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Microsystems: Using the 'building blocks' of quality improvement

Proponents say they hold the key to improving patient care

The Institute of Medicine (IOM) has expressed great interest in them. The Institute for Healthcare Improvement (IHI) refers to them as if they were an integral part of the quality improvement process.

They're called microsystems, and they already exist in your institution — even if you don't know it.

"Microsystems are the building blocks that form the health system, the fundamental organizing unit around which patients, physicians, and providers meet — the sharp edge of the delivery system," says **Eugene C. Nelson**, DSc, MPH, professor of community and family medicine at Dartmouth Medical School, and director of quality education, measurement, and research at Dartmouth-Hitchcock Clinic in Hanover, NH.

"The essential notion is that the microsystem is the smallest fractal unit that emulates the larger system, the smallest unit of an organization that still maintains the properties of the larger whole," adds **James Espinosa**, MD, FACEP, FAAFP, chairman of the emergency department at Overlook Hospital in Summit, NJ.

"Microsystems are where patients and the competency of health care meet," asserts **Paul Batalden**, MD, professor and director of the health care improvement leadership development group at the center

Key Points

- Microsystems exist as a natural component of a health care facility.
- Approach helps focus on the individuals who directly affect patient care.
- Each microsystem contains the same basic characteristics as the overall organization.

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for the evaluative clinical sciences at Dartmouth College and, along with Nelson, one of the leading authorities on microsystems and co-author of several studies.

Already a fact of life

One of the most fascinating aspects of microsystem theory is that you don't create microsystems or even discover them; they simply exist.

"It's not just a way of looking at things; the microsystem already exists in the world," Espinosa says. He personally defines a microsystem as the smallest unit within a health care organization that could spawn a Baldrige application — referring to the Malcolm Baldrige National Quality Award — if it were allowed to.

"This entails such things as leadership, strategic planning, results, human resources, and a focus on the patient," he explains.

For nearly 80 years, Espinosa notes, hospital organizational charts and procedures have reflected a military perspective, complete with departments, units, orders, and so on.

"But if you look at it from a patient's point of view, they are relatively uninterested in peoples' departmental lines," he says. "You look for function; what you realize when you are in the [emergency department (ED)] world, is that it has its own culture."

But microsystems are not necessarily the same as departments; in fact, often they are not.

"If you actually wish to improve in quality or safety, you have to recognize the real structure of the system," Nelson notes. "It may involve a series of closely coupled microsystems, such as the operating room and post-acute care unit, or loosely coupled ones, such as the nutrition department and behavioral medicine. Sometimes, you might want nutrition and behavior to join hands for treatment. Referring physicians are loosely linked to inpatient services. With this approach, you start to recognize the true structure of the delivery system.

"Oftentimes, we are organized along profession lines, like the department of medicine or the

physical therapy department, yet when physicians in the department of medicine are actually in the process of providing care, they no longer are in their department," he continues. "They are generally meeting face to face with patients in a setting [that] often has an interdisciplinary team and support staff around them. In other words, traditional organization doesn't often coincide with the actual small systems of care."

"If we don't understand microsystems, we are held hostage to the old dynamics," Batalden asserts. "With microsystems, patients, providers, and information technology are all part of the same system, but we rarely make change that way. The myths of professional autonomy have become the way in which we have customarily led; since that disregards the facts, it makes it very tricky to facilitate improvement."

Opening new vistas

Recognizing the existence of microsystems, and more importantly, recognizing your own microsystem, is a powerful force for change, Espinosa observes.

"This involves recognizing what I feel to be an organic reality, becoming a self-aware microsystem," he says. "If you are a microsystem and don't know it, it does not mean you are not one, but it means you are merely functioning as a department."

If you become a self-aware microsystem, you have the capacity to think differently, he continues. "We blew up departmental meetings and developed a microsystem meeting once a month," he says. "This reconfigures everything, and the spirit of the meeting is different."

Recognizing microsystems helps you "keep your eye on the ball" — the patients and the needs of the patients, and doing the right thing for them, Nelson says.

