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MAY 1999

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A quality manager's place is in the thick of Y2K planning initiatives

Strong preparation programs rely on global vision, teamwork, analysis

If you're on the fringes of your organization's year 2000 (Y2K) initiative, you might be in the wrong place, say quality managers from several facilities whose plans have been under way for two years or more. Though you're probably not a computer wizard by trade, don't underestimate the skills you could bring to the table. Your organization's millennial passage might well be smoother if your signature is on the plans.

The now-familiar terms "millennium bug" and "Y2K problem" refer to the host of potential disruptions that could occur if computers mistake the date code "00" for the year 1900 instead of 2000.

Why is Y2K your business?

At the very least, QI professionals are responsible for raising awareness about quality concerns. "Assuming that other people are going to look after each part of Y2K planning is the wrong attitude to have," asserts **Kay Beauregard**, director of Clinical Management and Quality at William Beaumont Hospital in Royal Oak, MI. She says QI managers should make it their business to ensure their organizations have provisions for media and patient communications in the event of glitches on

Key Points

- Planning for year 2000 (Y2K) computer-related failures involves more than technological fixes; it's a systems issue.
- Quality improvement professionals specialize in the skills and experience needed for readiness.
- Vital skills include big-picture views, problem analysis, interdepartmental coordination, and community outreach.
- Y2K planning presents an opportunity to upgrade disaster plans.

(See related articles: "Where to find Y2K resources," p. 54, and "Hospital covers all its millennial bases," p. 55.)

Jan. 1, 2000. "Everyone is accountable for how problems are going to affect patients in their area." On that score, Beaumont Hospital has a well-developed blueprint in place. **(See related story, "Hospital covers all its millennial bases," p. 55.)**

Depending on your job description, however, your involvement in Y2K could be more duty than option. "If QI directors are responsible for risk management as well as quality improvement, they had better be on their organization's steering group and involved in every step of the plan," says **Mara Fellhoelter**, director of Quality and Resource Management at White Memorial Medical Center in Los Angeles.

How can you help?

When you look at Y2K as a systems issue, it's clear that you have much to offer. After all, who has a better grasp of the interdependencies of systems than QI people? **Ruth Loncar**, MBA, CPHQ, corporate director for quality and outcomes management for Adventist Health in Roseville, CA, says, "Quality managers not only know how to use coordination techniques, but they have over-arching responsibilities, so they're familiar with different levels and departments of the organization."

Fellhoelter adds, "We're good at methodically looking at issues instead of using gut-level reactions." Analytical skills are especially important since Y2K contingency initiatives don't have precedents to fall back on.

QI specialists know team process and time-line construction inside and out. **Nancy Richman**, PhD, and **Colleen Lewis**, RN, quality managers at Kewanee (IL) Hospital, say they see those as necessary competencies on Y2K projects.

If you have support staff, don't forget to keep them current on your facility's plans, advises Fellhoelter. If worst comes to worst, they, along with everyone else, might find themselves helping out on tasks far removed from any job

Where to Find Y2K Resources

Just in case you're still looking for resources, here is a selective list. The World Wide Web sites are especially useful for up-to-the-minute information.

- **www.hcfa.gov:** Click on Year-2000 compliance for the latest information concerning Medicare- and Medicaid-specific Y2K information. You'll also find test plan guidelines and compliance definition fact sheets.
- **rx2000.org:** This is a health care-specific clearinghouse featuring digests of Y2K news and governmental events concerning health care. Links to dozens of other sites are included. There is also a vendor registry.
- **www.y2k.com:** Among the many features of this site are downloadable presentations and articles, vendor links, tips on liability protection, and links to government Y2K sites.
- **www.year2000.com:** As a forum for information exchange, this site features discussion groups. A collection of current articles is readily accessible. And, just in case you need a break from the din of millennial doom mongers, check the cartoon of the week each Monday.

Vendors galore stand ready to help, whatever your stage of preparedness may be. The following have diverse and useful services:

- **Data Integrity Inc.:** Provides solution and verification products for mainframe computer systems. Instead of scanning line by line, this method finds and adjusts the arithmetical mistakes the computer could make by reading a "00" year date as 1900 instead of 2000. A company spokesperson says the solution is 40% faster than line-by-line methods and costs 20 cents per line or less. For information, contact Chris Doudell at Data Integrity, Waltham, MA. Telephone: (781) 890-2069. Fax: (781) 890-6572. E-mail: info2000@dii2000.com. World Wide Web: www.dii2000.com.
- **Y2Kplus:** Describes itself as a one-stop shop for analysis, remediation, and testing needs. The company has a line of tools for medical equipment. It can plug into a Y2K preparedness project at any point in its progress. Clients may choose individual tools as well as an integrated set of products. For information, contact Jerry Kaufman at Y2Kplus, Lexington, MA. Telephone: (781) 863-8111. Fax: (781) 863-7273. E-mail: jkaufman@y2kplus.com. World Wide Web: www.y2kplus.com.

COMING IN FUTURE MONTHS

- Press, Ganey warns that satisfaction report cards fail to 'show the quality'
- Can patients handle the truth?
- Observation in ED improves quality
- Award-winning outpatient surgery techniques
- Healthy caregivers: Key link in quality care for chronically ill

description they've ever seen.

