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INSIDE

JUNE 1999

VOL. 9, NO. 6 (pages 65-76)

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Special Report: Cost vs. Quality

This is part one of a three-part series: Parts two and three of this series will take a closer look at the relationship between cost effectiveness and care quality, as well as the strategies health care systems are using to take care of their human resources. Here are the issues examined in this installment:

- Today's low unemployment climate throws health care into heavy competition for qualified workers.
- The health care work force consists of a high proportion of 40-ish workers. They don't adapt to the pressures of speed and change as readily as their 20-something counterparts.
- Nursing ranks are thinning due to retirements and shortfalls in nursing school enrollments. Already lean, nursing staffs suffer from the gaps caused by hard-to-fill vacancies.
- Pharmacists feel stress from two directions: higher production expectations and underutilization of their skills.
- Physicians struggle to uphold their clinical standards as practice costs exceed revenues.

(See "Nursing shortages compound workloads and tight budgets," p. 68; "Medical practice overhead outstrips revenue by 5%," p. 69; and "Nursing schools offer dim hope for fresh troops," p. 69.)

How smart is it for clinicians to work harder and faster?

As workloads increase, does quality suffer?

Peeling minutes off of cycle times, multitasking at every opportunity — we hail such strategies as success. But this month, *QI/TQM* takes a look at the underside — the stress brought on by the push to work harder, faster. What does it do to the quality of clinical decisions? Is it driving away highly trained, experienced staff who chuck their positions for alternate career paths or early retirement? And, finally, what role does the current worker shortage play in health care's need to keep a fresh supply of qualified employees?

If you've gone to any job fairs lately, you know that health care recruiters are right out there with the rest, courting workers and offering signing bonuses and flexible hours. The frenzy to recruit is due partly to

the country's low unemployment rate. Last March, the U.S. Department of Labor reported that 95.8% of the work force had jobs. Unemployment is the lowest since 1970.

Another side of the picture, however, is the average age of the health care work force. It's over 40, observes **Patrice Spath**, a consultant in health care quality and resource management with Brown-Spath & Associates based in Forest Grove, OR. Consider the implications: If you've ever tried telling a 50-year-old that, starting next week, she'll have to work faster and smarter, you know she's not likely to respond cheerfully. "Where a 25-year-old might see change as a challenge," Spath explains, "a 50-year-old wants a more comfortable, predictable job. And health care jobs are anything but comfortable and predictable. So we see a lot of 50- to 55-year-olds retiring rather than learning how to work faster and smarter."

A study by the Hay Group of Walnut Creek, CA, confirms Spath's point. Retirement ranks as sixth among the 29 most common reasons for job changes among nurse middle managers, and 11th for registered nurses. **(For other findings from the study, see box, at left.)**

Still another piece of the picture is the downtime from job-related injuries. It escalates among older employees, says **Susan Johnston Lynx**, RN, JD, director of practice, education, and policy for the Minnesota Nurses Association in St. Paul. When hospitals are hurting for clinicians in the first place, it doesn't help when people have to stay home with injuries.

According to the association's (soon-to-be-updated) research, injuries among RNs rose 65% between 1990 and 1994. Among technicians, respiratory therapists, and other staff, the increase was 116%, and 85% among other professionals. The causes, Lynx says, lie in the more serious nature of illnesses among hospitalized patients and leaner staffing patterns.

While common sense

Where Have all the RNs Gone?

Following are the reasons that nursing middle managers (NMM), RNs, LVNs/LPNs, and unlicensed assistants (UA) resign, ranked 1 through 29 by the prevalence, according to patient care executives. (Some selected more than one reason.)

	NMM	RN	LVN/LPN	UA
Characteristics of their old job environment				
Inadequate advancement	24	19	26	24
Inadequate stimulation	29	29	28	28
Lack of growth opportunity	23	16	19	20
Perception of pay inequity relative to the market (external)	10	6	10	9
Perception of pay inequity relative to the organization (internal)	22	24	16	17
Discontent with amount or pace of organizational change	4	7	11	11
Increased workload	2	3	2	3
Lack of preparation for the role	8	21	20	12
Changes in care team model/design	14	14	13	16
Lack of recognition	18	15	15	19
Lack of autonomy	25	28	25	25
Inadequate decision making authority	16	27	23	26
Quality of management	20	20	24	23
Poor relationships with peers	26	25	17	18
Poor relationships with superiors	19	18	18	13
Poor relationships with physicians	15	23	29	29
Characteristics of their new job environment				
Career change	5	13	14	8
Change to a different clinical practice venue	9	9	7	15
Change to a different nursing role	3	8	8	14
Better hours	12	2	3	2
Availability of benefits	28	22	22	22
Higher pay for the same job	11	5	5	6
Perceived better work environment for same job	7	4	9	7
Perceived better care team model	27	26	27	27
Lifestyle changes				
Relocation	1	1	1	4
Retirement	6	11	4	10
To stay home	17	10	12	5
To return to school	13	12	6	1