"If you wanted to improve care for community-acquired pneumonia, a traditional approach might say, 'Search the evidence, bring guidelines off the web, develop a pathway, and let people know about it,'" he observes. "But they mostly sit

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in health care

Must the macrosystem give permission?

Let's say you've recognized that you are a microsystem and would like to begin approaching quality improvement from that perspective. Do you need permission from your hospital macrosystem to do so?

Not necessarily, but it sure would help, according to the experts.

"I think we have lots of evidence that suggests people who regularly work together in microsystems come together and make tremendous improvements," says **Paul Batalden**, MD, professor and director of the health care improvement leadership development group at the center for the evaluative clinical sciences at Dartmouth College in Hanover, NH.

"To the degree their work together is recognized and rewarded as a microsystem, it will influence the degree to which changes will be retained and spread," he says.

"People can make lots of improvements. The question is, how badly does the macrosystem want to sustain those gains and spread them?"

Do microsystems make changes within macrosystems that don't recognize their existence? "It happens all the time," Batalden says.

"But if the macrosystem does not understand, the microsystem leaders become frustrated that they can't make it last or happen in another branch. The microsystems that do make significant improvements have an opportunity to share what made it possible for them to do that," he adds.

Without the recognition of microsystems, he says, "Things are done in the name of making

things better, but inadvertently centrifugal force pulls you apart from the natural systems."

For example, a hospital may want to improve care in the outpatient setting, Batalden says. "We get a group together and decide we want to work on access systems and the way we triage patients. The macrosystem decides the physicians still don't get the message, so we create an incentive program for the doctors. Lo and behold, the group that had come together decided that if the docs were the only ones getting recognized, they didn't have to sit in on the sessions.

"And the docs who wanted to optimize their income realize if they don't see the more complicated patients, they can see more patients and make more money," he points out.

"Currently [in many facilities], if you're aware an action has to occur, you have to work through a circuitous route to get it done," says **James Espinosa**, MD, FACEP, FAAFP, chairman of the emergency department at Overlook Hospital in Summit, NJ.

"If it's a medication issue, you talk to the nurses who give meds, then maybe to a safety committee. But the 'voltage step-off' for each step is severe. Paper has to be moved, and everything takes a long time. If you had an empowered microsystem, the macrosystem says if something needs to be fixed and it does not affect major hospitalwide procedures, fix it first and then tell us about it," Espinosa says.

The bottom line is this, says **Eugene C. Nelson**, DSc, MPH, professor, community and family medicine at Dartmouth Medical School, and director of quality education, measurement, and research, at Dartmouth-Hitchcock Clinic: "A macrosystem can be no better than its microsystems." ■

on the shelf. They're not adopted into the real flow of the real work. There are people already fully engaged in the real work, but absent the recognition of an inside-out understanding of the nature and feel of the delivery system, you have little hope of finding 'best practices.'"

One of Nelson's Dartmouth students addressed such a problem. "Remembering that the bouncing ball is the patient, he started to map the trajectory of certain patients to see where they were landing and how they flowed through systems. This way, you could see the common pathways of care they are taking," he relates.

"If we wish to improve, what it means in this particular hospital is that we've really got to develop an effective program of care within the ED and handoff to four inpatient nursing units, and we have to involve the medical staff associated

with the patient most often. It really becomes a case of optimizing care and the handoff of care within small systems," Nelson adds.

Under a more traditional approach, two departmental nurses probably would develop a guideline and believe that should be enough, he says.

"They know feedback is important, so they throw in a little guideline compliance and show mortality trends. But the cell must take it up and float it around — they are the receptor sites for the new process — literally in the microsystem," Nelson says. "That means staff, patients, and information systems."

One of the major advantages of the microsystem is its ability to respond quickly, Espinosa says. "If a complaint emerges at 3 p.m., the best people to address it are found at the microsystem level.

