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New performance model helps transform Veterans Health agency

Delivery of health care and management structure change radically

Any change model that can transform a government agency successfully must be powerful stuff indeed, and it seems that the High Performance Development Model (HPDM) at the Department of Veterans Affairs/Veterans Health Administration (VHA), in Washington, DC, has done just that.

It all began in the mid-'90s, recalls **Larry Bifareti,** executive work force planning and development officer for the VHA.

"Prior to that, we were a caricature of government, and of medicine in general. We were inpatient-based, very centralized, with a confusing chain of command and most decisions made in Washington. Staff offices had line authority but no accountability. One center would compete against another, sometimes trying to steal prestigious programs. But two dynamic leaders [Jesse Brown and Ken Kaiser] transformed the VHA into what we truly feel is a world leader in health care delivery," he says.

The HPDM must be seen in a whole context, Bifareti adds. "Yes, we emphasize primary care, appropriate medical care, and quality," he says. "But there has been an equally dramatic transformation on the management side. Decision making has been decentralized; we have gone from 100 independent centers to major geographic regions — 22 area networks." These 22 networks are referred to as Veterans Integrated Service Networks (VISNs).

VHA leadership recognized that the culture of the organization

Key Points

- Core competencies are identified to aid in employee assessment.
- Program is introduced at organizationwide summit meeting.
- Each network and facility is charged with creating its own initiatives.

didn't fit what needed to be done, Bifareti explains. "That's why we moved from a handful of decision makers to a more broad-based approach," he says. To bring about the change, a select group met on a monthly basis, to serve as a guiding force.

"Leadership saw succession as a key issue — to change the way leaders thought, and to transform them into team players, network builders," he notes. **(See box, p. 64.)**

In order to determine how best to proceed, the group benchmarked a number of high-performing organizations in the private sector. "We saw that we had to address the entire organization," Bifareti says. "We came back with a number of concepts that became the framework for the HPDM." The report for the model and all its elements was presented toward the end of 1996.

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The benchmarking process had revealed one common theme: Actions consistently based on core competencies lead to success.

Accordingly, the model included the following core competencies:

- organizational stewardship;
- systems thinking;
- creative thinking;
- flexibility/adaptability;
- customer service;
- interpersonal effectiveness;
- personal mastery;
- technical skills.

For each core competency, there is a general description, behavior examples for four different levels, an extensive list of learning opportunities (books, videos, CD-ROMs, and so on). The four levels are:

- **Level I** — frontline staff, those without supervisory responsibility;
- **Level II** — first-line supervisors and team leaders;
- **Level III** — division or product-line leaders and other middle managers;
- **Level IV** — senior executive leaders.

"Clearly, these represent the level of supervisory or managerial responsibility for a given individual," explains **Sarah Gurwitz**, MA, human resources consultant with the VHA Human Resource Management Group. "You can look at the behaviors for the various core competencies and see the skills you need to develop to prepare yourself for the next level up."

There is a progressive nature to the competencies, adds **Mary "Bunny" Huller,** MA, HPDM coordinator for Employee Education Systems. "When we depicted them in a triangle of core competencies, we found that those competencies that were more focused on self — personal mastery and technical skills, for example — build to those broader in scope at the top of the triangle. From a leadership perspective, if you look at oneself first, you are better able to look at other core competencies."

In order to trace individual core competency progress across the four levels, the VHA uses a 360-degree assessment/feedback model.

"The 360 degrees really refers to the face of a clock," explains **Sue Dyrenforth**, PhD, director of the VHA National Center for Organizational Development. **(See sample, p. 63.)**

"In order to really progress along the levels, one of the most important foundations is to have accurate feedback that you can use: feedback on

Overall Results

VHA HPDM 360 DEGREE ASSESSMENT

OVERALL RESULTS
PARTICIPANT: Group Identified

BACKGROUND INFORMATION: There were a total of 13 respondents. This feedback will help to understand areas of strength and opportunities for development.

AREAS OF STRENGTH: These are the top five areas of strength that identified across all the respondent groups. Behaviors identified as the areas of greatest strength are listed first. The behaviors are linked to the corresponding HPDM Core Competency.

QUESTION NUMBER	QUESTION/BEHAVIOR	CORE COMPETENCY
6	Focused on the importance of customers (i.e., guest relations, patient satisfaction, stakeholder support) when making decisions.	Customer Service
12	Understands how the contributions and needs of the program and/or facility fit into the broader picture of the VA/VHA.	Systems Thinking
26	Encourages and listens to the ideas and opinions of others.	Interpersonal Effectiveness
40	Actively maintains, builds, and applies subject matter knowledge required to accomplish business and work objectives.	Technical Skills
22	Uses facts and logical arguments to resolve conflicts and negotiate effectively.	Interpersonal Effectiveness

AREAS FOR DEVELOPMENT: These are the top five areas of greatest developmental need identified. Behaviors identified as the areas of greatest development are listed first. The behaviors are linked to the corresponding HPDM Core Competency.

