AMERICAN HEALTH CONSULTANTS®

QI/TQM®

TOOLS FOR CREATING CHANGE

Clinical Improvement Strategies • Outcomes Management • Benchmarking
Re-engineering • Process Improvement • Data Collection • Patient Satisfaction

INSIDE

■ **State Baldrige-based award:** California honors first health care winner 3

■ **Baldrige applications:** Fact pack 4

■ **Hospital customer satisfaction ratings:** Up last year, still behind 1995 5

■ **Guest Column:** Donna Fisher offers internal networking tips. 7

■ **Quality Talk:** Laheys Sanford Kurtz reveals data-to-practice strategies 8

■ **News Briefs:**
Physicians tell whats wrong with managed care 11
Guidelines for pediatric emergency equipment 11

■ **Grass-Roots QI:** M.D. Anderson Cancer Center slashes lab cycles 50%. . . . 12

JANUARY 1999

VOL. 9, NO. 1 (pages 1-12)

American Health Consultants® is A Medical Economics Company

Baldrige quality awards contest opens up to health care organizations

New forum to showcase excellence, exchange knowledge

Health care specialists at the Malcolm Baldrige National Quality Award office are still celebrating the congressional funding for awards to the health care and education sectors. With the $1.9 million appropriation, passed late last year, nonprofit health care facilities are eligible to compete for "the Baldrige" in 1999. The prize is regarded by many as the nation's premier quality award. However, as in most quality efforts, the bulk of the reward is in the journey. Consequently, just applying for the Baldrige could be the best thing that ever happened to your organization.

Mary C. Bostwick, health care specialist at the Gaithersburg, MD-based Baldrige award office, says she cheers the federal appropriation as a "real milestone" in the industry's journey toward excellence. "Health care providers have a long tradition of attention to quality; it's part of their values and culture," Bostwick notes. "Since the mid-1980s, health care organizations have worked hard to incorporate quality improvement principles. This [Baldrige award category] gives us the ability to disseminate best practices information faster."

One of many private sector leaders who devoted countless hours to securing the new appropriation is **Barry Rogstad**, chairman of the

Key Points

- Late last year, Congress approved the addition of health care and education categories to the Malcolm Baldrige National Quality Award contest. (Other categories include manufacturing, service, and small business.)
- The event allows nonprofit health care organizations to compete for what many regard as the nation's premier quality award.
- Experts deem the Baldrige application process and subsequent industry-wide sharing of quality practices as valuable as the prize itself.

(See related stories "St. John's updates itself using Baldrige criteria," p. 3 and "1999 Malcolm Baldrige National Quality Award," p. 4.)

Malcolm Baldrige National Quality Award Board of Overseers and president of the American Business Conference in Washington, DC. He notes, "This appropriation brings the tool kit of Baldrige quality criteria to two of the most important sectors of society: health care and education."

Application is its own reward

The sweetest fruits of the competition actually are within reach of all applicants, Bostwick explains. The Baldrige process is as much about transfer of knowledge as about recognition of industry stars. Indeed, as the application-feedback cycle commences, the whole health care community stands to improve immeasurably through the dissemination of best practices as demonstrated by applicants and winners.

Rewards start with the application, Bostwick explains. "Just the act of filing gives extra mileage on your quality journey," she says. Applicants receive feedback via reviews by outside experts. "It's like bringing a top consultant team into your organization," she explains. "Most applicants build that feedback into their planning processes and get a whole cycle of improvement in their quality programs."

But let's not discount the joy of winning, either. Winners in each category bring a handful of employees to the presidential awards ceremony in Washington, DC. The organization's highest official receives a gold-plated bronze medallion encased in solid crystal from he president of the United States. Winners participate in a three-day Quest for Excellence conference, exchanging knowledge with employees from the public and private sectors.

Currently 35 state quality award programs are open to health care organizations. Many of the local programs use Baldrige criteria as a basis for their applications. But whether the recent national appropriation will stir up more health care involvement at the state level, Bostwick can't say. However, she says, "I do foresee some organizations choosing to go through the state awards programs because that's their market, so a state award might be more meaningful than a national one."

Whether the competition is local or national, it directs all eyes toward an applicant's standing among its customers, peers, and competitors. "It's the issue of how you serve your market," Rogstad says. "Baldrige is an alignment question for the total organization. It's a tool kit that brings the total organization on to the same page.

"Sometimes you'll have one part of the organization in line on customer service or other quality issues, but when you start to use the tool, you might learn that you've got other big components of your organization out of alignment," he notes.