He recalls a specific instance at Overlook where the ED was running low on a particular medication because of supplier delay. "We talked about it in microsystem, and then I was able to go to the pharmacy and talk with them directly. The problem was solved in two hours, and a procedure was instituted to prevent this from happening in the future."

Some things can be done effectively only at the microsystem level, Espinosa asserts. "If the health department gives marching orders that we must be safer with needlestick, they flip it down to the next logical system: the hospital," he hypothesizes. "The hospital can get a team together, or form a committee, but once you get down to the granularity of many safety concerns, you're talking about microsystems."

As another example, some problems in the ED may have many different determinative factors. "There may be transfer problems with the OR, faulty equipment, or medication delivery problems," he explains. "The ability to collect data, to make sense of it, and to implement solutions only can be done culturally at the microsystem level."

When you meet problems as a microsystem, it allows you to ask what needs you have that the hospital cannot possibly satisfy for you, he continues. "For example, we didn't have a system that enabled us to know what the cycle time was between patient arrivals and their being seen by a nurse and doctor," he recalls. "So, we set up our own tracking system."

One of the defining factors of a high-functioning microsystem, Espinosa says, is information technology. "You need to have a software guy who can build the subsystems to do what you need."

Making the transition

Even if you accept the concept that microsystems already exist within your hospital "macro-system," it takes more than mere recognition to put them to work for you.

"First, you have to draw out a picture of the microsystem you want to work with, draw a visual artifact to work on," Batalden says. **(To find examples of these visual artifacts, see recommended reading, at the end of this article.)**

"If you tell the truth about the way things actually work in your facility, you will see an enormous amount of foolishness that goes on every day," he continues. "Once you reveal the way things fail time after time, you run a little test

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For more information on microsystems, go to:

- ☐ **Institute of Medicine**, Washington, DC. Web site: www.iom.edu.
- ☐ **Institute for Healthcare Improvement**, Boston. Web site: www.ihl.org.

change. It may be as simple as changing the way calls are answered. But as you start to understand the way things really work, you begin to see the things you are not so happy about, and you work on them."

Through this process, you begin to realize you are on the front lines not just for yourselves, but for the aim of relieving the illness burden. "Connect the aim and the purpose to this group of people, and suddenly it gets a lot more complicated," Batalden notes. "What are we doing here? How do we know this current design is the best we can do for people? You wrestle with having a clear set of goals and aims, and their relationship to daily functioning. This is very helpful because it opens up the possibility of redesign; people realize there are other ways to do things," he points out.

The final step involves strategic invitations to change. "People will come along and say, 'Let the patient decide,'" Batalden says. "You think about ways to integrate that approach, and then make modifications. You might experience some interest learnings.

"So people go through that process, testing strategic change, and out of that you begin to have a sense you could actually create some measures to monitor your own performance over

time. Then, you create a data wall to measure what's required."

(For a more detailed description of this process, see the Clinical Microsystem Action Guide Version 1.1. An unpublished PDF version is available on the web for free download at www.ClinicalMicrosystem.org.)

Thinking differently

The microsystems approach also puts you in a better position to conduct appreciative inquiry, a relatively new approach to change, Espinosa says.

"You can go after fixing the system either by seeing where you screwed up or by asking yourself what went unexpectedly well and seeking to make that more common," he explains. "Ask yourself, 'What's the best we've been?' A microsystem can do this in spades."

At Overlook, he says, "We don't just bring in the patients to tell us what went wrong, but what went unexpectedly right. This property of a good family has wide applications inside microsystems toward creating a culture of reliability. When a negative thing comes through, you have the energy to say, 'That's not who we are.'"

When your microsystems adopt this approach, a tech can tell a doctor, "Excuse me, that's not done here," Espinosa adds. "In the traditional model, certain behaviors might be reported to risk management, then to the state, and so on. But it turns out that much of safety deals with real-time recognition and reaction."

Espinosa says that microsystems may hold the key to safety improvement. "There ain't such a thing as a whole hospital culture; it's a whole combination of *different* cultures. Just because a memo goes out doesn't mean the culture changes; it has to be bought and embraced by the microsystems.

