achieve such levels, institutions must consistently receive fours and fives on a scale of one through five. "And you can't do that unless you exceed expectations."

3. The area's largest medical group, consisting of 100 physicians, recently contracted to admit all of their patients to Brockton Hospital. Martin credits the arrangement to the facility's longstanding record of excellent patient care and its growing reputation for stellar customer satisfaction. ■

Need More Information?

For information on integrating customer satisfaction into your organization's culture, contact:

❒ **Carol Martin**, Director of Cardiopulmonary/Rehabilitation Services, Brockton Hospital, 680 Centre St., Brockton, MA 02402-3395. Telephone: (508) 941-7231. Web site: www.BrocktonHospital.com.

Informal interventions clear ICU logjam

Doctors heed chart notes, LOS drops 36%

Eighteen months ago, staff at Our Lady of the Lake Regional Medical Center in Baton Rouge, LA, realized that the open admission policy in the adult intensive care units (ICU) needed to be revised.

A random survey revealed that nearly 40% of the patients had conditions more appropriate to regular medical-surgical nursing units, intermediate long-term care, or their own homes. That's why patients who needed care often had to wait.

Since Our Lady of the Lake offers all services except obstetrics and transplants, both specialists and primary care physicians admit patients to the medical ICU beds. Analysis of the reasons for ICU placement, revealed many instances of observation. In other cases, families resisted the idea of moving their loved ones to more suitable settings and doctors acquiesced.

"We needed to do something because the winter onslaught of flu and pneumonia was coming," says **Rose Marie Patin**, BSN, RN, MA, divisional nursing director of Cardiology / Critical Care.

On the strength of their survey findings, Patin and a multidisciplinary team launched a highly creative intervention that increased ICU admissions by 33% within 12 months. She credits administrative support as the chief contributor to their success. Other elements include:

• partnership with a group of pulmonary disease specialists who provided medical leadership;

• rapid-cycle improvement techniques and ventilator protocols learned through the Boston-based Institute for Healthcare Improvement.

Relying on influence rather than authority, the improvement team initiated daily rounds of the four ICUs (12 medical beds, 12 surgical beds, 10 coronary care beds for heart surgery patients, and 10 cardiac care beds for medically treated heart patients). The improvement goal was to reduce average length of stay from 4.5 days to 3.4 days.

Besides Patin, team members included an ICU nurse as the team leader, a pulmonologist, a pharmacist, and a dietitian.

Patin explains that all the patients were under the care of private physicians, which meant that the team had no authorization to write on their charts. "So we found a politically correct alternative," she says. They affixed salmon-colored self-adhesive notes. The first messages were introductory: "Dear doctor, we wish to notify you that we are rounding in ICU." Then the tone shifted to "May we suggest?" offering ideas for alternative handling of intravenous (IV) medications and ventilators.

Physician responses ran the gamut from tearing up the notes and tossing them into the waste basket to presenting the team with detailed rationales outlining why their patients were in ICU. "Mostly they fell right in with our efforts," Patin says. "Many of our suggestions were taken, and patients began to move out of the unit faster." Length-of-stay samples from December 1998 to April 27, 1999, averaged 2.9 days, a 36% reduction. In the few instances where inappropriate practices came to light, the hospital's medical administrators discussed the cases with the attending physicians.

As the team tracked the time and place of ICU admission, they found transfers from regular nursing units and the emergency room. The attending physicians would authorize placement by phone during nighttime or early morning hours. "When the doctors came in the next morning, they might find that the patient didn't need to be there," Patin says. "Then we had to get the patient a regular bed, which could take hours."

ICUs are really for nursing care, she explains. "The primary candidate is a person with a life-threatening condition who could not survive without the intensive care. But it had gotten way beyond the original use."

Subsequent policy changes and practice guidelines led to a 30% increase in medical intensive care unit admissions. **(See graph, p. 106.)** Changes and guidelines included:

• protocols for ventilator weaning, insulin management, and potassium replacement;