Source: Hay Group, Walnut Creek, CA.

might lead us to conclude that heavier workloads compromise excellence of care, others say it is not so. *QI/TQM* asked **Colleen Conry**, MD, whether the press to see larger numbers of patients affects the clinician's ability to know patients well enough to make good diagnoses. "I have no concrete evidence to say it does," says Conry, president of the Denver-based Colorado Academy of Family Physicians. "[Clinicians] believe it's healing to know patients, to have time to talk with them about their health. It's one of the things we value. While we get very good at doing it faster, we could reach a limit at how fast we can go. But I have not yet seen it as a widespread problem in the quality of care."

Spath suggests that when job responsibilities are reconfigured, they offset larger numbers. Bedside nurses are taking care of more patients today, she concedes, "but often they are doing fewer functions. Nurses themselves are struggling with the question of how much nursing time is needed if they are doing clinical assessment instead of changing bed sheets. It's not unusual to see big hospitals with 25 to 30 case managers doing some of the care coordination and discharge planning that nurses used to do."

Spath says that even in the heat of finding workers in a tight labor market, the technical quality of the health care work force is adequate. But, she adds, the quality of service is being undermined because younger workers do not have the interpersonal skills that it took their senior colleagues years to polish.

Within nursing circles, the jury is still out on the effect of fast work on the quality of care. The concern of the moment centers on the scarcity of nurses. A study by the American Organization of Nurse Executives in Chicago shows that even when facilities look for nurses, they have trouble finding them, especially experienced ones.

For example, it takes 45 days on average to fill vacancies for experienced nurses and 20 days to fill vacancies for new graduates. "That's a lot of patient days on understaffed units," Lynx notes. **(See "Nursing shortages compound workloads and tight budgets," p. 68, and "Nursing schools offer dim hope for fresh troops," p. 69.)**

Downsizing creates local shortages, she adds. "When nurses get laid off, a lot of them move on and find other jobs, inside or outside of health care, so when hospitals need to increase their staffs, the nurses are not available to come back."

Through state and national nursing contacts, Lynx hears about ethical dilemmas rising from the combination of larger workloads and higher numbers of gravely ill patients. "They're not complaining about breaks — those went out a long time ago. But assessment time is a big frustration for nurses," Lynx contends. Although she points out that her information is anecdotal, she adds, "I hear many of them say they are frightened for patients' safety when they feel they cannot do good nursing assessments. A lot of them are getting out of direct patient care because they don't feel safe. Good nursing care depends on thorough assessment, just as good medical care depends on physicians having time to do their exams." For example, she explains, "Intensive care units, by regulation, must have a certain number of RNs per patient. But nurse aides are not regulated — so they get laid off. That leaves the nurse to do nursing and non-nursing tasks. Care becomes fragmented."

Conversely, where regulations allow higher numbers of less-skilled personnel, Lynx says, licensed nurses face a similar problem. "Patient

Data From Pharmacist Quality of Work Life Study

How often is patient care diminished because of the time you spend on insurance-related problems?

(Respondents could mark on a continuum between 1 and 5, where 1 = never, and 6 = very often.)

Chain/Supermarket	4.1
Independent	3.9
Hospital/Institutional	1.7

I am able to take bathroom breaks when needed.

(Respondents could mark on a continuum between 1 and 6, where 1 = strongly disagree, and 6 = strongly agree.)

Chain/Supermarket	2.6
Independent	3.7
Hospital/Institutional	5.0

Source: Reprinted with permission from *Pharmacy Today* 1999; 5:1. American Pharmaceutical Association, Washington, DC.

Nursing shortages compound workloads and tight budgets

As if cost cuts and higher production pressures weren't enough, health care facilities face a dearth of nurses even when they have the money to hire them. A study, "Nurse Staffing Survey," released earlier this year by the Chicago-based American Organization of Nurse Executives, reveals that not only hospitals are facing competition for a diminishing supply of nurses. Managed care, pharmaceutical, and non-health-related companies want them, too. Moreover, because the average age of nurses is 44, retirements will thin the ranks over the next decade or so. The study, conducted in cooperation with the American Nurses Association and the Division of Nursing of the American Society for Health care Human Resources Administration, surveyed 388 acute care hospitals. Key findings follow:

Most critical priorities:

- ✔ Finding nurses with appropriate skills, competency, and experience.
- ✔ Managing flexible staffing to accommodate the fluctuating patient census and use of temporary staffing.
- ✔ Handling increased paperwork and decreased financial support for nursing management support systems.