"Until microsystems can talk to each other fluently and feed back to each other their concerns, there won't be reliable safety in play," he says.

Recommended reading

- Mohr JJ, Batalden PB. Improving safety on the front lines: The role of clinical microsystems. *Quality & Safety in Health Care* 2002; 11:45-50.
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Group closing GAP in heart attack care

System of reminders boosts quality of care

A team of 10 Detroit-area hospitals, led by physicians from the University of Michigan Health System in Ann Arbor, has reported significant success in improving the odds that heart attack patients will get the medicines, tests, procedures, counseling, and follow-ups that have been shown to improve the chances of surviving and returning to a full life.

Guidelines continually communicated

The initiative and attendant study, sponsored by the American College of Cardiology (ACC) in Bethesda, MD, is called GAP, Guidelines Applied in Practice. The guideline-recommended therapies, tests, and counseling include:

- aspirin in the emergency department (ED) and after discharge to prevent clotting;
- beta-blockers to reduce arrhythmias;
- angiotensin-converting enzyme inhibitors to aid the heart's recovery from damage;
- blood cholesterol tests and, in appropriate patients, treatment to lower cholesterol;

Key Points

- System includes reminders, checklists, stickers, standard orders, reference cards, and educational materials.
- Hospitals are given the option of choosing the tools to use in their program.
- Pre-implementation contacts help obtain buy-in from physicians.

- measurement of the pumping capacity of the heart's left ventricle;
- cardiac catheterization or other heart imaging studies in certain patients;
- angioplasty or bypass surgery in selected patients to open or go around blocked arteries;
- smoking-cessation counseling (smoking doubles the long-term risk of another heart attack);
- diet counseling, with emphasis on low-fat diets;
- referral for outpatient rehabilitation.

The guidelines continually were communicated to physicians, nurses, and in some cases, patients, through a system of reminders, checklists, stickers, standard orders, reference cards, and educational materials.

When compared with their previous records and with hospitals that did not use the system, the participating hospitals significantly boosted the percentage of their patients who got aspirin, beta-blocker drugs, and advice on stopping smoking.

Hospitals have options

Each participating hospital could choose which of the tools in the GAP tool kit they would use. Their options included:

- standing orders for medication and tests;
- pocket cards of medications and guidelines for medical staff;
- clinical pathway that guides nurses through their daily activity;
- special patient information form;
- stickers for the patient's chart;
- chart that shows the hospital's overall performance;
- discharge checklist for physicians or selected nurses to review with patients;
- patient education materials, including written and verbal instruction on therapy and lifestyle.

"We presented these to all the hospitals, and they selected the two or three things they felt were most appropriate," says **Rajendra Mehta**, MD, MS, clinical assistant professor of cardiology at the University of Michigan Health System.

"Most chose standing orders and patient education, and all of them chose the physician pocket guide," he says. Some chose critical pathways for nurses."

The laminated pocket guides, about 4 inches by 6 inches, contain reminders of ideal care, such as when to prescribe aspirin or beta-blockers, or thrombolytic therapy and contraindications.

Need More Information?

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"They cover all basic care needs given while in the hospital and at the time of discharge," Mehta says.

Patient education guidelines included a patient visit by the physician at time of discharge. The session included questions the patient had to answer, such as, "I was having a heart attack because . . ." Patients also had to provide the following type of information: "My cholesterol level is ____, and my goal is ____," or "I have an appointment to see Dr. ____ on (date) at (time)."

Laying the foundation

A significant factor in the program's success was extensive communication before implementation, Mehta says. "We communicated with the cardiologist champion and quality managers at each facility, as well as with the CEO. We wanted administrative buy-in," he explains.

The program kickoff took place in the form of grand rounds. Internal medicine, family practice, cardiology, and the ED all were invited, but this was not the first time they had been exposed to GAP.

"At the end of grand rounds, the nurse champion got up and spoke for 20 minutes, reviewing those tools that particular hospital had chosen to use," Mehta explains. "But long before that, the program had been presented to the physicians at their monthly meetings. So we had physician buy-in even before grand rounds, which I think was very important to our success."