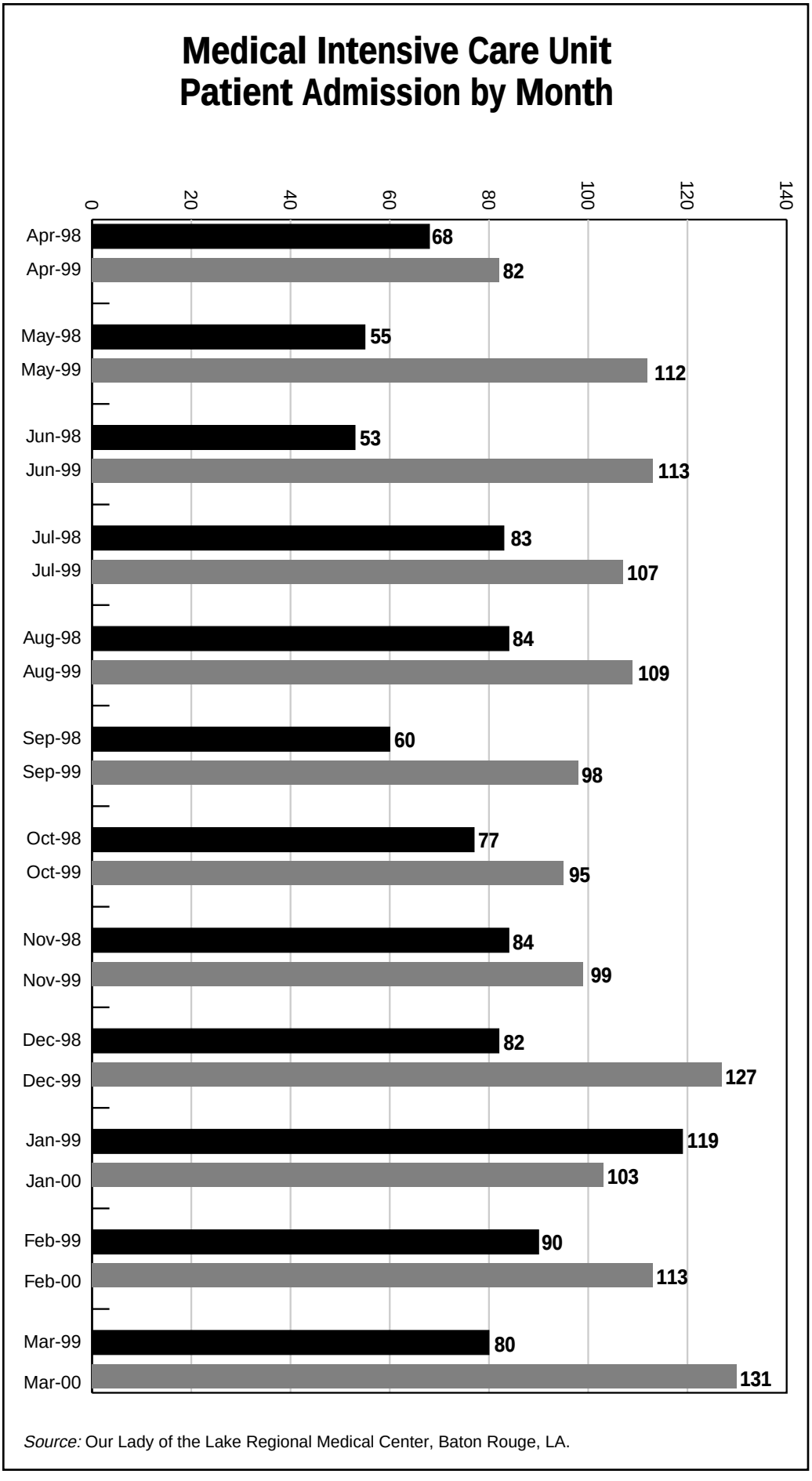
• timely administration of medications enabled by more extensive mixing and preparation of IV solutions in the pharmacy;

• guidelines for maximum time between ICU admission and visit by the attending physician.

Need More Information?

For more information on intensive care unit practice guidelines and process improvements, contact:

❒ **Rose Marie Patin**, BSN, RN, MA, Divisional Nursing Director Cardiology/Critical Care, Our Lady of the Lake Regional Medical Center, Baton Rouge, LA. E-mail: rpatin@ololrmc.com.



Source: Our Lady of the Lake Regional Medical Center, Baton Rouge, LA.

For example, if the emergency room physician admits a patient to ICU, then the attending physician visits the patient within 10 to 12 hours;

• triage procedures for respiratory services.

The team continues to round daily, working on remaining issues. The following improvements are in progress:

1. Training of new respiratory therapy professionals. The pulmonary disease specialists who worked with the improvement initiative from the inception donated their compensation to a fund for staff seeking to earn respiratory therapy credentials. The hospital also is exploring federal grants to train additional therapists.

2. Collaboration with pastoral care staff to assist patients and families with decisions about end-of-life care. Patin explains that this service will help with unexpected crises that sometimes loom before physicians have time to discuss such options. The existing support group helps families establish do-not-resuscitate directives and move patients from ICU to intermediate care where visitation policies are more liberal. **(For further information on end-of-life care, see *QI/TQM*, September 1999, p. 106.)**

3. Review of computer software packages that help physicians assess potential outcomes of ICU placement. "We're

trying to convince the medical staff that critical care should not be viewed as a distinct service but as a part of other services, such as medical or surgical," Patin says. ■

Kids with terminal cancer need better palliative care

Pressed by demands from within the industry and from consumers, health care systems are improving end-of-life care.