Contingency plans for equipment breakdowns are half of the picture. Disaster planning is the other half for the eventualities that nobody can predict. Loncar notes, "Usually disaster plans are made pretty much at the higher levels of the institution. But this is an opportunity to take them down to each department and get people involved so we'll be prepared to handle Y2K emergencies. We can come out of it with stronger disaster plans than we've ever had before."

The quality manager's global vision should extend to other hospitals in the community, notes **Larry Randolph**, associate hospital director at William Beaumont Hospital. And it's more than altruism, he adds. "The more hospitals share Y2K plans, the better we'll all be prepared to pitch in with extra patient care if we have to." ■

Hospital covers all its millennial bases

Here's what a good Y2K plan looks like

A typical model of year 2000 (Y2K) preparedness plans in use by leading hospitals and integrated health networks is at William Beaumont Hospital. Beaumont is a 929-bed facility in Royal Oaks, MI, a suburb of Detroit; it has a 189-bed satellite in Troy. Beaumont's initiative involves equipment readiness and disaster preparedness. Plans have been in full swing for better than two years.

The equipment piece of the initiative consists of the search for computer programs and chips that might mistake the date code of "00" for the year 1900 instead of 2000.

Planning for disaster

The disaster plan involves preparations for failures among critical suppliers such as the local electric power company, as well as glitches in internal systems that slip by Beaumont's preparedness initiative.

Beaumont's 105,000 pieces of equipment came up for scrutiny. The plan was to identify which items needed upgraded computer chips and which should be replaced.

"We had to budget for unknowns," explains **Larry Randolph**, Beaumont's associate hospital director. "We thought it would be prudent to put the money into a pool for the whole hospital instead of budgeting for Y2K by department. Right away, we ran into complications." On older equipment, they had to decide, case-by-case, whether to upgrade a computer chip or to buy a newer model.

Replacements are either charged to Y2K preparedness or to obsolescence. Decisions on when to replace big-ticket equipment depend on the patient care or customer service risk posed by a malfunction. The project actually became one of the most in-depth equipment inventories the hospital has had in some time.

The second part of Beaumont's preparation is a department-level contingency plan. "That could be overwhelming," Randolph admits, "when everyone is so busy anyway. Contingency plans are easy to put off.

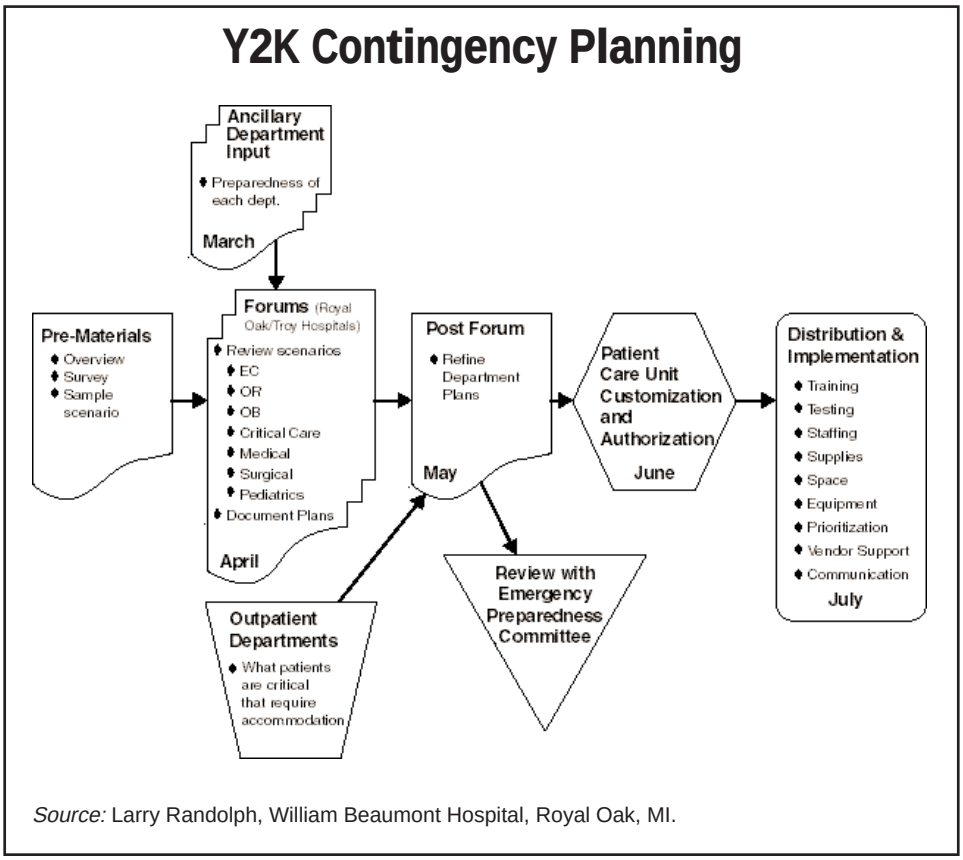
"But we're trying to be sensitive to our workers by providing forums where people from each unit [functional area] can get together. If each department has something to start with, and if they can learn from one another, they won't have to come up with their plans from scratch."