Recruitment issues:

- ✔ Urban hospitals have substantially more trouble filling vacancies than rural hospitals.
- ✔ Rural and smaller hospitals take longer to recruit in specific areas and have difficulty hiring widely experienced registered nurses with expertise required to function in a small facility.
- ✔ Nurses spurn flexible staffing and shift schedules required to accommodate fluctuating patient census.
- ✔ Large facilities, as well as urban ones, increasingly hire agency and contract nurses.

Retention issues:

- ✔ Respondents report concern about creating an environment conducive to professional practice including leadership, educational support to promote professional development, and career opportunities.
- ✔ Shortages in nurses in clinical specialty areas, as well as nurse executives and managers, create the perception that clinical and management support for staff nurses is lacking. This promotes general dissatisfaction among experienced nurses, novices, patients, and physicians. ■

information gets lost because the unlicensed person doesn't recognize what's important to pass on to the RN, or nurses don't have time to collect data for full clinical assessments." She also expresses concern about pre-surgical intake interviews, which are often conducted by minimally trained workers via telephone the night before the patient is admitted for surgery.

Pharmacists have not escaped the industry's efforts to do more with less. "For the first time, we are seeing pharmacist shortages in pockets around the country," says **William Ellis**, RPh, MS, executive director of the American Pharmaceutical Association Foundation's Quality Center in Washington, DC. A quality of work life study, conducted by the foundation in conjunction with George Washington University, shows a significantly lower level of job satisfaction for pharmacists in hospital/institutional settings and chain/supermarket pharmacies than those in independent pharmacies or other practice settings. **(For selected findings, see chart, p. 67.)**

And, yes, time pressures do compromise a pharmacist's ability to do a thorough job, although "we may not see a connection as far as documented studies are concerned," notes Ellis.

Even so, the pharmacists' situation represents a dichotomy. "Part of the answer to the time pressures on other clinicians can be found in the pharmacy department," he points out. But one of their great frustrations comes from being treated as pill counters instead of skilled contributors to collaborative provider teams, Ellis adds.

With cost reduction and quality improvement efforts, however, he is optimistic about the growing recognition of pharmacists' skills and their role in good patient outcomes.[1] "For some pharmacists, this a time of crisis, and for others, it's an opportunity," he explains.

"There's a greater realization that appropriate medication use impacts on quality. When pharmacists get involved in direct patient care issues, patient outcomes are better. So health care systems and providers are beginning to see pharmacists as an untapped resource to produce a better quality of patient care," Ellis says. **(For more on this issue, see *QI/TQM*, February 1999, p. 17.)**

The belt tightening reaches beyond hospital walls into physicians' offices, according to a study by the Englewood, CO-based Medical Group Management Association. Between 1996 and 1998, net revenues, after operating costs, dropped 5.5%.

Medical practice overhead outstrips revenue by 5%

For the 11th straight year, billed charges collected by multispecialty practices remained static or declined, a new study shows. Because of this trend, physician salaries stayed the same. To stretch dollars, groups are hiring medical assistants to do some of the duties previously performed by RNs, such as taking patients to exam rooms and recording vital signs.

"Good RNs are not cheap," says **Cheryl C. Ange**, administrator of the Cardiovascular Center in Newport News, VA. "They're great at answering patient questions and performing telephone triage, so we are planning to continue utilizing them in that capacity," she adds. She observes that practices are hiring more nurse practitioners and physician assistants to do caregiving tasks previously left to physicians, such as patient education.

Other findings from the study, Cost Survey: 1998 Report Based on 1997 Data, show that to obtain managed care contracts, medical groups offer insurance companies increasing discounts. Here are a few financial highlights from the study period of 1996 through 1997:

1. **Total net medical revenue for multispecialty groups increased 2.4%.**
2. **Total operating costs increased 2.5%.**
3. **Group practices collected 69.2% of gross charges.** ■

"It is a daily struggle to find a balance between what we want to do for our patients and insurance not reimbursing. It's hard to survive," admits Conry. **(See "Medical practice overhead outstrips revenue by 5%," above, for figures on the disparity between costs and earnings in doctors' offices.)**

Conry says she is not convinced that managed care is the problem. It just happens to be today's economic solution to the enormously expensive job of providing health care in a society where the clinical "tool box" grows each year.

It's even more complicated when clinicians and patients hold different values, she notes. For example, sometimes patients want prescriptions for antibiotics, while doctors would rather use the time to teach them why antibiotics are not good treatments for their problems. Patients drive up costs when they choose convenience over appropriate use of resources, Conry adds, by going to the emergency room after hours for non-urgent care.

She predicts that before the growth of new health care products and consumer demand peak, providers will hit the wall in how much they can do with limited resources. She insists, "We have to be sure that patients are part of the solution to this issue."

Need More Information?