The results indicate that they did something right. The percentage of patients receiving aspirin when they entered the hospital went from 81% to 87%, and the proportion receiving aspirin therapy guidance before they left the hospital jumped from 84% to 92%. Beta-blockers on admission rose from 65% to 74%, and stop-smoking counseling went from 53% to 65%. The highest levels of guidance adherence — more than 77% and up to 100% — were in the one-quarter of patients whose charts showed evidence that the GAP tools had been used. ■

Collaborative project tackles palliative care

Hospital fund, RAND, IHI join forces in NYC

A partnership comprised of The United Hospital Fund in New York City; The RAND Center to Improve Care of the Dying in Arlington, VA; and the Institute for Healthcare Improvement (IHI) in Boston is working with 21 New York City hospitals, nursing homes, hospices, and home health care agencies to improve care for people with advanced chronic illnesses and those at the end of life.

That partnership, the Palliative Care Quality Improvement Collaborative, is charged with the goal of achieving measurable change in how each of the participating organizations provides palliative care. It will work to define which practices are to be changed and how, and determine how to measure quantitatively the effectiveness of the change.

"In 1996, we began working with health care providers, predominantly hospitals, to help them to implement serious initiatives for palliative and end-of-life care," says **David A. Gould**, PhD, senior vice president of the United Hospital Fund (UHF), a health research policy analysis and philanthropic organization focused on improving health care in New York City.

With some small grant initiatives, the fund was able to identify champions who took on the challenge. "We are very proud of what we did," he says. "But we wanted to find a way to engage more health care organizations."

Gould had been impressed with IHI's approach to quality improvement and was aware of national RAND/IHI collaboratives. "We were interested in recasting that model as a regional initiative," he explains.

Getting started

After a series of discussions, RAND officially was called in as a consultant to UHF. "We started brainstorming in late 2000," recalls **Sarah Myers**, MPH, associate social research analyst with RAND. The model they used, developed, and adapted for health care by IHI, follows the "Plan, Do, Study, Act" cycle.

Potential participants applied directly to UHF. "They were looking for people who had the aim

Key Points

- Nursing homes, hospices, and agencies participate with local hospitals.
- The goal is to take a national program model and apply it regionally.
- The program includes pain reduction, improved advance care planning, and continuity of care.

in mind to improve care and demonstrated an organizational commitment, and who could put together a team to work on this over a nine-month period," Myers says. Of the 21 participants selected, 11 were hospitals.

"We realized if we restricted the project to New York City, it would reduce the expense of travel and make it easier for smaller organizations to participate," Gould says. "We sent invitations to all hospitals but to only a select group of nursing homes, agencies, and hospices." To make participation more attractive, UHF awarded a grant to help underwrite a significant portion of the cost of participation.

Targeting change

Based on data generated in earlier collaboratives, it was determined that several issues would be addressed by all participating organizations. They include:

- pain reduction;
- improved advance care planning;
- improved continuity of care between the hospital and nursing home;
- better follow-up on referrals for hospice care;
- patient/family education;
- patient/family communication.

"These are broad domains — areas that teams in our national collaboratives focused on and have amassed the most expertise in, and shared with the teams," Myers explains.

At the beginning of the project, all participants were given some interviewing tools and exercises in their pre-work packages to help them diagnose additional targets for change. For example, they would be asked to call 10 families of patients who had died recently and ask them what else could have been done for their loved one.

"A lot of the answers they had anecdotal evidence for, or they knew on their own, but we asked them to think about what they would find unsatisfactory if they were a patient," Myers says. The teams also had expert faculty available to

them for consultation.

The framework for the questions were RAND's seven promises a health care system should be able to make to someone nearing the end of life, Myers says. (See box, below.) "Some of those promises can be kept now, and some eventually, but a system should be able to promise these things to a patient," he says. "If they can't, they should think about how they can get in the position to make those promises."