Key Points

Location: William Beaumont Hospital, Royal Oak, MI — 989 beds; satellite in Troy, MI — 189 beds.

Situation: More than two years ago, the managers started contingency plans for possible computer problems arising from the failure of the equipment to read the "00" year code as the year 2000.

Solution: Beaumont's initiative consists of a massive equipment inventory, accompanied by decisions to upgrade with the purchase of new computer chips, or to replace obsolete equipment with current models. The second part of the initiative involves a disaster plan for which each department must develop a detailed emergency preparedness program. The facility is working with external suppliers to assess their readiness and adjust its plans accordingly. The contingency effort will involve wider provisions for housing employees, their families, and even patient families if necessary.



Source: Larry Randolph, William Beaumont Hospital, Royal Oak, MI.

Forums began with the ancillary units: labs, radiology, respiratory therapy, and facilities management. Next came the medical/surgical units, critical care, pediatrics, and emergency care.

To conserve time, Randolph and his team designed a template that units could tailor to their operations. Points of accountability for each unit include:

❒ plans for equipment failures, starting with the lifesaving items, for example, IV drips and heart defibrillators;

❒ projections of how long each backup plan would be sustainable;

❒ provisions for staff training relative to backup plans;

❒ vendor lists;

❒ supply needs;

❒ staff needs in-house and on call;

❒ management support necessary to implement backup plan;

❒ description of tests to be run at 12:01 a.m. on Jan. 1, 2000, before seeing patients.

All departmental plans will be turned in to Beaumont's disaster control unit before the end of the year. The unit, consisting of key managers, will be at the hospital on New Year's Eve. **(For a flowchart of the process, see diagram, above.)**

"Throughout the hospital, we're trying to control the vacation leave at the end of this year and for the first two weeks of the new year," Randolph adds. And just to be safe, medical equipment technicians and information systems specialists are being asked to work during late December and early January.

Living with the unknowns

Y2K planning can overwhelm a facility unless you temper each move with a grain of common sense, Randolph says. For example, Beaumont's plans are most detailed for Jan. 1 and 2 when the biggest jolts are likely to occur. Weather-related contingencies are factored in with Y2K possibilities — in Michigan a midwinter blizzard could complicate a Y2K-related power failure.

As the 1999 calendar winds down, "we ask ourselves — what's our level of confidence that this or that will happen?" Randolph says. In some ways, he adds, hospitals have an easier time of Y2K preparations because "we have a lot of home-grown systems that we know how to change." On those,"we're way ahead. But then, you're only as ready as those you do business with."

Randolph admits to shaky confidence in some of the facility's vendors. He says he wonders whether the regional water processing plant is ready, for instance. This summer, he plans to confer with them and review emergency plans. Based on confidence levels after that meeting, the hospital will finalize contingency plans for emergency water supplies.

As for other vendors, Beaumont's materials

Need More Information?

For information on comprehensive Y2K planning for a hospital, contact:

❒ **Larry Randolph**, Associate Director, William Beaumont Hospital, Royal Oak, MI. E-mail contacts only: lrandolph@beaumont.edu.

management department has issued a twofold request:

1. to certify Y2K-compliance based on a set of hospital-specific criteria;

2. to submit testing instructions so the hospital can double-check its equipment. To that request, Randolph says, the response has been poor, although more vendors are posting instructions on their Internet sites.

When it's all said, though, the real spirit of millennium preparedness should hold the hospital as a place where the community can turn to. To that end, Beaumont's Y2K disaster plan will include a report on the readiness of various hospital buildings to shelter and feed employees and their families, and even patients' families.

"We need to focus on taking care of our patients and our community instead of just keeping ourselves out of trouble," Randolph says. ■

FAST unit reduces use of ED as regular admit route

Admissions in 40 minutes, first meds in 30

Employees at Wadley Regional Medical Center knew the emergency department (ED) was fertile ground for quality improvement.

But they figured their 400-bed hospital in Texarkana, TX, didn't have enough emergencies for a full-scale QI initiative until one "really bad" night in 1996. An unusually large number of patients came in with orders for initiation of treatment plans, highlighting what ED staff knew all along — the ED was being used to bypass regular admissions.

The two ED nurses used the momentum from that crisis to organize an improvement effort. Baseline data gathered by the ED director "showed us a tremendous opportunity for improvement," notes **Fiona Adams**, RN, MS, vice president of administrative services.

"But you don't know these things until you actually look at the data," she explains. Beyond long door-to-drug times for heparin and antibiotics, data revealed that the regular admissions process was just a minute shy of five hours.

The improvement effort, launched in late 1996, worked under the moniker FAST (Focused Admission Service Team). In less than a year, the team cut the admissions routine by three hours and pared door-to-drug times to less than 30 minutes.