Communities benefit, too

It's almost as though the application itself is a prize. "The vast majority [of businesses] apply so they can get the real time feedback from the site visit," Rogstad stresses. Some even apply three or four times, and they don't always start off with the notion of winning, he adds. For example, in the 42 states with business and industry quality competitions, over 5,000 manufacturing applications come in every year. "All these entries make an impact on the quality of business in local communities," he notes.

"Participation has a more important impact than the award — that's what we're trying to reinforce without negating those who achieve the standard and win," Rogstad continues. "Some businesses apply once, then they apply again two to three years later. Their CEOs tell me they want those site visits. They want to make sure they haven't lost ground."

(For more discussion of the benefits of participating in local award programs, see related story, "St. John's updates itself using Baldrige criteria," p. 3.) ■

COMING IN FUTURE MONTHS

- Despite proven benefits, doctors drag feet on computer use
- Teen violence prevention outpatient guidelines
- FAST unit improves admissions
- VA hospital trims $187K off workers comp charge-backs
- Managing congestive heart failure by phone

St. John's updates itself using Baldrige criteria

Depth of change unimagined

What started in 1995 as an internal self-assessment turned into an unimagined retooling management style, and eventually a first-ever state award for St. John's Regional Medical Center in Oxnard, CA.

"Instead of targeting single areas for improvement, we started applying the Baldrige criteria to our process management so we could involve the greatest number of people at once," explains St. John's vice president of Medical Affairs and Clinical Operations, **Ross DiBernardo**, MD. DiBernardo is referring to the Malcolm Baldrige National Quality Award Health Care Criteria for Performance Excellence.

In 1997, St. John's became the first health care organization to win California's Golden State Quality award for Quality in the Community. "It was St. John's real caring about the community that caught the judges' eyes. They reach outside of their normal patient area to survey the needs of their community at large," says **Barbara Blalock**, president and executive director of the California Center for Quality, Education, & Development (CalQED) in Danville. The facility is a nonprofit hospital, part of Mercy Healthcare, a division of Catholic Healthcare West.

Key Points

Location: St. John's Regional Medical Center, Oxnard, CA

Situation: Seeking to update its management style, the nonprofit hospital launched an internal self-assessment using the Baldrige criteria for excellence. In the process, many assumptions went by the wayside. For example, St. John's learned that building blocks of excellence are the same for health care as they are for business. Staff's attitudes were more customer-oriented than the operational systems.

Solution: St. John's applied for a 1997 California Governor's Golden State Quality Award, less with the intention of winning than to incorporate the feedback into future quality improvements. It received the feedback it sought and became the first health care organization to win an award in the state's Baldrige-based competition.

Managers had to become coaches

Several years ago, St. John's looked at where health care was headed and realized that they were going to miss the boat unless they changed their approach to business. "We became convinced that a different management style would be required, so we could start to base our decisions more on the requirements of our customers, especially our patients," DiBernardo explains.

But it took little time for the St. John's management team to realize that superficial alterations would never shape up the organization to Baldrige caliber. "We had to restructure our leadership styles so that managers became more visible to the people we manage. As managers, we had to become coaches," he says.

Employees had to broaden their skill bases to include problem-solving tools and data-based decision making. That began with trainers who educated senior management. In turn, managers continuously teach and coach their staff to incorporate the new ways of working. DiBernardo describes the shift: "In the past, we were guided by opinions. Now we use patient data to guide our decisions." If the profound organizational changes didn't spin heads, many more surprises were on the way.

Where DiBernardo expected resistance, he found little. "Many of our people are patient-focused in the first place, so changing attitudes was, frankly, easier than I thought. But the systems were not customer-focused and changing them is tough." Nonetheless, a series of process improvement projects has chalked up some noteworthy results:

❒ Inpatient pain relief ratings rose, thanks to faster call-light response.

❒ Patient satisfaction in the emergency department improved 5% in six months.

He credits that to waiting room hosts and hostesses who decrease the mystery and unpredictability by telling patients and families how long their waits will be depending on the volume at the time. At each step of the emergency care process, patients also receive explanations of what to expect and why.

As St. John's worked with the Baldrige criteria, another surprise unfolded, DiBernardo explains.