Each team was asked to answer the following questions:

- What is your goal, and what do you want to accomplish?
- How will you know a change is an improvement?
- What changes can we make that will result in improvement, i.e., what can we do differently?

"Every month, the teams review the data to see what else they need to do," Myers notes.

"If we've been surprised by anything, it's been the ability of the organizations to internalize the

7 Promises Health Systems Should Be Able to Make

- 1. Good medical treatment:** You will have the best of medical treatment, aiming to prevent exacerbation, improve function and survival, and ensure comfort.
- 2. Never overwhelmed by symptoms:** You will never have to endure overwhelming pain, shortness of breath, or other symptoms.
- 3. Continuity, coordination, and comprehensiveness:** Your care will be continuous, comprehensive, and coordinated.
- 4. Well-prepared, no surprises:** You and your family will be prepared for everything that is likely to happen in the course of your illness.
- 5. Customized care, reflecting your preferences:** Your wishes will be sought and respected, and followed whenever possible.
- 6. Use of patient and family resources:** We will help you consider your personal financial resources and will respect your choices about using those resources.
- 7. The best of every day:** We will do all we can to see that you have the opportunity to make the best of every day.

Source: Americans for Better Care of Dying, Washington, DC.
Web site: www.abcd-caring.org.

Need More Information?

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change model and to really come to believe it in a relatively short period of time," says Gould. "In the last few weeks, we had a comment from one of the nursing homes who said it's the most significant vehicle for change because it got everybody excited."

Once the practice changes have been identified and put in place, the participants will look to spread them to other parts of their organizations, Myers says.

However, Gould adds, that's only the beginning for UHF. "We need to identify how many participants want to continue another year, and bring on the next generation as well," he says. "Having done this, we will take a real hard look at the model and how it might be used to begin change practices, say, in ambulatory care." ■

Program links financial, nonfinancial incentives

Combination seen as most effective quality strategy

What types of incentives are most effective in improving quality: financial incentives, or nonfinancial incentives? According to the Washington, DC-based National Health Care Purchasing Institute, part of the Academy for Health Services Research and Health Policy, the answer is "both."

"They are most effective when used in combination," says **Sarah R. Callahan**, MHSA, deputy director of Rewarding Results, a new initiative of the Princeton, NJ-based Robert Wood Johnson Foundation and the Oakland-based California HealthCare Foundation, and senior manager of the Academy for Health Services Research and Health Policy. The National Health Care Purchasing Institute administers the program,

Key Points

- Reward programs use 11 different incentive models.
- Some nonfinancial incentives may be as attractive as bonus dollars.
- Standard performance measures such as Health Plan Employer Data and Information Set are to be employed.

the evaluation of which will be co-funded by the Agency for Healthcare Research and Quality and the Robert Wood Johnson Foundation.

Several incentive models used

The \$8.8 million initiative is designed to help employers, health plans, and state Medicaid agencies develop and implement incentives to reward physicians and hospitals for higher quality. Initially, it will use 11 incentive models. The financial incentives will include:

- quality bonuses;
- compensation at risk;
- performance fee schedules;
- quality grants;
- reimbursement for care planning;
- variable cost sharing for patients.

The nonfinancial incentives will include:

- performance profiling;
- publicizing performance;
- technical assistance for quality improvement;
- practice sanctions;
- reducing administrative requirements.

The bonuses, either a set dollar amount or a percentage of total compensation (5% to 10%), will be guaranteed to providers after a certain measure is achieved.

“Alternatively, the provider or employer might set aside a large pool of funds, to be disbursed if a predetermined performance threshold is reached,” Callahan says.

In most cases, standard performance measures such as the Health Plan Employer Data and Information Set or the Consumer Assessment of Health Plans, which already are widely accepted, will be used. If none exists for a specific target area, participants may create their own measures.

Whatever measures are used, “Viable incentives share certain characteristics,” Callahan says. “They should target areas that are priorities for the organization that is setting them, such as care management for diabetics. They also need to be

easily understood and measured.”