For more information on clinical staffing issues, contact:

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- ❑ **American Association of Colleges of Nursing**, One Dupont Circle, N.W., Suite 530, Washington, DC 20036. Telephone: (202) 463-6930. Fax: (202) 785-8320. World Wide Web: www.aacn.nche.edu.
- ❑ **American Organization of Nurse Executives**, One N. Franklin St., 34th Floor, Chicago, IL 60606. Telephone: (312) 422-2800. Fax: (312) 422-4503. World Wide Web: www.aone.org.
- ❑ **Medical Group Management Association**, 104 Inverness Terrace E., Englewood, CO 80112-5306. Telephone: (303) 799-1111. World Wide Web: www.mgma.com.

Reference

1. Classen DC, Pestotnik SL, Evans RS, et al. Adverse drug events in hospitalized patients: Excess length of stay, extra costs, and attributable mortality. *JAMA* 1997; 277:301-306. ■

Nursing schools offer dim hope for fresh troops

Whether recent nursing school enrollment figures are good news or bad depends on whether your facility needs advanced practice or entry-level nurses.

Last year, master's degree enrollments fell by

2.1%, but it's only a small blip in the upward trend of the last decade. The more distressing news is at the undergraduate level: Enrollments dropped 5.5%. It was the fourth consecutive year of decline.

Given the 44-year-old mean age of today's nurses, and the fact that only 9% of the RNs are under age 30, demand will probably exceed the supply of RNs within the next decade. The findings were released this year by the American Association of Colleges of Nursing (AACN) in Washington, DC.

Nurse educators are concerned about the lingering effect of media headlines two to four years ago announcing nurse layoffs due to managed care cost pressures. They fear that many potential students may have based their decisions not to enroll on false perceptions, given today's expanding nursing job opportunities.

On the other hand, many schools have scaled down class sizes to cope with faculty shortages and other resource shortfalls. "Students need to know, too, that while many nursing schools with resource constraints had to turn away numbers of qualified applicants to entry-level bachelor's degree programs this past fall, other schools reported having several vacant seats remaining," notes **Andrea Lindell**, DNSc, RN, president of AACN.

Another factor in reduced enrollments is the tightening supply of clinical training sites. Hospitals with fewer inpatients train fewer students. Community-based facilities, including HMOs and primary care clinics, apportion training slots to medical students and physician assistant trainees as well as student nurses.

Although hospitals may trim their inpatient RN staffs, needs soared in certain niches:

- ❒ community health centers, up 42%;
- ❒ long-term care facilities, up 32%;
- ❒ outpatient, labor, and delivery, up 25%;
- ❒ emergency departments, up 15%;
- ❒ surgical facilities, up 10%. ■

Teamwork and diplomacy improve X-ray turnaround

Image-to-report cycle drops to overnight

In earlier times, when transcribers took radiologists' notes in shorthand, they could produce typed reports six hours later — so you'd expect electronic technologies to do better. But if layered on to existing processes, they can bog it down as much as seven to 10 business days. It happened at James A. Haley Veterans Hospital in Tampa, FL.

"The physicians were screaming about the delays," says **Kaye Hixon**, MS, RN, CPHQ, executive assistant for continuous quality improvement. They would have been happy seeing their routine X-ray results within two or three days."

When Hixon phoned other facilities seeking local benchmarks for Haley's radiology reporting QI initiative, she learned that others had similar problems. A Haley team set internal customer wishes as the benchmark to beat: "The doctors wanted two- to three-day turnarounds, so we aimed for one to two days," she says.