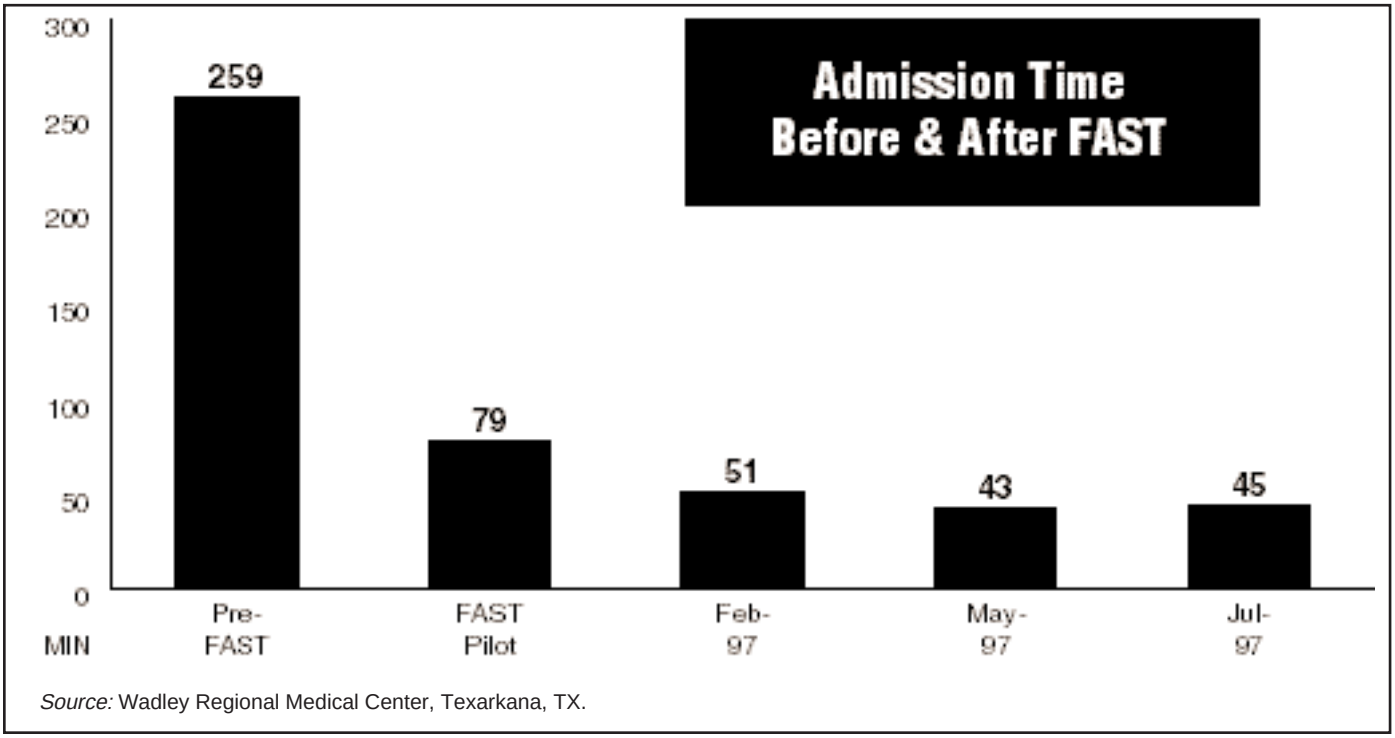
FAST soon learned that a better admissions process was critical to speeding up door-to-drug times and to easing the ED's growing workload. "Everybody's time is divided," Adams concedes.

Key Points

Location: Wadley Regional Medical Center, a 400-bed hospital in Texarkana, TX.

Situation: Increasing numbers of patients were being admitted through the emergency department in an effort by physicians to sidestep the hours-long regular admissions route. Not only was the process tiresome for patients and their families, but the delays in administering first medication doses were clear concerns for quality of care. Even after the long admission routine, patients often arrived on the nursing units with incomplete orders, thus delaying first doses still longer.

Solution: An improvement project called FAST (Focused Admission Service Team) addressed the problem, first by documenting the turnaround times on test results, admissions procedures, and door-to-drug times. In setting improvement goals, the team benchmarked another hospital with an acknowledged state-of-the-art admissions function. A one-month pilot implemented care protocols and converted two beds to use for incoming, nonemergent patients. While patients were in the FAST unit beds, staff completed the admissions paperwork and initial tests. Further, they administered first doses of meds including heparin and antibiotics. When patients arrive on the nursing units, all preliminaries are complete, so the staff can implement care plans. Admission times dropped by 83% and the emergency department is back to taking care of emergencies. Patients receive first meds in fewer than 30 minutes. The now-permanent FAST unit consists of six beds and functions from 7:30 a.m. through 11:00 p.m.



Source: Wadley Regional Medical Center, Texarkana, TX.

"And the nurses on floor have different priorities than the emergency department. They think the current patients are sicker so the new admits don't get immediate attention."

Nor did the fragmented admissions process make it easy for unit nurses to initiate care for the new admits. Despite the hours-long admissions routine, new patients often arrived on the floor with incomplete orders or incomplete intake information on their charts.

While sending non-emergent patients through the ED is an obvious misuse of resources, the logic is obvious — the maneuver produced faster turnarounds on lab, X-ray, and EKG reports as well as first dosing of meds. For patients and their families, admission through either route was long, confusing, and anxiety-producing due to the parade of different caregivers giving multiple tests.

Teamwork and benchmarks

From a nucleus of the ED's two nurses and director, FAST grew to embrace these staff whose jobs would change and who could streamline or stonewall the project:

✔ director of process design, a specialist in planning and implementation of organizational processes;

✔ director of business support to manage the financial ramifications;

✔ care coordinator to preserve continuity of care from the inpatient unit to the community;

✔ ad hoc members from nursing, medical staff, and the ED medical director.