1999 Malcolm Baldrige National Quality Award

- ✔ **Key dates:**
  April 15, 1999 — eligibility forms due.
  June 2, 1999 — applications due.
- ✔ **Application criteria:**
  The 1998 performance excellence criteria may be used for 1999 Baldrige award applications. The criteria include: 1. Leadership; 2. Strategic planning; 3. Focus on patients, other customers, and markets; 4. Information and analysis; 5. Staff focus; 6. Process management; 7. Organizational performance results.
- ✔ **How to obtain copies of criteria and application details:**
  (1) Call Baldrige National Quality Program: (301) 975-2036. (2) Download criteria from the program's Web site: http://www.quality.nist.gov. (3) Mail a request to: Customer Service, Malcolm Baldrige National Quality Award, NIST/NQP, Administration Building 101, Room A635, Gaithersburg, MD 20899.
- ✔ **Notes on the awards:**
  The number of awards per category will be raised from two to three this year. However, the judges have never awarded the full number of awards per category since Congress established the Baldrige National Quality Award in 1987. Since 1988, there have been 32 Baldrige winners. As of last year's expansion, there are now five categories: education, health care, manufacturing, service, and small business.
- ✔ **Application-feedback loop:**
  The 322-member board of examiners presently includes 50 to 60 health care professionals. Applications go to mixed teams of reviewers from health care and business fields. Award process: Stage 1: Independent review and selection for consensus review. Applicants eliminated receive reviewers' feedback. At this stage, each application can have up to 14 readers. Stage 2: Consensus review and selection for site visit. Again, those eliminated receive feedback. Stage 3: Site visit reviews. Site visit teams include six to nine judges. Applicants eliminated receive feedback. Finally, winners are chosen and they receive feedback.
- ✔ **Confidentiality:**
  Applicants have full assurance that their names and application details will not be disclosed by the Baldrige program.
  (To learn about the qualifications for examiners, see *QI/TQM*, December 1998, p. 167.)

"At first, we thought we would have to modify the Baldrige criteria to fit health care. But when we got into it, we saw that if we use fact rather than opinion to guide our decisions and if we offer good service at affordable cost, we're not that different than any other service business."

Blalock supports DiBernardo's observation noting that the health care and business criteria are essentially the same with the language being the primary difference. The health care criteria are simply stated in health care terminology such as patient, nurse, clinician, etc.

Having progressed through the Baldrige self-assessment process, DiBernardo explains, "we decided to submit an application for the state award as a way to inspire and reinforce our managers."

St. John's takes statewide honors

St. John's entered the CalQED Golden State Excellence competition primarily for feedback on its overall management systems, but it came back with much more. Blalock notes that one pocket of excellence caught the judges' attention — the institution's community service program. So St. John's became the first health care applicant to win the prestigious CalQED award. The health care category, established in 1996, had no winner the first time out. At this writing, 1998 winners are yet to be announced.

Highlights of the community service program include:

❒ **Baby, Think It Over** gives teens a taste of single parenthood responsibilities. Area high school students take 24-hour care of computerized baby dolls programmed to eat, cry, and wet diapers. Now in its second year, the program surpassed by 20 its first annual goal of 100 placements. Though the logistics are difficult, DiBernardo says, the immense potential for change makes small numbers worthwhile.

❒ **Healthy Beginnings** increases birth weights of infants born to low-income women. St. John's matches mothers-to-be with participating physicians. In addition to doctors' appointments, the women learn how to give their babies a healthy start by curtailing drinking and smoking, as well as taking vitamins and eating a balanced diet.

"The women are delighted with the education, and they appreciate the extra care," he explains. The results represent good news for area neonatal health care resources as the 472 Healthy Beginnings mothers delivered no very

Need More Information?

On building top-notch community programs, contact:

- **Ross DiBernardo**, MD, Vice President for Medical Affairs and Clinical Operations, St. John's Regional Medical Center. E-mail contacts only: rdiberna@chw.edu.

On Baldrige-based state health care and business awards, contact:

- **Barbara Blalock**, California Center for Quality, Education, & Development, P.O. Box 1929, Danville, CA 94526. Telephone: (925) 210-9766.

low birth weight babies in 1997.

Beyond prevention and health education, St. John's provides $4 million-worth of "pure charity" care annually — "care that we agree to without expecting compensation," DiBernardo explains. He adds, there's an additional $12 million of "uncompensated care — where we learn after the fact that the patients would not be able to pay."

Journey without an end

Looking back, DiBernardo reflects that the depth of change at St. John's is still hard to comprehend. The flow of resources into QI efforts is constant as 22 teams work on process and management improvements. The average team spends six months per project, involving salary expenditures $2,700 to $6,000.

"The quest to improve is never ending," he observes. "We're still getting used to that. We make one change today, and we're satisfied. But then we say, 'OK, what do we do tomorrow?'" ■

Better hospital ratings: Good news, bad news

Satisfaction still trails 1994 scores

Patients are happier with their hospital experiences today than they were two years ago, but that's nothing to brag about, according to recent figures from the Milwaukee-based American Society for Quality. In the annual American Customer Satisfaction Index (ACSI), data from first-quarter 1998 figures, hospitals garner 72 points, compared to 76 for motion pictures and 71 for hotels and motels. The three industries comprise the ACSI's service sector.