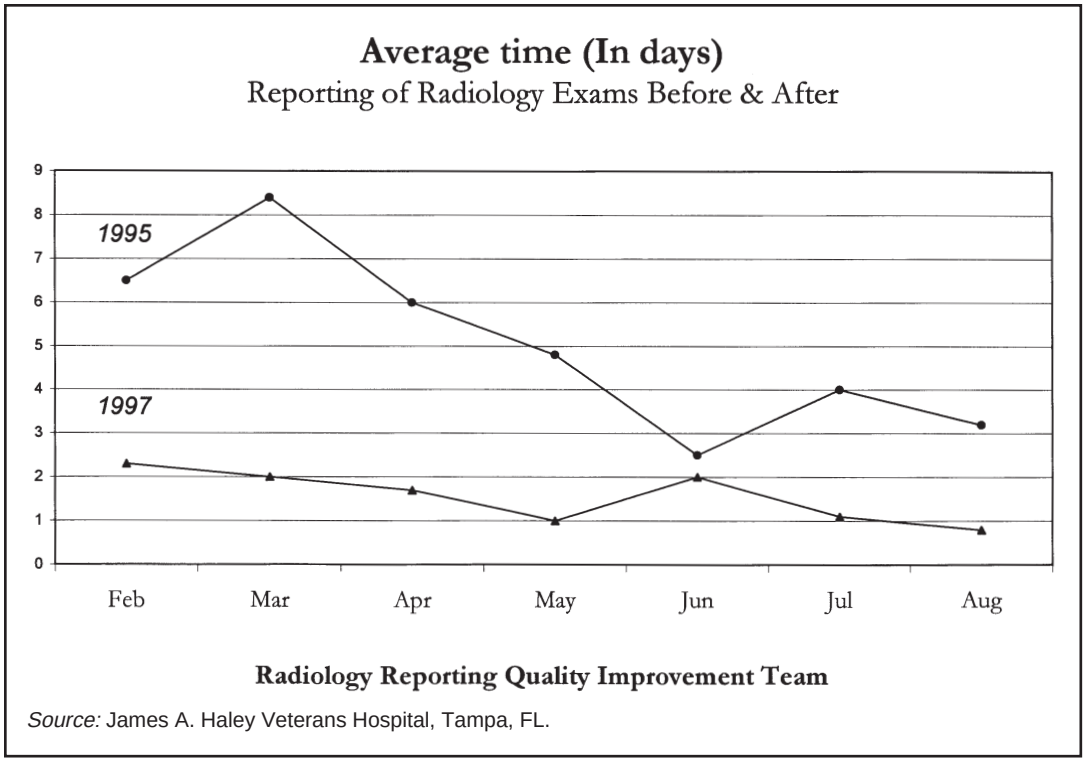
Using criteria from the Malcolm Baldrige National Quality Award as the framework, the interdisciplinary team bumped the average

Key Points

Location: James A. Haley Veterans Hospital, Tampa, FL: A 300-bed facility with 2,500 employees. Last year, Haley ranked first in outpatient visits among the Veterans Administration hospitals with 600,000 visits.

Situation: The turnaround times on radiology notes were seven to 10 business days. The physicians would often call radiologists to get verbal reports in order to write patient care orders.

Solution: Using Baldrige criteria, an interdepartmental QI team took on the objective of shortening the cycle. Physicians, whom the team targeted as its internal customers, requested two- to three-day turnarounds. The team set its goal for same day or overnight. By eliminating several unnecessary steps and adding new technology to replace some of the manual processes, they achieved the team goal. Key to the success of the project was involvement of the radiology department as well as cooperation by the transcription contractor. The improvements cost approximately $1 per report.



Source: James A. Haley Veterans Hospital, Tampa, FL.

image-to-report cycle from 7.8 business days down to same day, or overnight for notes submitted after 5 p.m.

Not only did the team wow its internal customers, the hospital won a Merit Award for improving customer service and saving tax dollars at the 1998 President's Quality Award Program. The awards are based on the Baldrige criteria. **(For a look at the time savings, see graph, above.)**

As described on its Web site (www.baldrige.org), the Baldrige Criteria for Performance Excellence, named for former Commerce Secretary Malcolm Baldrige, are used worldwide by thousands of organizations to assess and improve their overall performance.

The criteria identify achievements and improvements made in seven key areas: leadership; strategic planning; focus on patients, other customers, and markets; information and analysis; staff focus; process management; and organizational performance results.

While it took less than two hours of active work to produce and deliver a final X-ray report, no one could account for the actual time lapse of 156 hours from image to report. "Nobody owned the process," Hixon explains. It was all too common for physicians to hunt for radiology reports by calling the radiology department, or the radiologist on the case. Often, patients were discharged before final reports ever caught up with their charts.

To track the long, mysterious journey of X-ray notes, the QI team flowcharted the process and uncovered several obvious time eaters. "Throughout the project, we challenged ourselves: Make it work better for the physicians, [the] end users of the radiology reports; but let's not do a bad process faster," Hixon recalls. **(See "Goal: Hard copy report available same day or less," p. 72.)**

Two dramatic improvements came easily:

• **Transcription cycle.** "When I asked our transcription contractor what it would take to get the tapes transcribed faster, they said they could do it right away," Hixon says. "They said 'Would you like yours in four hours like the other hospitals? Nobody ever asked us, so we assumed you weren't in a hurry.' That taught us how important it is to partner with our suppliers."

• **Elimination of stopover in transcription department.** The team eliminated this step, probably a remnant of an old process, for a gain of 1.5 days. Other changes presented greater challenges than deleting a step or making a phone call.