The group augmented internal data analysis with a literature search of best practices and a site visit, in May 1996, to Muhlenberg (NJ) Medical Center to study the center's state-of-the art admissions processes.

FAST's goals were as follows:

✔ Design an efficient, seamless admissions process for all patients.

✔ Initiate admission orders within 30 minutes.

✔ Divert the load of non-emergent patients from the ED to regular admissions.

✔ Increase utilization of care protocols.

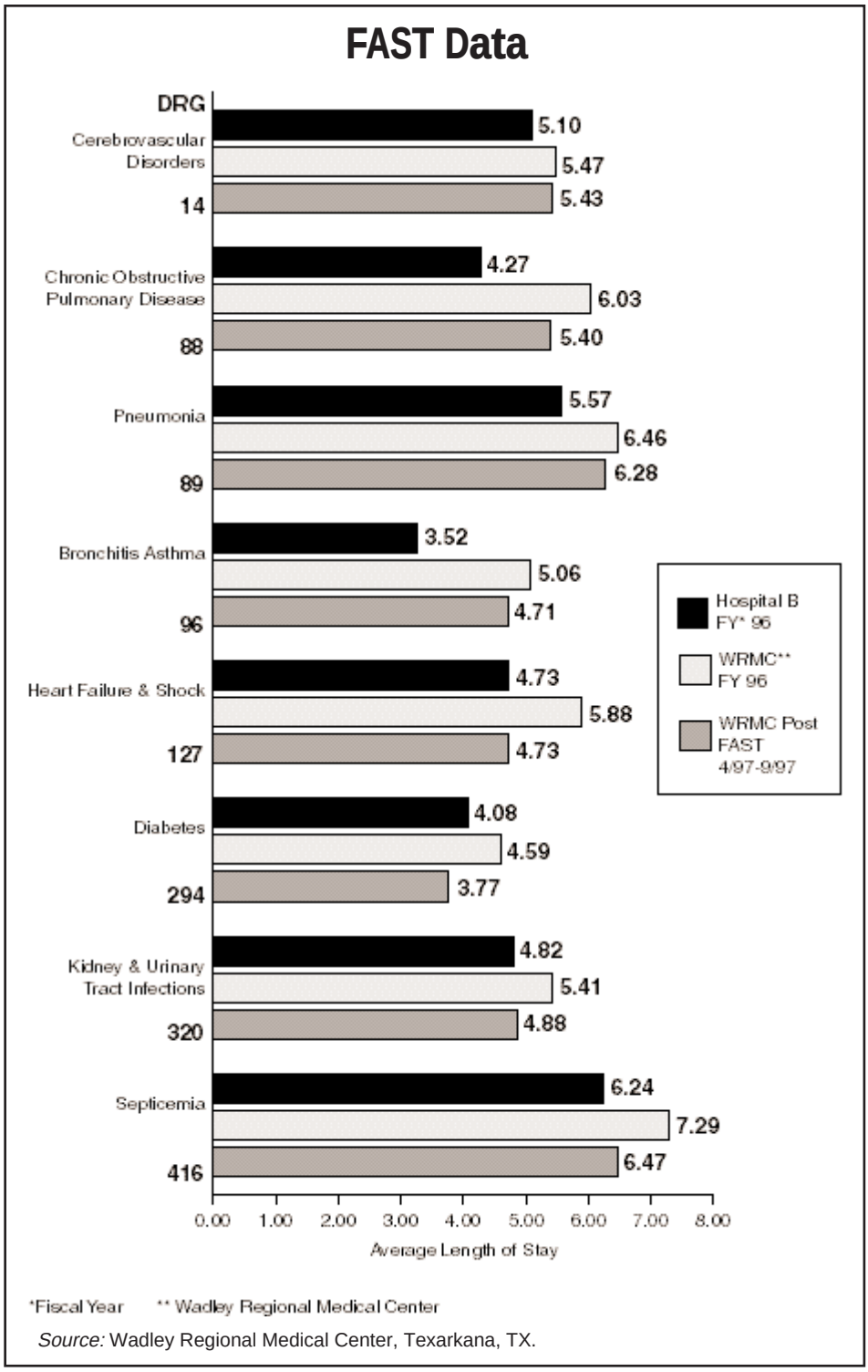
✔ Initiate care plans and patient/family education at the point of admission.

✔ Improve care outcomes.

Test site 'hijacked' from oncology

In early 1997, FAST opened a month-long pilot. The two-bed "FAST unit" consisted of "two beds hijacked from the oncology outpatient unit," quips Adams. It would serve as the admissions channel for all Wadley patients except those headed to intensive care, labor and delivery, pediatrics, or chemotherapy. Hours of operation were 8:00 a.m. to 5:00 p.m.

Both the ED and admissions staffs were cross-trained to complete the admissions paperwork as well as draw blood samples and do



Source: Wadley Regional Medical Center, Texarkana, TX.

EKGs. "We learned how important it is to choose the right people for the job," explains Adams. "People who succeed in the FAST unit are those who can focus on a set of procedures. They have to be caring and efficient at the same time and move the patients on to the next step of treatment.