39	Does not seek out feedback from others relating to his or her strengths and weaknesses.	Personal Mastery
1	Has difficulty handling multiple inputs and tasks simultaneously.	Flexibility/Adaptability
19	Tailors his or her interpersonal style appropriately for diverse groups of people and situations.	Interpersonal Effectiveness
44	Initiates his or her own career planning and development to achieve long-term, challenging career options.	Personal Mastery
45	Avoids evaluation meant to improve his or her performance.	Personal Mastery

Source: Department of Veterans Affairs/Veterans Health Administration, Washington, DC.

your performance as perceived by your boss or bosses, your peers, and those who report to you." The person who is to receive the feedback originates a list of those from whom they wish to receive that feedback. "These people are then notified and can go on the intranet site to respond," Dyrenforth says. Responses are given in each core competency, and for each individual item.

"They indicate where they see the person currently performing, where they would prefer to see them performing, and what changes are required to get to that next level," she notes.

When it came time to introduce the HPDM, instead of dictating the new model from "on high," it was unveiled at a huge summit meeting, to which each network sent six representatives. "This helped make implementation a huge success," Bifareti says.

The representatives were encouraged to identify two implementation initiatives that would be most appropriate for their organization — either as a network or as a facility. "What happened was that implementation was unconstrained," he notes. "This resulted in a number of innovative programs that met local culture. If the change had come from Washington, DC, they would have drawn boundaries; this approach was really enriched."

Incentives also helped spur innovative plans. "We gave out grants of $25,000 to networks that came up with plans," Gurwitz notes. "You had to have measurable results; in other words, did you do what you said you would do?" These programs were shared with the other networks through the VHA web site. They included awareness programs, leadership development, and various assessment tools.

As the incentive program evolved, three prizes of $75,000 and a grand prize of $150,000 were awarded for outstanding initiatives. "You could receive an award based on one component of the model or on the broadest use of it," Gurwitz explains.

"The incentive strategy, the prizes in and of themselves, have stimulated a lot of innovation," Dyrenforth adds. "We received an award for continuous assessment the first year, and we used it to fund postdoctoral fellowships in organizational development. That program has now gone national."

"Network directors are a very competitive group; they want to be successful," Gurwitz says. "In the first year, we received submissions from 11 VISNs. The second year, we got 19.

"I've gotten e-mails from people telling me how excited they are about the program, expressing the feeling that maybe they are finally doing the right things," she continues. "One VISN put their money into an award program for facilities, to spur individual employees to compete at the grass-roots level."

The impact of the HPDM is widening as the program evolves. "We did a pilot study last spring [April to June 2002] with more than 500 participants and 5,000 respondents," Dyrenforth explains. "As a result, we now have VHA norms, and can not only look across the whole country and systemwide, but over specific occupations and levels of organization."

Aggregate data can be used for strategic planning, she notes. "This can help us figure out what

Need More Information?

For more information, on the High Performance Development Model, contact:

- **Department of Veterans Affairs/Veterans Health Administration**, Washington, DC. Web site: www.va.gov/visns/visn02/emp/learning/index.html.

VHA: Past and Present

This is a comparison of the pre- and post-High Performance Development Model implementation:

PAST	PRESENT
Status quo managers who supervised people	Leaders who can facilitate change
Were expected to know all the answers	Are externally customer-focused
Had an internal focus	Can create learning organizations
Managed schedules and work	Who coach and mentor
Narrowly structured career tracks	Promotion based on performance
Service silos development	Broad career
Limited development opportunities	Alignment around core competencies
Expectation of lifelong employment	Expectation of lifelong employability

Source: Department of Veterans Affairs/Veterans Health Administration, Washington, DC.

direction we need to go in for all our developmental programs; it really helps in the planning process," she says.

The 360-degree assessment "is an operationally excellent example of tracking continuous assessment," Dyrenforth continues. "When we have the 180-degree assessment [so that even frontline employees who do not have supervisory responsibility can get feedback], all VHA employees will be able to get this kind of feedback on demand." Currently, assessments are conducted every 18 months, she notes.

The HPDM has provided a framework for further organizational change, Bifareti notes. "The next step in trying to move organizational culture was in-depth work force analysis and succession planning to address the aging work force," he says. "We created a model in 1999, and in 2000, came out with a whole series of recommendations, one of which was to establish at all levels of the organization consistent leadership development programs. It has been rolled out all around the HPDM. The main concept is that every employee should be a leader."