(The hospital satisfaction ratings are illustrated in the graph "Hospitals: ACSI ratings from 1994 to 1998, p. 6.)

Consumers haven't singled out hospitals for lackluster performance, however. Overall service sector ratings are sliding downward as this decade moves to a close, a mistake for which the society's past president **Jack West scolds** the industries.

"Company executives — and employees — cannot lose sight of the fact that their job security and the financial future of their enterprises depend on customers," he says. "These creeping reductions in customer satisfaction across service industries ought to be addressed firmly and immediately."

The ACSI is the nation's uniform, national, cross-industry index measure linking customer satisfaction to financial performance. It is produced through a partnership of the American Society for Quality, the University of Michigan Business School, and the accounting firm Arthur Andersen, LLP.

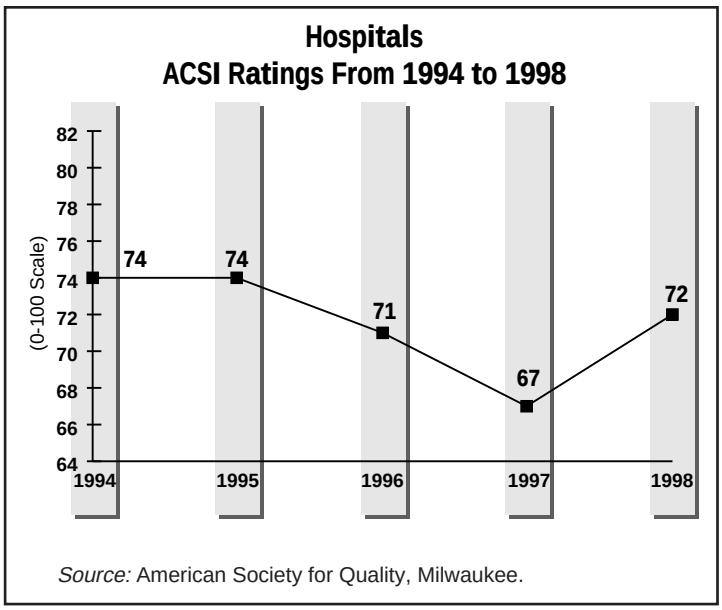
Unmet expectations

As consumers become more sophisticated about health care, they want more from their encounters with providers and hospitals. High expectations are fueled by media scrutiny of unrest within the industry.

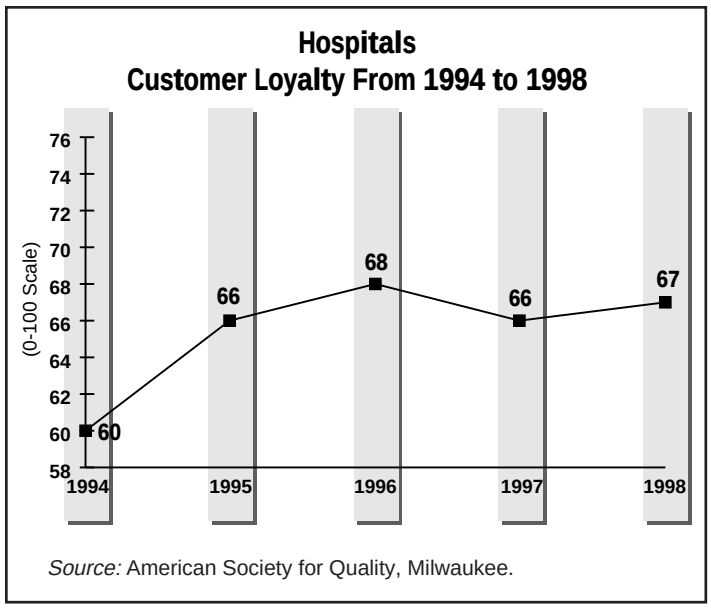
For example, the ACSI report mentions reverberations from nursing unions and consumer advocacy groups' exposure of proposed and actual reductions in professional staff.

Key Points

- Consumers are more satisfied with hospitals in 1998 than in 1997. However, the ratings still trail behind 1994 and 1995 levels.
- "Customization of services," such as convenient hours of operation, is a factor in consumer perceptions of quality in health care services.
- Providers who are determined to improve patient care consider patients' feedback their primary navigation tool.



Source: American Society for Quality, Milwaukee.



Source: American Society for Quality, Milwaukee.

Source: American Society for Quality, Milwaukee.

(A look at the graph "Hospitals: Customer expectations, perceived quality, and perceived value from 1994 to 1998," above, shows that perceived quality still trails 12 points behind expectations and perceived value.)