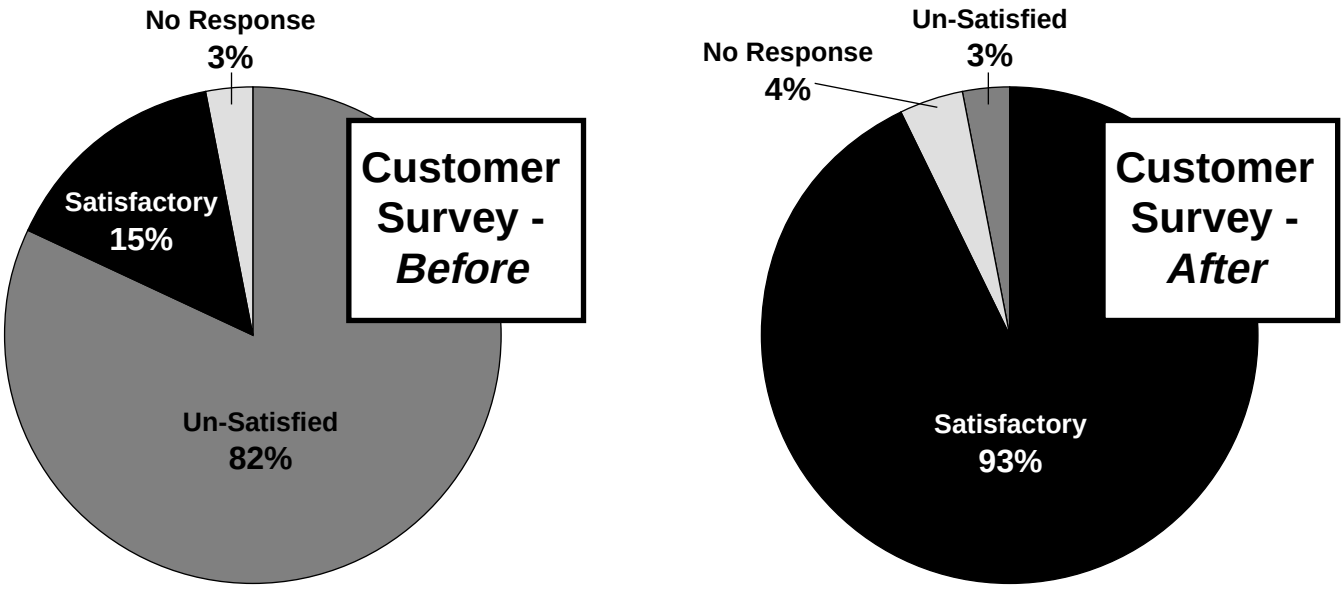
Challenges to the new plan surfaced in these three areas to which the team applied fixes of new work tools and old-fashioned diplomacy:

1. Inpatient units opposed the prospect of having radiology reports uploaded to their overworked printers. Dedicated printers were installed on approximately 10 units. Hixon estimates cost, including the wiring, at $2,000.

2. Physicians chafed at the prospect of editing their reports on-line. The medical champion of the project talked trade-offs with his colleagues. When staff radiologist and associate professor of radiology at the University of South Florida, **Edward Eikman**, MD, showed how much they could gain by spending an extra hour or two self-editing, the radiologists warmed up to the idea.

The hospital went on to replace 1980s-vintage word processing programs with graphical software

Changes in Customer Satisfaction



Source: James A. Haley Veterans Hospital, Tampa, FL.

that was relatively easy to use. And they installed additional workstations so doctors could find a computer terminal anytime they had a few minutes for editing.

Hixon recounts, "The first few times the doctors got their routine X-ray results within one day, they thought it was an accident." Referring to Eikman's involvement, she adds, "The most successful QI teams at our facility are the ones that have physician involvement."

Hixon underscores that timely X-ray reports are especially important in light of Haley's 600,000 outpatient visits per year. "Now the physicians can be confident that the X-ray results will be there when they schedule a patient for a three- or five-day follow-up visit," she notes.

3. Legal requirements dictate that X-ray reports must have a radiologist's signature. Each physician received a coded electronic signature that's as valid as a handwritten one. Hixon observes, "Getting buy-in from the radiologists was a big accomplishment." Eventually Eikman assured them that the electronic signatures were valid and admissible in case the reports ever went to court.

Eikman costed out the new solutions, including physicians' editing time. "It costs us an average of one dollar per report to cut six or seven days off the turnaround," he says.

The radiology QI project, like all the hospital's efforts, used all seven Baldrige criteria. Hixon

Goal: Hard Copy Report Available Same Day or Less

Process steps

✔ **Transcription**
— Information Management Service develops software enabling X-ray technician to print the case number in bar code format. Bar code enhances patient safety by matching reports to charts by Social Security number and full name. Bar codes aid in keeping each patient's reports together.
— Contractor upgrades dictation system software to read bar-coded patient information.
— Contractor upgrades dictation system to allow clinicians to access reports by e-mail.

✔ **Report matching**
— Eliminated by uploading electronic reports.
— Reports completed but not signed are automatically routed to radiologists for electronic verification/signature.

✔ **Editing and verification**
— Several steps removed as radiologists replace hand signatures with electronic signatures entered while reports are on-line.