"The VHA saw HPDM becoming a long-term strategy," says **Nancy Sadel,** VHA HPDM coordinator. She heads a national program office for HPDM to coordinate activities and share data on work force development. Her office also supports the web-based development for the program.

"We plan to do a national web-based personal development plan for each individual in a national leadership program," she explains.

"Together, these individuals with their mentors and supervisors will plan and develop individual development strategy through self-assessments and assessments from others." This program will be launched this month, Sadel says.

The HPDM has widespread support among those instrumental in implementing the program. "It is owned throughout the organization," Bifareti adds.

"The model is a tool for what we hope will continue to transform the organization," Dyrenforth says. "One of the things I look forward to is to follow outcome measures as well as activity. My personal evaluation is I have the best job in the universe; this is the most exciting organizational undertaking I've ever been involved with."

"This has been such a rewarding initiative," Gurwitz adds. "I see the VA moving toward meeting employees' needs as well as veterans' needs and putting them together. This was just the initiation of the health care phase; now, it's being taken on by the rest of the organization." ■

New application tracks nursing care, results

Standardized nomenclatures aid benchmarking

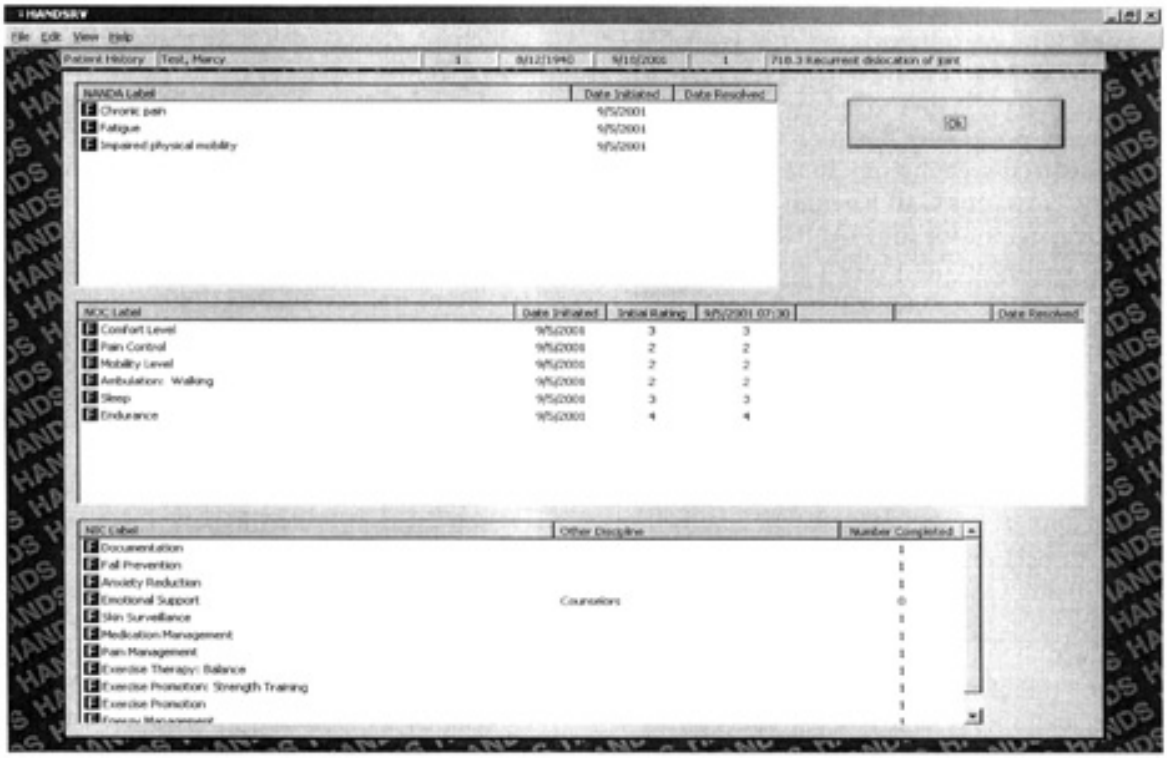
A software application developed by the University of Michigan School of Nursing in Ann Arbor offers the promise of providing a means to collect comparable data for nursing care in the areas of diagnosis, intervention, and outcomes, resulting in far more accurate information both for self-evaluation and benchmarking

(Continued on page 66)