"This is not everyone's cup of tea," she adds. "Some nurses like more excitement. They belong in the emergency room. Others like to spend a lot of time at the bedside learning the patient's background and explaining treatment plans."

The FAST unit staff sends patients to inpatient beds with the following in place:

✔ initial assessment with complete patient admission profile;

✔ care plan;

✔ diagnostic tests / studies ordered, including lab, EKG, basic radiological studies, referrals, specimen collection, first dose of medications, IV insertion and therapy, urinary catheterization, and respiratory treatments;

✔ completion of physicians' initial set of orders to include order entry;

✔ initiation of patient education;

✔ initiation of discharge planning.

At the end of the pilot, the team knew they had a winner. "The floor nurses loved it. They thought it reduced their workload," Adams says. Physicians readily use the FAST unit instead of slipping non-emergent patients in through the ED. Patient satisfaction runs close to 100%. Admission times dropped by 83%, compared to the baseline data. **(To track the improvement progression, see graph, p. 58.)**

FAST unit here to stay

The permanent FAST unit opened with six treatment beds in April 1997. It has a workstation, cardiac monitoring system, and supply storage area. Hours of operation are 7:30 a.m. to 11:00 p.m. Adams explains nighttime volumes are too low to make 24-hour operations worthwhile.

Forty-minute admissions are now the norm. "When you've got a focused unit," Adams says, "they get the job done."

Wadley's before and after figures on length of stay (LOS) for patients who could be admitted through the FAST unit show shorter stays. While

Need More Information?

For information on streamlining inpatient admissions, contact:

❒ **Fiona Adams**, Wadley Regional Medical Center, Texarkana, TX. E-mail only: fiona @wadleyrmc.com

Adams points out that many factors affect LOS, she believes that the FAST unit deserves much of the credit. **(For pre- and post-FAST numbers, see graph, p. 59.)** ■

QUALITY TALK

How FAACT measures what consumers want to know

*(**David J. Lansky**, PhD, is the president of FACCT, the Foundation for Accountability in Portland, OR. FACCT is a not-for-profit organization whose board of trustees represents consumers, corporate, and government health care purchasers. All told, the trustees represent 80 million Americans. FACCT is dedicated to creating tools that help people understand and use quality information in making health care decisions.*

Before joining FACCT, Lansky was regional director of clinical information for the Oregon-based Providence Health System, an integrated system including hospitals, ambulatory, and home health services. His team was responsible for outcomes research, measuring consumer satisfaction, and for developing electronic records.)

Q. *What sets Foundation for Accountability measures apart from other types of consumer satisfaction measures?*

A. FACCT measures are intended for a particular purpose, which is to support the ability of consumers and purchasers to make decisions in the health care marketplace. We design the measures with a strong emphasis on what patients and consumers tell us they care about.

We are trying to build a comprehensive profile of the quality of care provided by health care organizations. Within that goal, consumer satisfaction is an important piece, but only one of several elements we think constitute a complete picture of quality.

Our measures are intended to cover the breadth of health care experience — both consumers' experience of interacting with the health system and their experience of illness, and hopefully, recovery as well as their experience of receiving necessary care. So, we've tried to develop measures that address three different types of health care:

1. The steps to good care, or process measures, tell you whether the right things are done.

2. The experience of care (which is where we put satisfaction measures) is how people experience their interactions with health care professionals and organizations.

3. The results of care show whether the intended benefits of health care are actually achieved.

Q. *Could the results measures that FACCT uses substitute in some instances — or maybe all instances — for the outcomes measures drawn from hospital association reports or from medical records?*

A. I wouldn't say our measures replace them. I would say we capture clinical outcome measures where they are available and appropriate. In the example of diabetes, the most important intermediate outcome is the maintenance of good blood sugar control, typically measured through the blood test for hemoglobin A1C level. That's really a concrete measure. To us, it's an appropriate results measure.

It reflects a lot of input to achieve that goal: good testing and good advice to the patient about diet and lifestyle. And where appropriate, good medications have to be made available and have to be used by the patient. All those things have to come together to achieve the results, so the lab test is a very elegant way of assessing health care performance by looking at an outcome. In our diabetes measures, we definitely capture that kind of indicator.

Q. *What are some questions a consumer might answer on the FACCT survey?*

A. For a patient with asthma, we would ask if he or she had been observed by the doctor or nurse using the inhaler, to make sure the patient

is using it correctly. Almost every patient says, "Yes, I have an inhaler. Yes, I have been given a brochure on how to use it." But only about half the patients have ever been watched by a professional while using it to make sure that they are doing it right. Put another way, about half the patients with moderate to severe asthma don't really know how to use the inhaler correctly.

Similarly, we ask patients if they know what to do when they have a severe asthma attack, if they know how to adjust their medications when their asthma gets worse, or if they know how to care for themselves when they have an acute asthma problem. Again, about half to a third of the severe asthma patients around the country don't know what to do when they have a severe flare-up. Which, of course, relates to unnecessary hospitalizations and other problems people encounter when they have asthma attacks.

Q. *What questions would you ask consumers to assess process measures?*

A. With diabetes patients, for example, it's easier to ask them directly if the doctor examined their feet to look for effects of vascular problems at their last visit. That information is more reliably obtained from the patient than it is from a medical chart review where it may or may not be noted specifically in the chart.