✔ **Delivery to units/wards/clinics**
— New software developed to print electronically verified/signed reports at the requesting site. Eliminates hand-carrying of hard copies to inpatient units or outpatient clinics. ■

observes that the radiology reports project impressed them forever with the importance of two elements in the Baldrige model:

• Supplier partnerships. "Your internal initiatives are only as good as the cooperation and quality you get from your vendors, whether they're doing a service like our transcription contractors or whether they're supplying your equipment."

She concedes that while all supplier changes probably won't be as effortless as that with the transcription service, "if they own part of the process, it will be easier."

• Customer satisfaction as improvement target. "The customers in this case were internal — the doctors." Indeed, the number of satisfied customers jumped 78% by project completion. **(See pie charts, p. 72.)** ■

Need More Information?

For more information on improving X-ray report cycles or the steps to implementing electronic signatures, contact:

❑ **Kaye Hixon**, Executive Assistant for Continuous Quality Improvement, James A. Haley Veterans Hospital, Tampa, FL. Please contact by fax: (813) 979-3683.

For more information on the Baldrige criteria for health care excellence, contact:

❑ **Baldrige National Quality Program**, Customer Service, Malcolm Baldrige National Quality Award, NIST/NQP, Administration Building 101, Room A635, Gaithersburg, MD 20899. Telephone: (301) 975-2036. World Wide Web: http://www.quality.nist.gov.

GUEST COLUMN

'Show me the quality'

Satisfaction report cards vs. QI measures

By **Irwin Press**, PhD
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As more states begin to mandate patient satisfaction report cards, increasingly cost-conscious hospitals may be tempted to save money by relying on report card satisfaction data rather than utilizing a true quality improvement monitoring system. It's a shortsighted move.

Here's just one example of what is happening with such state-mandated satisfaction data. In November 1998, a consortium of Massachusetts hospitals, health plans, and business coalitions, plus the state Hospital Association and Medical Society, published a massive report card in which a number of state institutions were rated by patients on satisfaction with care. Participation in the study was voluntary, and close to 50 hospitals participated.

Although the stated goal was individual hospital quality improvement — not competitive comparative rankings — all of these hospitals' patient satisfaction scores became public property.

Public release of quality performance data isn't limited to hospitals. The Health Care Association of Michigan will soon be releasing (via paper and Internet) a guide to the quality of all 450 state-licensed nursing homes. Not only will inspection citations be listed, but also family satisfaction results from over 300 nursing homes that had volunteered to be surveyed.

What's happening is that previously in-house data are now becoming public property. Americans are no longer taking the quality of hospitals, physicians, home care, nursing homes, or other providers for granted. The new rallying cry for those who are shelling out more and more money for their own care, or for their customers' or members' or employees' care is, "show me the quality."

As the new millennium opens, "quality" is the key word. Price is still important but will likely level out among providers competing for HMO and other purchaser contracts (higher-cost institutions will simply have to offer deeper discounts). This leaves quality as the differentiating factor. And patient (customer) satisfaction is a key indicator of quality because of these factors:

❒ readily understandable;

❒ comprehensive in its coverage of care;

❒ spin proof. Health care providers can't excuse low satisfaction scores by claiming to have sicker, poorer, older, or dumber patients.

All patients deserve the highest quality technical and personal care. Because of these advantages, satisfaction will match or even exceed "harder" clinical or financial data in importance as a key quality indicator.

Any information on quality gathered by payers, agencies, or interest groups external to the

provider can be called report cards. These external entities either survey your patients themselves — HMOs sending out the HEDIS survey, for example — or ask providers to send surveys out for them. Either way, external entities, and often the public, get to see and evaluate your performance on the basis of the report cards.

This means that a lot of people outside your organization are going to be looking at your patient satisfaction scores and basing judgments of your quality on them. At present, many such report cards are still voluntary. But peer pressure alone will soon force providers to participate in statewide or systemwide surveys.

Ultimately, some report cards will be mandated. A half dozen different entities may simultaneously be judging your performance, either by requiring you to survey patients or by doing it themselves. (Your patients, after all, are their customers or constituents.)

State-level health care organizations will publish the results. (This kind of action is consistent with their stated mission.)

Managed care organizations and business coalitions will be more than happy to use report card results to:

- contract with one provider rather than another;
- pressure providers into accepting lower reimbursements.

This goes both ways, of course — and that's the whole point. Providers with superior report cards will be able to compete successfully for contracts and leverage higher reimbursements from payers. An HMO cannot afford to risk credibility by leaving out of its roster a hospital with very high local patient satisfaction.