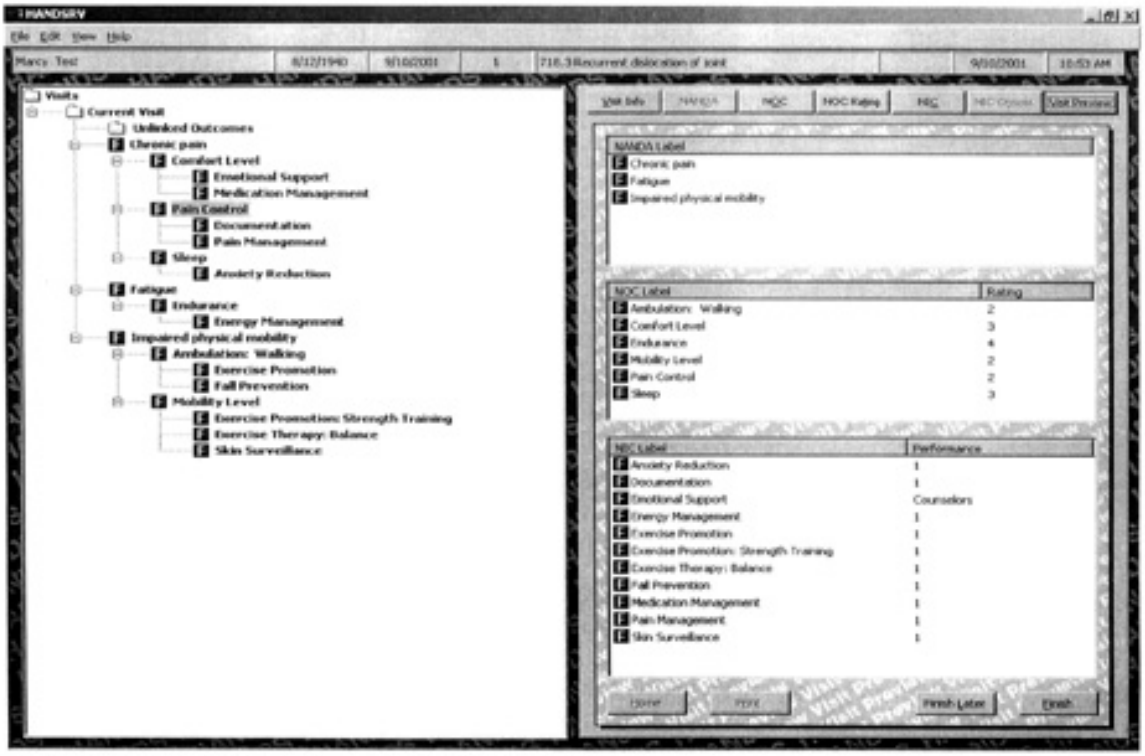
Key Points

- More accurate information available both for self-evaluation and benchmarking.
- Outcome performance improvement can be tracked over time.
- Web-based version is under development.

Episode-of-Care History Screen



Visit Summary Screen



Source for both charts: University of Michigan School of Nursing, Ann Arbor.

across health care organizations.

Called HANDS (Hands-on Automated Nursing Data System), the application was developed over the past four years. Currently, it is available in a CD-ROM version, but its developers hope to have it converted soon to a web-based format.

"The nursing profession had already developed standardized terminology to represent nursing care," explains **Gail Keenan**, PhD, RN, principal investigator for the HANDS project. "The reason we began our project was to enable them to pick up common information about patients across a continuum, within units and across organizations."

Although a common language theoretically was available to all nurses, health care organizations still were measuring different things in different ways, she notes. There were common terms for diagnosis (NANDA or North American Diagnoses Association, classifications), outcomes (NOC or Nursing Outcomes Classification) and interventions (NIC or Nursing Interventions Classification).

However, "if that term is used differently in different organizations, or if you use some parts of the nomenclature and not others, depending on what the organization wants, that means you're not going to have a standardized way of communicating your data," Keenan explains.

So, for example, two organizations may do the same things, but use different terms to describe them. "Some people may say abdomen, some tummy, and others, the lower quadrant," offers **Marcy Treder,** BSN, RN, HANDS project manager. "We're all speaking about a particular location but capturing it in different terms."

"Take hyperglycemia management, which is an NIC term," Keenan says. "There is a set of terms called 'activities.' So the term hyperglycemia management actually reflects not just monitoring blood glucose, but administering glucose, monitoring ketones in the urine, and so on."

On a larger scale, she says, there are some 470 NIC terms. "A given organization might limit the number of terms they would use to, say, 30," she posits.

"They might not include hyperglycemia management, while other organizations would have access to all the NIC terms to describe their care. If you had only 30, those areas not covered by NIC terms would have to be written up in narrative terms," Keenan adds.

Although care differs across units, they should have access to the same set of terms all the time, the HANDS team argues. That's the impetus for the project.

"HANDS is a standard interface through which everyone collects the data in the same way," Treder explains.