Customer loyalty a delicate matter

While a hotel might write off a night's stay or a theater might issue a free pass to win back an upset patron's loyalty, a hospital can't give back the extra hour a consumer waits for lab test results or pain meds. And irate consumers do serious damage to a hospital's reputation.

Because hospitals have limited means to woo back alienated customers, it pays to identify and deliver services in forms that consumers perceive as quality. For example, the ACSI findings cite customization of services as a factor in favorable perceptions. Customization includes convenient hours of operation and individual attention from hospital staff. **(For four-year ratings, see the graph "Hospitals: Customer loyalty from 1994 to 1998," above.)**

Stay tuned to the customers

Just because the whole service sector is getting a bad rap from consumers, your facility need not follow suit. If you listen to your public, advises **Susan Edgman-Levitan**, president of the Picker Institute in Boston, they can clue you on how to build loyalty and satisfaction. She shares these three tips from Picker's widely-renowned customer satisfaction research:

☐ **Run planned improvements past your patients before implementation.** "When hospitals plan changes in response to problems patients identify, 99% of the time the interventions are off-base. Sometimes, I think if we could quantify the money we waste providing inappropriate solutions to people's problems, we would probably have all the money we need."

☐ **A correlation exists between patients' perceptions and the technical side of quality.** "We've noticed in our work [at Picker] that when measures of morbidity and mortality are above

Need More Information?

On the American Customer Satisfaction Index (ACSI) as well as other quality improvement studies, workshops, and publications, contact:

- ❏ American Society for Quality, 611 E. Wisconsin Ave., PO Box 3005, Milwaukee, WI 53202-3005. Telephone: (800) 248-1946. Fax: (414) 272-1734. World Wide Web: http://www.asq.org.

On patient satisfaction research findings and patient satisfaction improvement workshops, contact:

- ❏ Picker Institute, 1295 Boylston St., Suite 100, Boston, MA 02215. Telephone: (617) 667-2388. Fax: (617) 667-8488. World Wide Web: http://www.picker.org.

the norms, patient satisfaction scores tend to slide also."

☐ **Patients talk about bad experiences more than they talk about good ones.** "When people have a bad experience with care, they are likely to tell between 10 and 20 people." ■

GUEST COLUMN

Ten tips for successful professional networking

By **Donna Fisher**

How about a fresh look at internal networking — creating a world of contacts that give you more knowledge, more opportunity? None of us is as smart as all of us, so we need to get to know each other better: Professionally and personally. These are the "how to's" of developing a networking approach to your job:

1. **Give up the Lone Ranger mentality.**
Some people have the misconception that it is a weakness to rely on others. Start creating a circle of colleagues who are good at what you are not: Not to substitute for your weaknesses but to reinforce and learn in those areas where you have no knowledge or inclination.

2. **Honor your relationships.**
Networking opens communication lines. What are those little things you can pass along that may help others? What goes around comes around. The more you give, the more others want to give in return. Never take advantage of a relationship. People tire of a mooch.

3. **Acknowledge others with a simple thank you.**
A genuine congratulations. A note of appreciation. Do you realize that acknowledgment and encouragement are the most valued yet underutilized tools today? And it doesn't cost that much to give. Do you want to look good? Brag on someone else's work.

4. **Send a note today.**
Get some 5-by-7 note cards within the next 24 hours, and dare yourself to write, or e-mail, one note a day. Two lines will suffice. Send it to someone who wouldn't be expecting it. "Just thinking about how much help you were on the task force." "Hope you are doing well at X." "I appreciate your support." "Give me a call."

5. **Manage yourself as a resource.**
What are your needs? What are your values? What are important things about yourself? What are you looking for? How do you want to interact? If you get a handle on these, you can do a better job of moving toward your goals.

6. **Take initiative.**
Get the flow going in terms of communication and understanding more about your co-workers and your organization. Don't wait for other people to come to you. Use the 3-foot rule: If someone is within 3 feet of you, find out something about them. It grows your scope of friends.

7. **Ask for what you want.**
If there is some help you are looking for, be specific and direct. Don't make the other person guess what you need. Avoid asking close-ended questions that can be answered with a yes or no. If the person cannot help you, then ask, "Who do you recommend?"

8. **Expand your horizons.**
Make it a goal to develop 50 close contacts.

These contacts could include co-workers or people from local businesses or insurance plans. The more you have, the broader your base for understanding the world around you.

9. **Follow the Golden Rule of networking.** Give unto others as you would have them give unto you. It has a boomerang effect. If you are continually taking, others will quickly know. If you are a natural giver, you will have an army of anxious friends ready to return the favor.