Our concern with the outcomes approach we have is to see whether the patients ultimately received benefit — if the asthma patients know how to take care of themselves, if heart patients take their aspirin.

Q. *How have you been involved in the measures coordination program announced last year by the Joint Commission on Accreditation of Healthcare Organizations, the American Medical Coordination Program, and the National Committee for Quality Assurance?*

A. We have had no involvement with them at all, and we were not contacted about it. That's really all I can tell you about that. **(See editor's note, p. 62.)**

Q. *Who uses the measuring guides that FACCT has developed and tested so far?*

A. We originally set out to develop measurements primarily for public accountability. For that purpose, the users tend to be groups of purchasers who want to get this information into their own hands and potentially into the hands of their employees or the population they are responsible for.

For example, the federal employee benefit program has been using our asthma measures in a pilot project. They are now thinking they want to get that data on a broader basis. The program contracts with a large number of health plans that cover 10 million people. Our efforts have been to work with specific regional or national purchasing organizations.

However, the more frequent use is not the one we intended. Health care organizations, integrated systems, and health plans have used the measures as an externally developed benchmark with some basis in scientific review and consumer input, to get a handle on their own asthma care, or breast cancer care, or whatever it might be.

Q. *What is FACCT's next objective?*

A. What is next for us is a stronger emphasis on helping consumers get information and make decisions. One thing we've learned is that the structure of American health care and the mix of purchasers

Good Ideas!

The 'outrageous approach' to testing significance

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

Invalid assumptions will eat up your analytical and operational resources. To zero in on invalid assumptions, use the "Outrageous Approach":

- Of course we must . . .
- Of course we can't . . .
- We can never . . .
- We must always . . .
- There is no way . . .
- It's impossible to . . .

Each invites a challenge of "WHY."

Source: Adapted from Dettmer W. *Theory of Constraints.* Los Angeles: Custom Publishing; 1995.

in this marketplace don't lend themselves to public accountability or broad information collection and disclosure. Therefore, we're turning our attention more to the question of how to support individual consumers and consumer organizations. We have a library of measures that we think is a starting point. The question is how to get that information into the hands of the public.

If we have no information on quality in this marketplace, we are doomed to cost competition. I don't know anyone who wants that as an outcome for American health care. Until we have some quality competition to balance cost competition, we're going to have a very unfortunate situation.

We think we need to build public demand for quality competition, so that's the direction we're going to be exploring for the next couple of years.

Q. *How can QI managers promote quality-based competition when they operate under so much pressure to contain costs?*

A. At a recent meeting of thinkers in QI, I heard a lot of doubt and frustration about getting continued support from both the administrative and clinical people in their organizations. While everyone believes that improving quality is important, and morally right, and will ultimately lead to more appropriate health care, making a case for that in a business sense is getting more and more difficult, whether in a hospital or an HMO.

One theme that came up at this meeting is that we all need to work together to build an external demand for quality and quality information. We won't get very far until we build a public expectation of accountability. Only then will quality be a competitive advantage, not a competitive disadvantage — which now it tends to be. If we could build that external expectation, it will permit greater resources and attention to go into the quality of work.

What I'm hearing is unless those of us on the external advocacy side are more successful, it's going to become more difficult to sustain a commitment to internal improvement.

(Editor's note: The August 1998 QI/TQM *cover story, "Top watchdogs vow to coordinate, simplify quality reporting systems," announced the accreditation agencies' plan to develop a common measurement agenda to promote greater accountability and ease the reporting burdens on health care facilities. A recent update notes that the coordinating council has met several times. No project completion date has been announced.*

The April 1999 QI/TQM *cover story, "Consumer-based quality measures gain support from buyers, accreditors," describes the framework on which FACCT's measures are organized and the reactions of a few purchaser groups who are piloting them.)* ■

Four ways to get people to return your calls

Voice mail is a nifty way to exchange information, but at the same time, it poses a terrible temptation to ramble way beyond your recipient's tolerance. Here's a QI strategy for your phone skills from **Steve Kaye**, president of Personal Quality in Placentia, CA. Try it and notice how it improves your connections.

1. Make it easy to reply. Write down your key points before you pick up the phone. If you suffer an unexpected attack of locked jaw when you hear the beep, don't worry; just hang up. It beats leaving an incoherent or incomplete message. Organize your messages like this: Greet the person by name. Identify yourself and give your phone number (slowly). State your purpose. Avoid personal messages because they could cause embarrassment if they fell upon the wrong ears. Suggest times you will be there for a return call. Repeat your number. Then, close with an invitation to action, such as "I look forward to talking with you."

2. Use voice mail to communicate with callers. Prepare your outgoing message with care and update it often to reflect changes in your availability. For example, "During the week of May 17 through 21, I'll be out of the office. However, I will check my messages frequently and expect to return calls every other day."

3. Short-circuit voice mail mazes. Find out, and use, your recipients' direct lines or extensions whenever possible. Instead of doing the telephonic shuffle (press seven if you want to

hear a message from the CEO), press "0" or "00" to reach an operator.

4. Practice professional courtesy. Call people back. Set aside a time each day for that purpose. It even helps to include in your outgoing message a clue regarding the time you typically make your callbacks.