"Everybody's got everything, and the search mechanisms to locate what they don't know," Keenan adds. "If you don't know the name of a term, you can search for it. In the glucose example we used earlier, you can search for interventions for high glucose levels or outcomes or problems that are related to glucose."

When using HANDS, nurses merely use a series of pull-down menus to access terms, and enter diagnoses, treatments, and outcomes for each patient. **(See sample screens, p. 65.)** They can not only track current cases but study their progress over time.

"For example, NOC has a measurement scale rating from one to five," Keenan says. "So a nurse is actually giving a rating to the outcome. They can then see if the outcome gets better over time."

The HANDS team predicts its project also can lead to wide-scale benchmarking studies. "We've developed a methodology for the way information is displayed and captured," Keenan explains. "By so doing, the information available across organizations is comparable. There is a whole host of information, and you keep gathering data around the same variables."

HANDS is *not* a recipe for how to operate a unit or a hospital, she adds. "However, since you use the same methodology, you can capture and compare differences," she notes. "One culture may be very different from the rest; there may be high staffing levels, good nurse satisfaction, and this may lead to different interventions and perhaps better outcomes. But by comparing the same information, you can benchmark against these other organizations."

The HANDS project has completed Phase I and

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currently is seeking funding for Phase II (converting the tool to a web-based application and making it operational at several health care facilities). Phase I consisted of setting the nursing outcomes classifications.

"The data set (patient names, diagnoses, interventions, outcomes) — all the variables were entered into HANDS," Keenan says. "We had nurse researchers shadow the nurses giving care. After talking with the nurses and observing what they did, they would record the information."

The nurses found the application very useful, she reports. "It provided information nurses usually don't capture; they got a clearer picture of what care was provided to the patient — and they could see everything at a glance."

As for training, nurses are educated to use the language of the three nomenclatures. "Most nurses have not been educated around that, but the software makes it easy," Keenan says.

"We've got the HANDS application up in 17 schools of nursing in Michigan, and those schools are all using it now, so their nurses will know it when they graduate. Those clinicians who do not know it will have to learn it," she adds.

HANDS is a particularly important initiative, Keenan notes, because "What nurses do is not visible to anyone — not even to the nurses."

Most people describe nursing as a caring profession whose members advocate for patients and carry out physicians' orders. "In reality, nurses carry out 80% of the hands-on patient care that is provided," she notes. "What they do has a tremendous impact on outcomes." ■

Hospital building design boosts patient safety

Safety-oriented construction planning process

Even before the first spade was turned in the ground, the new St. Joseph's Hospital building in Westbend, WI, was far safer than its predecessor. This was by design — construction design, that is.

"Ever since the [Institute of Medicine] report in 1999, which contained very powerful data in terms of error rates, we have been talking about the whole issue of human error and patient safety," notes **John Reiling,** MBA, MHA, CEO at St. Joseph's, part of a small, regional health system. "One of our administrative staff said we should start thinking about how to increase safety through hospital design as well."

Key Points

- Learning lab leads to pre-construction design process and guiding principles.
- Safety improvements are designed into new hospital building.
- The way a building functions can affect changes in organizational culture.

About a year ago, Reiling also had the opportunity to discuss the issue with national leaders in the area of patient safety, including representatives from the American Hospital Association; the Joint Commission on Accreditation of Healthcare Organizations; the American Medical Association; the Institute for Healthcare Improvement; and several nursing schools. This was made possible through a "learning lab" program funded by a grant from the University of Minnesota.

The bulk of the work took place even before the design process began, Reiling notes. "We developed two key themes," he says. "First, that facilities design can impact patient safety; the very nature of a facility can cause you to make errors. It can be something as simple as where to put a sink so people will be more likely to wash their hands."

The second theme revolved around learning about designing safety. "The people we spoke to were not aware of any institution that had done homework on this subject, so there was nowhere to go to find out about designing safety," Reiling notes. "However, we realized [what we learned] could be helpful to the industry."

The learning lab was held April 18-19, 2002. "We were really honored by the caliber of participants," Reiling says.

In addition to the aforementioned organizations, participants included key physicians, board members, nurses, management, frontline employees, and supervisors. "We also included health systems we compete with and collaborate with in the region," he notes. In addition, the architects and contractors, who by then had been retained, participated in observing the learning lab; and some actively participated in the discussions.

"We talked about safety relative to the process of design, and whether there was something we should do differently," Reiling says. "We also talked about precarious events, which are somewhat similar to sentinel events. We went through

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major errors; for example, with falls, we discussed how to use facility design to lower the fall rate."

Through this series of discussions and breakout sessions, a series of recommendations was created, described in a six-page brochure. "We came up with our guiding principles of design and a checklist for employees to use to see if they were hitting the mark," Reiling explains.