10. **Make networking a way of life.** Make your giving-attitude a skill. Be sure you don't make the mistake of not asking for help because they may say no. Don't decide for the other person. It may be their pleasure to help. You may be shutting down a valuable association that would have a lasting benefit into the future.

Printed with permission of Donna Fisher, author of Power Networking and People Power. *For further information, contact: Donna Fisher, 6524 San Felipe, #138, Houston, TX 77057. Telephone: (800) 934-9675. World Wide Web: http://www.donnafisher.com.* ■

QUALITY TALK

Cutting data-to-care cycles where it counts

***Sanford R. Kurtz**, MD, joins us to discuss ways of accelerating the cycle of converting clinical research findings into patient care practices. He is vice president and chief medical officer at the Lahey Clinic in Burlington, MA. In addition to overseeing quality initiatives at the clinic, he is clinical associate professor of Pathology at Harvard Medical School. Kurtz is often an invited speaker at forums on clinical guideline practice, disease management, and making change for clinical improvement.*

Q. At Lahey Clinic, you're involved in the Accelerating Clinical Improvement initiative which specializes in converting clinical knowledge into real improvements in everyday patient care. Will you explain how it works?

A. We utilize Deming's model, the plan-do-act cycle. Essentially we try to build two sets of competencies into all our improvement work. One is the competency to successfully implement improvement. The second is to make our improvements in a more rapid cycle time.

So our improvement model is pretty straightforward. It involves three large areas: (1) We have a workshop and a workbook for our improvement teams. (2) We create the teams. Each team has a facilitator and a data analyst and a sponsor. The teams reach an agreement on what they are trying to accomplish. (3) We look at current knowledge, from which we establish measures of quality.

We create our own measures and use external benchmarks. Then we create a cycle for learning and improvement. We develop a small test of change, and implement a change. Then we measure it and create another cycle of change and continue to make progress like that.

Leading indicators drive QI improvement

We establish measures based on our aims. For example, if it is to improve access in a clinical area, then the team establishes the measures of access. It might be third next available appointment, or it might be a measure based on when new patients need to come into the system.

Those measures are our leading indicators. Financial indicators frequently are lagging indicators. In other words, we know what they are, but they don't help us change the cycle to improve things. So we try to find leading indicators. And we also try to pick indicators that are key levers, that is, they are critical measures absolutely necessary for success.

Q. What would be an example of a key lever?

A. I think access was a good one for us. I would say that new patients seen within one week of request is the leading indicator. And that's a more important indicator than the number of visits if you're looking at access. So that would be a key lever. Conversely, we don't want to know the number of patients the doctor saw as a measure of access. We would like to know how many new

patients he sees because new patients are much more important in terms of our growth over time.

Or, instead of knowing how many dollars a month we spend on pharmacy costs, it might be more important to have a measure of how many of our beta-blockers are on the managed care formulary.

Another example is pneumonia and the tendency to look at length of stay. In fact, one of the key levers is when people are switched to oral antibiotics because that determines how soon they can go home. How many hours from the time they are admitted until they are put on oral antibiotics will ultimately dictate the length of stay.

Frequently, what you find in large organizations is a group of improvement personnel that operate in a vacuum. They have no direct line authority to make change, and the savings generated are frequently determined by them.

Q. You mentioned that each team has a sponsor. Why is that important?

A. Sponsorship is frequently lacking and that leads to failures in improvement projects. People can have a very good improvement model, and be very good at creating teams and team leadership. But frequently, no similar attention is paid to creating sponsorship at the highest organizational levels. So teams feel they're operating in a vacuum. They have no ability to implement the changes needed to make their work successful.

One of the things we do with every improvement team is to ensure that sponsorship rests in leaders who are capable of understanding what they are responsible for, and who have the ability to implement changes created by the improvement team. We are trying to link sponsorship to the actual improvement cycle.

Q. How do you choose team sponsors?

A. We frequently like to have a physician in partnership with an administrator. We need physician accountability for many of the changes.

And then we might choose the vice president for ambulatory operations, for instance, because we know that in order to implement an improvement in access, we would need the vice president who is responsible for the appointment office. And for some changes, we might take someone from our board of governors.

Q. Have you been successful in acquiring that high a level of sponsorship?

A. You bet. Now not every team is successful, for all sorts of reasons, but I believe we have done two things to dramatically improve our success. The first is sponsorship by leaders, as I have described. Second, we have required that our key improvement projects be identified during the budget process so the finance department puts a value on the improvement process.

So from both from a strategic and a financial perspective, the organization feels that the few projects we are going to focus on are the critical ones and that they have a measurable value built into the budget. That has enhanced the accountability and the responsibility.

Frequently, what you find in large organizations is a group of improvement personnel that operate in a vacuum. They have no direct line authority to make change, and the savings generated are frequently determined by them.