However, a particularly vulnerable group of dying patients is often left out of the picture, according to a recent study. Only 27% of the parents whose children died of cancer between 1990 and 1997 say the pain treatment their children received was successful. Of those treated for dyspnea (shortness of breath), 16% report success. The results were compiled from 103 interviews of parents whose children were treated at Children's Hospital and the Dana-Farber Cancer Institute, both in Boston.[1]

These additional data were derived from medical records:

- About 80% of the children died of cancer.
- About 20% of the children died of treatment-related complications.
- 49% died in the hospital; nearly half of the hospital deaths occurred in the intensive care unit.

The investigators point out that cancer is the second leading cause of death in children, following accidents. Nonetheless, they write, "Little is known about the symptoms and suffering at the end of life in children with cancer."

The findings from this research indicate that parents might be an overlooked source of critical information. Review of the medical records reveals that:

- Parents were much more likely than physicians to report that the child suffered fatigue, poor appetite, constipation, and diarrhea.
- Suffering from pain was more likely in children whose parents reported that the physician was not actively involved in providing end-of-life care.

The study notes that children who die of cancer receive aggressive treatment at the end of life. "Many have substantial suffering in the last month of life," the researchers contend, "and attempts to control their symptoms are often unsuccessful."

In a related opinion piece, **Elaine R. Morgan**, MD, and **Sharon B. Murphy**, MD, both of Children's Memorial Hospital in Chicago, comment that children should be added to the list of groups more likely than others to have inadequate relief of pain.[2] Already on the list are women, the elderly and members of racial or ethnic minorities. While the use of hospice care began to gain acceptance in the 1980s, they write, today, only half of adults who die of cancer receive hospice care.

Many needs of dying patients aren't met, including adequate control of pain and symptoms. Patients also don't receive relief from:

- loss of dignity and autonomy;
- lack of opportunity for patients and their families to openly discuss death;
- a sense of separation from and abandonment by the primary care team. "Available information

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GRASS-ROOTS QI

During morning and late afternoon peak times, the managers at Brockton (MA) hospital escort patients and visitors to their destinations. "It's the difference between having somebody point to something or take you there," explains **Carol Martin**, director of Cardiopulmonary/Rehabilitation Services and quality improvement coordinator. Since this 288-bed facility admits 14,000 patients annually, handles 30,000 clinic visits, and sees 50,000 emergency department patients, the escorts need their walking shoes when they report for duty.

✔ IMPROVEMENT OPPORTUNITY

• Guests were frequently lost in the vintage facility's corridors and hallways.

• Even the best directional signs weren't the answer.

• Management deemed it inappropriate to expect volunteers to greet injured and seriously ill patients at the high-traffic emergency entrance.

✔ SOLUTIONS

Vice presidents and department heads were assigned to cover the emergency and front entrances on a rotating schedule of one-hour shifts. In case of schedule conflicts, they find substitutes.

Since the emergency entrance is busiest, greeters check it before going to the less busy front door. Perhaps predictably, the nonclinicians initially avoided the emergency entrance. "However, after they overcame their uneasiness, they couldn't wait to tell their stories. One vice president helped a woman in labor check into the emergency room," Martin notes. "Everyone gets some patient contact," she says. If front entrance greeters have down time, they deliver flowers to the patients' rooms.

✔ RESULTS

• Many managers call it the best hour of the week. Greeters now update emergency patients and their families on expected wait times.

• Administrative employees welcome management presence. "Managers will resolve a problem immediately or hand it over to somebody who will fix it," Martin says.

• Patient satisfaction scores on "ease of finding your way around" rose from the 80th to 90th percentile.

✔ KEYS TO SUCCESS

"It works well because the clinical and nonclinical managers are learning — or re-learning — our real business," Martin notes.

✔ CONTACT

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suggests that these issues are important for both adult patients and children. Despite the unmet needs," they add, "there are currently only a handful of organized palliative care services for children in the United States."

Given the differences between children and adults, a blanket extension of adult palliative care to children is inappropriate and ineffective. "Caregivers skilled in the care of dying adults generally lack the expertise to deal with the unique medical and psychosocial needs of children," the researchers said. As oncology teams focused primarily on cure often lack training and experience in end-of-life care, a multidisciplinary approach might be best. They issue this caveat, however: "This [approach] should be flexible enough to provide support for both the children whose disease can be cured and those for whom a cure is not yet possible."

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