In a traditional hospital design process, Reiling explains, you go through what is called a roll-in program, which encompasses how many beds you need to fill, what your patient volume will be, and so on. "Then, you basically translate rooms into spaces, then department adjacencies, and then you design a detailed drawing of each space," he notes.

The St. Joseph process was impacted by the safety emphasis. "When we talked about the rooms we needed, and the size required for, say, nursing rooms or radiology, we asked ourselves if they should be the same size if safety was our goal. This led to some changes," Reiling notes.

One of the areas impacted was adjacencies. "We conducted a failure mode analysis around each design phase," Reiling reports. "We tried to figure out the impact of adjacencies on safety."

For example, a draft of the adjacencies was studied for its impact on the most vulnerable patients. "We went through the [emergency department and asked what would happen if we had to do a direct admit to the [intensive care unit]," Reiling observes. "We talked about what could go wrong. As result of those exercises, we did modify our adjacencies."

Reiling says that St. Joseph's change in design strategy has contributed to a cultural change at the hospital. "We wanted this to change the culture of the organization, to make it more centered on safety, and there's no question it did this," he asserts. "If you focus on patient safety in design, you *will* change the culture."

Once people become engaged in the issue, the elements of a patient-safe culture were reinforced, he explains. "Take reporting what your errors are — you need to know that because you want to design around it," Reiling says. "Then, we started dealing with blameless cultures."

Designing a hospital takes a lot of organizational energy, Reiling adds. "If throughout the process, you talk about safety all the time, that in itself makes it a high priority, and you start to change how you operate. If you really think about facilities, they are the mechanisms through which we create processes."

The site dedication for the new facility was held in late October. It will have 80 beds, as opposed to the 100-plus currently operating in the existing facility. "It will be scaled down, but it will take care of a growing population," he says.

Reiling says the hospital is slated for a May 5, 2005, opening. And at what stage is his ongoing initiative? "We are in the process of doing detailed design by department," he reports. ■

Physicians help achieve quality diabetes care

Physician-level quality measurement stressed

A program cosponsored by the Washington, DC-based National Committee for Quality Assurance (NCQA) and the American Diabetes Association (ADA) in Alexandria, VA, has placed a strong emphasis on physician-level quality measurement and reporting for diabetes treatment. The initiative, called the Diabetes Physician Recognition Program (DPRP), recognizes physicians who deliver superior diabetes care and appears to have had an impact on improving quality of care.

The program was initiated in 1997, and through the end of 2001, more than 1,500 physicians have achieved recognition, impacting care to an estimated 500,000 patients with diabetes. Aggregate performance results indicate that DPRP-recognized physicians provide quality care and have

Key Points

- Participants show superior results in reducing diabetes risk factors.
- Cosponsors indicate level of evidence that exists for clinical guidelines.
- Differences between measures and guidelines must be clearly understood.

NCQA/ADA Diabetes Physician Recognition Program

Measures for Adult Patients

Required Measures	Goal	Points	Frequency
HbA_{1c}* (most recent result)	93%	NA	Once per year
Proportion w/ HbA_{1c} • 8%	55%	5	
Proportion w/ HbA_{1c} >9.5%*	• 21%	10	
Eye exam*	61%	10	Annual**
Foot exam	80%	10	Annual
Blood pressure frequency (most recent result)	97%	10	Once per year
Proportion <140/90 mm Hg	65%	5	
Nephropathy assessment*	73%	10	Annual**
Lipid profile*	85%	5	Annual**
Proportion with LDL <130 mg/dl*	63%	5	
Total Points		**70**	
Points to Achieve Recognition		**52**	
Optical Patient Survey Measures	**Goal**	**Points**	**Response**
Tobacco status & counseling^^	76%	10	Yes
Self-management education	90%	10	Annual
Medical nutrition therapy	90%	10	Annual
Self-monitoring of blood glucose:			
— noninsulin-treated patients	50%	1	Yes
— insulin-treated patients	90%	4	Yes
Patient satisfaction with:			
— diabetes care overall	58%	1	
— diabetes questions answered	56%	1	Excellent, Very
— access during emergencies	46%	1	Good, or Good
— explanation of lab results	50%	1	(on a scale of
— courtesy/personal manner of provider	77%	1	Excellent to Poor)
Total Points (including Required Measures)		**110**	
Points to Achieve Recognition		**82**	

***Notes**: * Consistent with DQIP and HEDIS measures. ** Measure may be performed in the past two years, based on patient-specific criteria. ^^ For calculation of results for this measure, the denominator for patients receiving a referral for tobacco cessation will be the number of patients from the applicant's sample who report in the patient survey that they use tobacco.*

Source: National Committee for Quality Assurance, Washington, DC; American Diabetes Association, Alexandria, VA.

improved care delivery between 1997 and 2001:

The average rate of diabetes patients who had Hemoglobin A_{1c} (HbA_{1c}) levels of less than 8% increased from 50% to 70%, an indication that more adults with diabetes are maintaining proper HbA_{1c} control. HbA_{1c} is a measure of average blood sugar over the previous three months.