For instance, if they take a day of length of stay and assume it's $1,300, they multiply it by all the days that have been saved and they say that the organization saved $4 million or $5 million that year. Finance hasn't signed off on that. The accounting can frequently be flawed. But then the improvement group presents their little report at the end of the year showing how many dollars they have saved. That, to me, is not a formula for success.

In our organization, we have the capability of doing only a few things very well. And the budget process lines up the needs of the institution with the resources we have to meet the needs. Finance is involved because the budget is based on some of the cost requirements or the improvement in revenue generated by those projects. So budgeting creates a level of accountability and aligns organizational needs with improvement initiatives.

Q. From your experience with accelerating clinical improvement, where should quality improvement managers be focusing their staffing and budgetary resources?

A. Our organization focuses on employee and patient satisfaction.

Q. Employee satisfaction — will you tell us more about your improvement efforts in that regard?

A. We have 3,000 or 4,000 employees. Through focus surveys and a whole series of process efforts, we have involved maybe 1,000 of them in areas they say are important. We've measured our employee satisfaction for the last three or four years. It's something that we feel is very important. You cannot have good customer satisfaction without employees who are satisfied with their work.

Q. Do you have leading indicators by which you gauge employee satisfaction?

A. Some of the major drivers we focus on are work environment, supervision, compensation, and communication. We have questions that relate to each of those areas. Supervision might focus on: fairness, gives feedback, supports new approaches, and listens to what I have to say, for instance. For work environment, areas to gauge satisfaction could be: leaders treat employees with respect, opportunities for advancement, or reasonable job challenges. The other clinical areas we are working on are high-risk population management and physician panels.

We're focusing more on identification of high-risk patients and on programs to monitor care than on management programs and clinical guidelines in the outpatient setting.It's slightly radical. But we think it is the best way to create a major improvement in care and in financial performance in a short period of time.

Q. The *Lahey Clinic 1998 Quality Report* mentions the fall-risk reduction program for the elderly. Is that what you would describe as a strategy for high-risk population management?

A. That's one of our efforts. And we have expanded beyond that. When you look at the literature, it turns out that 5% of a population can account for 50% of your cost. We have a special software system that prospectively identifies high-risk patients, and we've found that .6% of our managed care patients account for 30% of our total managed care expenditures. In other words, less than 1% of our managed care patients account for 30% of Lahey Clinic's managed care costs.

We have a targeted, aggressive ambulatory case management program focusing on those patients. It extends out into the community where they live because part of the reason they generate all this cost is the hospitalizations and interactions with the emergency department. **(For a description, see QI/TQM, December 1998, p. 163. For information on obtaining a copy of the *Lahey Clinic 1998 Quality Report*, see note, below.)**

Q. Tell us about the physician panels — what are they, and how do they work?

A. Our primary care physicians have a group of managed care patients. They are responsible for the care of those patients and for the cost of the care. We use the term high-risk patient population management to help our physicians identify the most at-risk patients in their panel. Then we direct a program of care management to those patients and that inevitably leads to more cost effective health care.

In identifying high-risk populations, I strongly believe that our social systems and other approaches tend to focus on the elderly vs. less elderly people, the line being around the Medicare eligibility point. But that's really an arbitrary designation.

We find that there are as many or more people in high-risk populations in the commercial programs as there are in Medicare. What we need to be doing is creating programs that deal with the burden of illness irrespective of the patients' age.

For single free copies of the Lahey Clinic 1998 Quality Report, *Lahey Clinic, Department of Public Affairs, 41 Mall Road, Burlington, MA 01805. Telephone: (781) 744-8733.* ■

NEWS BRIEFS

Medical directors: U.S. needs universal insurance

Inappropriate use of resources and waste top the list of problems in managed care, say a group of medical directors surveyed by the Medical Care Management Corporation of Bethesda, MD, and the National Association of Managed Care Physicians of Richmond, VA. The third problem is the increased number of uninsured.[1]

Among the practical changes that would most improve America's health care system: universal, basic, affordable health insurance (31% of the respondents), and more information on a given intervention's cost effectiveness / benefit and patient outcome data (23%). The respondents perceive patients' most pressing concerns about managed care as: access / barriers to care (24%), loss of trust in the system / physicians (18%), covered services / benefits reductions and limitations (11%), and loss or limitation of choice of physician (11%).

The survey population of 158 consisted of medical directors employed by managed care organizations and self-insured employers, as well as administrative heads of the medical components of organizations. Excluded were medical directors of hospitals, long-term care facilities, and other provider institutions. Clearly, managed care is a work in progress, the report observes. The authors note that while managed care deserves credit for slowing rising health care expenditures, they wonder whether the savings are sustainable.