The source of data and the methodology also must be agreed upon. “That’s why using things that are already out in the public domain and accepted is preferable,” Callahan explains.

When new areas must be addressed, she adds, it’s especially important to get all the stakeholders together in setting the measures.

Nonfinancial incentives such as publicizing performance can be equally effective. “You could call them indirect financial incentives, because by publicizing results it could cause a change in volume,” Callahan notes. “Transparency of information is key; the providers need to understand that they are making decisions that affect the quality of care patients are likely to receive.”

The reduction of administrative burdens is another attractive incentive. “If you set it up so that a provider organization that meets a certain level of measures doesn’t have to do some onerous paperwork, that may in some ways be as useful as additional financial compensation,” she observes.

But will it work?

Do the sponsors of Rewarding Results know that these types of incentives work based on similar programs, or are they looking to prove a theory? “Actually, it’s a little bit of both proof and theory,” Callahan says. “It’s a program looking to show over a three-year demonstration period that by aligning the financial and nonfinancial incentives in a way that makes sense for people, you will improve quality of care. We assume doctors want to provide quality, but right now the incentives are so perverse for them. They are currently not incentivized to do e-mail care messages, for example. If we change the incentives so it makes sense to do care management, they can do the right thing and not hurt their practice.”

It might seem like a good thing for hospitals to get people well and out of their beds faster, but

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they may lose revenue by doing that, Callahan adds. "It's not surprising that people don't choose to do things that hurt them," she says. "We'd like to see the reimbursement system aligned in such a way that people will do the right thing. We're looking to demonstrate that financial and nonfinancial incentives, aligned in the right way, can improve quality. Then, we'd like to see this replicated and reproduced beyond the final set of grantees we are going to have."

Applications to participate in Rewarding Results will be open until May 31. Interested organizations can visit www.nhcupi.net/news, to find information on the call for proposals, detailed selection criteria, application forms, a resource page, information about the incentives, and frequently asked questions. ■

QUALITY TALK

Part 1 of 2

Health care is ready for the seven levels of change

Start by doing the right things

By **Duke Rohe**, FHIMSS
Performance Improvement Specialist
M.D. Anderson Cancer Center
Houston

You can't find an environment that has a nobler mission than a hospital. How well or how poorly it operates has a significant impact — directly to the patient's outcome and indirectly to his or her pocketbook. I truly believe we are not

short on employees with great ideas; we are just short on environments to receive and place these ideas into operation FAST.

Having worked at St. Luke's Episcopal Hospital, an organization known for its innovative culture, and M.D. Anderson Cancer Center in Houston, a hospital unparalleled in the care its patients receive, I have seen real-world illustrations of the seven levels of change in health care. Here are some examples:

✓ Level 1: Doing the Right Things

Focus is so important in a hospital setting. The complexity of a situation, patient conditions, overlapping symptoms, and the situation's urgency, often cause energies to be spent in less than effective areas. At one hospital, before starting any major effort, its query mantra started with three questions:

- What are you trying to achieve?
- How will you know you got there?
- How do you plan to get there?

If the answers to these question cannot be stated clearly, don't begin. And this is repeated throughout the project to focus and refocus.

In a customer service initiative in a phlebotomy (blood collection) area, phlebotomists established their vision to be vastly better than any similar service. Although their services inflicted pain on their customers, they were going to be known for minimizing patient discomfort and anxiety. They created "Inspiration Alley" — one-page character-building reading pieces framed and placed in the line of sight of the draw chair. Oh, and if your birthday is the day of your draw, just like in a restaurant a "special" phlebotomist comes in wearing a birthday bow to sing "Happy Birthday."

Roadblocks are only means for creativity to the phlebotomists. There were small holes in the walls of some of the draw rooms due to equipment movement. The funds weren't available in the budget to fix them immediately, but the staff

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didn't let that stop them. They called the leader of the pediatric unit and "commissioned" the cancer children (M.D. Anderson is known for its Christmas cards) to paint little pictures around holes (such as a ladybug). Of course, the children signed their fine artwork for all the adults to appreciate.