The rate of diabetes patients who had properly controlled low-density lipoprotein (LDL) cholesterol gained 35 percentage points (37% to 72%).

The rate of diabetes patients monitored for kidney disease rose from 60% to 84%.

"We felt it would be useful to create a program whereby providers who provide what we think is superior care get recognition," explains **Nathaniel Clark,** MD, MS, RD, vice president for clinical affairs for the ADA. "They are listed on our web site and receive a certificate to hang on their wall. When anybody contacts us and asks for advice on who to see, these physicians would be preferentially recognized and referred."

Initially, clinical practice guidelines were developed based on available clinical evidence. "In the past two or three years, that process has become much more rigorous, so that now when we make recommendations, we specify what level of evidence exists," Clark explains. The guidelines are updated every year.

Another significant change occurred with the establishment of the Diabetes Quality Improvement Project (DQIP), which began as a coalition of the ADA; NCQA; the Centers for Medicare & Medicaid Services; the American College of Family Physicians; the American College of Physicians,

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American Society of Internal Medicine; Foundation for Accountability; and the Veterans Health Administration, but which now represents more than 30 national organizations. The DQIP has its own set of measures; the DPRP's are consistent with those measures but go beyond DQIP by applying performance criteria to each measure. **(See chart, p. 69.)**

There is a fine distinction between measures and guidelines, Clark explains. "The purpose of a measure is to determine for a population what percentage are, in theory, doing well or are not doing well," he notes. "A guideline is a statement of what the ideal is."

For example, says Clark, the measure that is used in this country for hemoglobin A_{1c} is how much of the population is above 9.5% and how much below. "The guideline is that a patient's hemoglobin A_{1c} should be less than 7%."

The reason this distinction is so important, he notes, is that if you chose that same 7% as a measure, most of the population would not meet the measure. "It's too strict," Clark explains. "Most people think the average A_{1c} is about 8.5%, or perhaps as high as 9%." Today, DPRP looks at what percentage of patients are above 9.5%, and what percentage are below 8%.

While the numbers achieved by recognized physicians are impressive, was their performance spurred by the incentive of increased referrals, or did those physicians who already were providing superior care submit their data to the program in order to receive the incentives?

"There's no question that those who choose to participate are highly likely to be giving a higher level of care," Clark concedes. "However, we've also seen there are people who decide to apply, start collecting data, and realize they have problems, which causes them to make changes — for example, increase the frequency with which they check patients' feet, or the number of patients they treat for elevated cholesterol levels. It's really a matter of providing an incentive for people who care for patients with diabetes to do a better job; we hope it will help ensure a higher level of care."

Clark admits that there currently are not a lot of incentives being offered. "One of the more hopeful developments was the recent announcement by GE that they have agreed to offer a higher level of reimbursement to providers who are recognized by the DPRP," he notes.

"Ideally, you shouldn't have to reward doctors to ensure superior care, but in this competitive environment where doctors are being pushed to see more and more patients, you need to have incentives to try to induce physicians to give better care," he continues. "I hope that the G.E. initiative will spread, and more and more health plans will do things for doctors who provide superior care. For example, they might decide to pay to help your office put in a computerized data system, which would be incredibly helpful. Or they might pay you more money for each diabetes patient you see. We need to create a business case for why quality needs to change; without that, you're really appealing to the martyrs." ■

Benchmarking process: Select targets for change

Baseline data provide foundation for next stage

[Editor's note: This is the second in a three-part series on the Catholic Health Association of the United States' (CHA) performance improvement program, "Living Our Promises, Acting on Faith." This installment will describe how the baseline data informed the selection of a specific area targeted for performance improvement. The final article will describe the practical application of the information gathered through the benchmarking process.]

Collection of baseline data was completed in spring 2000; the findings did not hold any major surprises, recalls **Julie Jones**, MA, director of resource development for the CHA. "The truth is,

Key Points

- Previously uncollected data will be used to fuel ongoing improvement.
- Aggregate data will be shared with all 239 participating facilities.
- Member survey identifies most beneficial areas to target.

there wasn't anything surprising, because our goal was to get a snapshot of where the ministry was and collect data we had never collected before, which would in turn fuel ongoing improvement efforts," she says.

Even the process of gathering the data, which was necessary to develop a measurement system, led to different types of conversations in the ministry, Jones notes.