In the short run, mergers of managed care organizations and providers may contain costs and prolong the life of many facilities, But in the long run, the authors warn, "consolidation may be accompanied by right-sizing, resulting in layoffs and in lowering the skill level of the remaining work force."

Reference

1. Goldschmidt PG, Liao JC. Trends in managed care: Results of the 1996 / 97 medical directors survey. *J Managed Care Medicine 1998; 2(1):36-43.* ▼

Guidelines released for pediatric ED equipment

Now you can provide your emergency department with the latest list of essentials for giving crisis care to children.

"These guidelines establish a national consensus about what equipment is necessary to provide high-quality care for children," says **Marianne Gausch**, MD, member of the development committee of the Washington, DC-based American College of Emergency Physicians, "and they allow for modification to address different severity levels of patient populations." Additionally, the guidelines contain charts of pediatric resuscitation medications.

The list is arranged in five sections. Following are selected items from each section:

1. Miscellaneous — infant formula and oral

QI/TQMfi (ISSN# 1075-0541) is published monthly by American Health Consultantsfi , 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid in Atlanta, GA 30304. POSTMASTER: Send address changes to **QI/TQM**fi , P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421. Fax: (800) 284-3291.
Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F, EST.
Subscription rates: U.S.A., one year (12 issues), $439. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $220 per year; 10 or more additional copies, $132 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $73 each. (GST registration number R128870672.)

Editor: **Mary Kouri,** (303) 771-8424.
Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com)
Production Editor: **Ann Duncan**, (404) 262-5463.

Editorial Questions

For questions or comments, call **Susan Hasty** at (404) 262-5456.

GRASS-ROOTS QI

The Diagnostic Center at M.D. Anderson Cancer Center untangled lab problems, netting 50% drops in blood draw-to-processing cycles. Performance improvement specialists, ***Mary Gibson and Duke Rohe*** *share solutions that could improve your cycle times.*

✔ PROBLEM

New software glitches delayed specimen label printing 60 to 90 minutes. Patients were irate. Within six months, front-desk positions turned over twice. "The learning curve at the time was pretty steep," Gibson says. "We were training the outpatient clinics and lab staff on the new system."

✔ SOLUTIONS

"Quick-draw McGraw" task force met for two months. Departments represented: Outpatient clinics; X-ray, whose schedule is affected by lab delays; and lab and information systems. "People learned they weren't the only ones having trouble," Gibson says.

Quick hit: (1) Lab orders cheat sheet disseminated to all involved staff. "If a patient shows up at 6:00 a.m. with an incomplete order, we would have to wait until the clinics open at 8:00 a.m. to straighten it out." Gibson says. (2) Computer glitch corrected to print labels as needed. Some patients have up to six blood samples. (3) Peak staffing 8:00-11:00 a.m. Mondays when 80% of volume (480 to 600 patients) occurs. Front-desk receptionists increased from two to five. One handles problem cases and patients without orders. Four run "express lanes," entering routine patients and answering phones. (4) Routers (new position) escort patients to phlebotomy stations and walk specimens to sending station for trolley and pneumatic tube transport to processing area. Phlebotomists stay put during rush hours.

In progress: Cross-training adds flexible coverage for peak hours, vacations, and sick time. Staff learn front-desk, router, and phlebotomist functions.

✔ RESULTS

Front desk turnover ceased. Waits dropped 10 minutes with labeling problem resolution. With further improvements, patient arrival to specimen arrival in lab processing area dropped to 30 minutes.

✔ KEYS TO SUCCESS

Peak hour staffing, addition of routers, and computer glitch correction.

✔ CONTACT

Duke Rohe, M.D. Anderson Cancer Center. Telephone: (713) 745-4433. E-mail: DRohe@pdq.net. ■

rehydrating solutions, pediatric restraining devices, resuscitation board.

2. Specialized pediatric trays — thoracostomy tube with water seal drainage capability; lumbar puncture (spinal needle sizes 20-, 22-, and 25-gauge).

3. Meconium aspirator; surgical airway kit. Fracture management — cervical immobilization equipment (sizes child to adult).

4. Extremity splints — femur splints (child and adult sizes).

5. Desirable equipment and supplies — medical photography capability.

For further information on the pediatric emergency guidelines, see: Committee on pediatric equipment and supplies for emergency departments, National emergency medical services for children resource alliance. Guidelines for pediatric equipment and supplies for emergency departments. *Ann emerg med* 1998; 31:54-57.

For a copy of the article, send your request with a self-addressed envelope to: American College of Emergency Physicians, 1111 19th St., NW, Suite 650, Washington, DC 20036. ■