✓ Level 2: Doing Things Right

Unless your process or work area is designed for things to be done right, sustained quality is a dice throw. The Japanese concept of visual control, the art of putting instruction (right way) into the point of action, was well employed in one hospital. A most memorable visual on an obstetrics floor was a diagram of a teardrop placed on the door of the moms who had lost their babies at childbirth. Beneath the teardrop was "Please check with the nurse station before entering." Instead of the usual inquiry of "How is your baby?" all caregivers would walk in with empathy, and guests were

cued in before entering. Small idea . . . *big* difference in terms of caring service.

✓ Level 3: Doing Things Better

In health care, if you are not doing things better today than you were yesterday, you are losing ground. One hospital created a "super unit" concept. This would be a prototype concept unit for new ideas. Extra support was provided in turning ideas into action. Some worked; some didn't. To be implemented, all the idea had to do was create a two-year payback on paper. If the implemented idea proved successful, it was passed on to the other 30 units for adoption. In the first year, 10% of the workload of the super unit was reduced. In three years, there were five super units competing to come up with the cleverest improvements.

Sometimes the smallest ideas are the most memorable: In the operating room suites, the compliance for testing heat and pressure of the

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Editorial Questions

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instrument sterilizer wasn't up to par. A special strip indicator was supposed to be dated with a special heat-resistant pen and placed in the morning run, but it wasn't getting done.

The manager inserviced the staff, stressed its importance, and followed up, yet the change was minimal. Then someone said, "Let's do something different." They purchased a plastic holder for the indicator strips, bought an adhesive pen clip from the local grocery store, and adhered them both to the sterilizer. Everything needed was obvious and close by. Compliance immediately jumped to 100%.

✓ Level 4: Doing Away With Things

Have you ever been to a Red Tag sale, where they tag items for quick sale to get them out of the way? In Japan, they use red tagging as a means to do Level 4 change.

In a collective environment, people tend to accumulate unnecessary things. They don't throw things away, because they don't know if someone might object or if it may still have use. Surgery suites in hospitals are notorious for getting new equipment and abandoning the use of older equipment without making the decision to get rid of it. There is a fear of possibly throwing away something that still may have value.

The surgery department in one hospital let physicians and staff know they were going to have Red Tag Day to clear out supplies and equipment in their way. Appointed staff, equipped with red tags, went around to every OR room and hallway, and for every item asked the local staff two questions: 1) Is this item needed? 2) Does this item need to be here, and in this quantity? If it failed either of these two tests, the item was tagged.

Tags were everywhere. After all areas were swept by the appointees, the tagged items were removed and placed in a red tag holding area. (The room was filled.) Physicians and staff had a week to make a case for why the item should be returned to its place. After that, the remaining red-tagged items were tossed/sold if they were not needed (Question 1) and stored away remotely if not needed in that quantity or that place (Question 2). Once the OR cleaned house like this, it repeated the process over time. Just like dusting, red tagging never ends.

Do you want to see how clutter sneaks up on you? Open up the top drawer of your desk and tag all items that don't pass the two "tagging" questions above. The best statement for "doing away with things" was coined by Holly Uverity of Office Organizers in Houston: "Remember, clutter is just

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the physical manifestation of indecision."

[This article is the first in a two-part series. Duke Rohe is performance improvement specialist at M.D. Anderson Cancer Center in Houston. He may be reached at (713) 745-4433. To access tools related to this series, visit the tools site: www.durationsoftware.com, then click Improvement Tools.] ■

Healthcare Benchmarks and Quality Improvement

The
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Beginning with the July 2002 issue, *QI/TQM* becomes *Healthcare Benchmarks and Quality Improvement*. We'll continue to give you the most useful and up-to-date information to help solve your toughest quality dilemmas — but we'll also give you expanded coverage of benchmarking and best practices.

We'll provide expert guidance on finding appropriate data sources, crunching the numbers, and, using the outcomes to improve quality at your facility. Stay tuned! ■