"For example, our ethical and religious directive No. 2 says that Catholic health care should be marked by mutual respect among caregivers," she explains. **(See *Healthcare Benchmarks and Quality Improvement*, October 2002, p. 43.)** "In our focus groups, we would ask, 'What data do you have that demonstrate this'? The response might mention patient satisfaction surveys or employee satisfaction surveys, so we'd cull all of this information together across the ministry. As they say, you pay attention to what you measure."

How did the baseline data inform the next steps? "They did so on a number of levels," Jones reports. "For example, when we collected the data, we promised the participants that they would get comparative data reports. So, if you were in a rural area with a 15-bed facility, you'd get a report back both on your data and that of comparative facilities. This could then be used by their QA teams to focus on a [performance improvement] project for the next year."

Every one of the 239 participating facilities received a report. In addition, the systems received aggregate data on how the facilities within that system had answered, so that they could determine areas to target and work on across facilities.

"Then, at the national level, we organized a collaborative benchmarking project that we would ultimately share with all of the members," Jones notes. "The baseline helped us identify topics of interest, which in turn would give the ministry ideas on topics it wanted studied further."

The ultimate decision in terms of selecting a performance improvement topic was reached through a member survey, Jones says.

"We asked those members that had participated in the data-collection process in which area would it be most helpful for them to have successful practices identified; in other words, what did we want to improve on together?" she adds. "'Employee satisfaction with involvement in decision making' rose to the top in terms of members saying this was an area about which they would really like to learn from one another."

This was, of course, the goal of the process: convening a collaborative through which members could share information and ideas.

The first step was to share the information with the collaborative benchmarking steering committee. Among the participating facilities were urban and rural, large and small facilities from across the country, as well as one community hospital partner of a Catholic health care system.

"The partners would then share beyond their group and inform the larger ministry," Jones says. "At that point, individual facilities might take on their own performance improvement projects." ■

Need More Information?

For more information, contact:

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IOM to study alternative, complementary medicine

The National Center for Complementary and Alternative Medicine (NCCAM) and 16 Federal cosponsors have unveiled plans for an Institute of Medicine (IOM) study of the scientific and policy implications of the use of complementary and alternative medicine (CAM) by the American public. The $1 million, nearly two-year study will be conducted by the IOM, a component of the National Academies.

COMING IN FUTURE MONTHS

- Deferring patients to next-day care relieves crowded EDs
- Benchmarking study evolves into performance improvement project
- AHRQ program supports primary care practice-based research networks
- Pain management: Quality and ethical implications and issues
- Why the pharmacist should be included on the health care team

The National Academies is a private, nonprofit, nongovernmental institution created by a congressional charter to be an advisory body for the nation on scientific and technological matters. The IOM draws upon volunteer panels of experts to examine policy matters regarding the public's health. NCCAM, the primary sponsor of the study, is the federal government's lead agency for scientific research on CAM.

The IOM will assemble a panel of approximately 16 experts from a broad range of CAM and conventional disciplines, such as behavioral medicine, internal medicine, nursing, epidemiology, pharmacology, health care research and administration, and education.

During the course of the study, the IOM panel will assess research findings, hold workshops, and invite speakers to address the panel, among other activities, in order to:

- Provide a comprehensive overview of the use of CAM therapies by the American public.
- Identify significant scientific and policy issues related to CAM research, regulation, integration, training, and certification.
- Develop a conceptual framework to help guide decision making on these issues and questions.

The value of undertaking this study emerged from discussions among members of the Trans-Agency CAM Coordinating Committee, chaired by **Stephen E. Straus,** MD, NCCAM director. The committee felt that the IOM had the expertise to critically consider questions of CAM research and policy.

"Americans use CAM therapies in record numbers," said Straus, when announcing the study. "The IOM's report will give us a clearer understanding of the scope of CAM use by Americans, as well as CAM's public health impact, and scientific and policy issues that will better inform our research decisions."

The IOM study, led by **Lyla M. Hernandez**, MPH, senior program officer for the Board on Health Promotion and Disease Prevention, will not conduct new surveys of the public regarding CAM use. Rather, the IOM panel will gather and analyze existing data. In addition, the IOM study, which already has begun recruiting panel members, plans to address many key questions, such as these:

- What are the methodological difficulties in evaluating some CAM therapies?
- How are the different CAM professions regulated in the United States?
- What is the current situation for coverage of CAM by insurers and other third parties?
- What are the policy and regulatory issues regarding licensing and certifying CAM practitioners?

The answers to these questions and the information generated by the IOM panel of leading scholars drawn from both conventional medicine and CAM, and from education, should serve to complement the recommendations of the White House Commission on Complementary and Alternative Medicine Policy released earlier this year. ■