[For more information, contact Steve Kaye, Personal Quality, Placentia, CA. Telephone: (888) 421-1300. World Wide Web: http://www.stevekaye.com. Also see: Kaye S. Attitude adjustments: Some proven ways to promote the exchange of ideas. Quality Progress *1999; 32(3):29-33.]* ▼

Ten-minute intervention for risky drinkers

The Portland, OR-based Foundation for Accountability (FACCT) recently reported that the more consumers learned about screening, intervention, risks, and costs of alcohol misuse, the more they believed the health care system should screen and refer those at risk. A recent FACCT report states that 25% of adults misuse alcohol: 5% are dependent, while 20% are at risk, meaning they regularly or occasionally drink more than is healthy. It's the at-risk drinkers who do not come to the attention of formal treatment services. That increases the importance of screening and education for alcohol misuse.

"Health care organizations that screen for potential alcohol misuse and provide effective prevention and treatment are ahead on two levels," according to **Thomas F. Babor**, PhD, professor and chairman in the department of Community Medicine and Health Care at the University of Connecticut Health Center. Babor is co-author of the paper commissioned by FACCT on alcohol misuse. "Services that help keep alcohol misuse problems from getting worse can improve the well-being of patients and enrollees — and reduce avoidable medical expenses," he says.

FACCT has developed a 10-minute protocol for screening and intervention:

- Physician screens patient for alcohol misuse (two minutes).
- Physician identifies the level of alcohol misuse in a patient identified as a "risky drinker" (three minutes).
- Nurse or health educator provides a "risky drinker" with enough information to often help change the behavior (two to five minutes).

[For more information about consumer-based quality measures, contact: Foundation for Accountability, 520 S.W. Sixth Ave., Suite 700, Portland, OR 97204. Telephone: (503) 223-2228. Fax: (503) 223-4336. E-mail: info@facct.org. World Wide Web: www.facct.org.] ▼

Health care Y2K resource is now available

With the year 2000 deadline fast approaching, hospitals, other health care providers and the medical device industry are scrambling to complete a process that in many cases was started too late.

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Editorial Questions

For questions or comments, call **Mary Kouri** at (303) 771-8424.

GRASS-ROOTS QI

At the 13 Advocate Health Centers in the Chicago area, the 1999 "No Flu" initiative is under way. **Cindy Welsh**, MBA, RN, director of quality improvement and credentialing; and **Kathleen Killoran**, RN, MS, disease management specialist, work with a steering committee, contacts at Advocate's clinics, and long-term care (LTC) facilities as well as home care staffs.

✔ IMPROVEMENT OPPORTUNITY

To meet regulatory requirements and Department of Health & Human Services' Healthy 2000 goals: Immunize against influenza 60% of Medicare clients, 80% of LTC residents, and 67% of staff.

✔ SOLUTIONS

Aim to improve on 1998 successes. What works: For employees — reminders in newsletter, posters, paycheck inserts, flu-shot days, on-the-spot shots at work stations, raffles of 100 extra vacation days and weekend wellness getaway, and "No Flu" lapel buttons. For clinic patients — standing orders to facilitate immunization for all adults and pediatric patients, reminders by providers, "November's not too late" postcards and newspaper announcements, walk-in and bring-your-neighbor days, "Just ask, no wait" banners. LTC patients — physicians immunize during visits. Home care — nurses immunize during visits.

The 1999 solutions involve Advocate's managers and marketing specialists in flu shot kickoff and publicity events; target urban centers to raise low immunization rates; offer more walk-in opportunities at clinics; through Advocate's advice line, collect data on patients who obtain shots from other community sources.

✔ RESULTS

Last year's 67% staff immunization rate tops Advocate's benchmark of 50%; 11 centers did better in 1998 than in 1997.

✔ KEYS TO SUCCESS

1. Killoran obtains clinician and administrator buy-in and does on-site inservices detailing the shot's benefits and limitations.

2. Advocate conducts an all-out push between Oct. 1 and Thanksgiving Day. Welsh notes, "If you don't catch people by Thanksgiving, they get too busy to come in."

✔ CONTACT

Cindy Welsh. Telephone: (312) 808-7300. E-mail: cindy.welsh@advocatehealth.com. ■

What may have once been a logistical issue is burgeoning into an overwhelming problem, compounded by the scarcity of time, rising costs, and a lack of programming resources and expertise.

As the Y2K issue moves far beyond a mere "technological" issue, American Health Consultants, publisher of *QI/TQM*, has published the *Hospital Manager's Y2K Crisis Manual*, a compilation of resources for nontechnical hospital managers.

This 150-page reference manual includes information, in nontechnical language, on the problems your facility will face, the potential fixes, and the possible consequences, including:

❒ Will your computers and software work in 2000?

❒ What does Y2K mean for patient care?

❒ What will happen to your medical devices?

❒ How can you make sure your vendors are Y2K-compliant?

❒ Are you at legal risk due to Y2K?

❒ Are you prepared if Y2K delays Health Care Financing Administration payments?

The Hospital Manager's Y2K Crisis Manual is available now for $149.

For more information, contact American Health Consultants customer service at (800) 688-2421 or www.ahcpub.com. ■