To stay on top of external evaluations, providers must be collecting patient satisfaction data by means other than report cards. There is a major difference between patient satisfaction surveys for internal vs. external use. External report cards are essentially global measures of performance and satisfaction. Hospital A is performing 41% below expected numbers. Physician practice B is in the top 10% of statewide medical practices. But, for both Hospital A and Practice B, it is essential to have data that help identify what could be called "causal elements."

Causal elements are any departments, services, units, or individuals that have patient contact and some level of responsibility for the patient's experience of care. This means that you need patient satisfaction measures that can break scores down by nursing unit, department, medical specialty, function, physician, or shift. If you can't do this, you can't identify top performers to use as internal benchmarks for recognition and rewards. You also can't identify units, services, or individuals who are having a negative impact on satisfaction and who need remedial attention.

Report cards, typically, don't break satisfaction scores down by actionable units of analysis. Moreover, most report cards are "one-shots" or annual surveys. A lot can happen between surveys. You're caring for patients continually, not once a year. You need quarterly or even monthly data.

Don't rely on old data

Perhaps most important, report card data tend to be old data. Most such report cards are published (let alone made available to the providers) months after the data are collected. Improvement processes cannot be effective if based on information as much as a year old. You need to be on top of patient satisfaction before you're slammed with low scores on some report card.

This means that you may have to pay for two patient satisfaction surveys — a sporadic report card (for others) and a continuous quality improvement program (for yourself).

There may be a temptation to avoid double-dipping by relying on the report card alone. The result will be sporadic, incomplete, and outdated information that can't identify good performers

COMING IN FUTURE MONTHS

- Patients listen to how — not why — you say it
- Strong QI initiatives include kids' health programs
- How one hospital solved unclear DNR policy
- Goal sheets for schizophrenic patients improve satisfaction
- Creating a database to integrate systemwide QI initiatives

or specific areas for improvement. Neither the quality of care nor external report card grades can be affected.

Providers must not confuse the functions of one-shot report cards and true ongoing quality improvement surveys. One is for outside evaluation. The other is for internal management — a tool that helps you to "show the quality."

[For further information on patient satisfaction measurement, contact Irwin Press, PhD, Press, Ganey Associates. Telephone: (800) 232-8032. World Wide Web: www.pressganey.com.] ■

Laparoscopy speeds recovery for kidney donors

Improved techniques for surgical kidney removal enable many donors to go home within 48 hours after surgery, according to a recent report from the University of Colorado Health Sciences Center in Denver.

A transplant team has used laparoscopic procedures to replace the earlier method of more extensive incisions. **Igal Dam**, MD, chief of transplant surgery at the University Hospital says, "Patients who undergo the standard procedure can often take four to six weeks to feel completely back to normal, but with the new laparoscopic technique, the recovery time is shortened to a matter of days."

The standard technique for surgically removing a kidney from a living donor requires an incision on the patient's side, involving cuts through several layers of muscle tissue. With laparoscopy, smaller incisions in the lower abdomen cause less pain and require a shorter recovery period for the patient.

The procedure is selective for patients who meet criteria for favorable outcomes. The University of Colorado's hospital is one of several transplant centers in the United States that currently use the laparoscopic technique. ▼

Functional status predicts mortality in elderly

For older hospital patients, the inability to perform activities of daily living is a strong indicator of a probability of death within three months to two years, according to a recent study. Researchers say that functional status is of key importance to health outcomes of the elderly. It even surpasses physiological problems. However, the report notes, "current risk adjustment and burden of illness assessment indices do not include these measures."

Such variables include physical, cognitive, and social functioning. Examples of physical variables are basic self-care skills of feeding, bathing, grooming, or walking. Some of the "instrumental" activities vital to functioning were using the telephone, grocery shopping, using transportation,

QI/TQM® (ISSN# 1075-0541) is published monthly by American Health Consultants®, 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**®, P.O. Box 740059, Atlanta, GA 30374.

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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, $351 per year; 10 to 20 additional copies, $263 per year. For more than 20 copies, contact customer service for special handling. 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.)

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GRASS-ROOTS QI

Sometimes first solutions prove to be learning opportunities that reveal the real problems and suggest appropriate fixes — but only to those astute enough to catch the clues. Such is the interdisciplinary Group Against Sharp Injuries (GASI) project at the 400-bed Rockford, IL-based SwedishAmerican Health System.

✔ IMPROVEMENT OPPORTUNITY

"We saw a gradual rise in injuries, especially from needles, as the nurses were working harder and faster," says **Henry Anderson**, MD, chief quality officer. In 1996, there were 56 injuries. "We've tried things, but we still have to make a big decrease in needlesticks," says **Kathy Howell**, RN, MBA, director of Women's & Children's Services.

✔ SOLUTIONS

Phase 1. Solutions uncover the real problems.

• New products with safety features were introduced throughout the system.

• Inservice education on new product use and review of hepatitis and HIV risks. Those solutions yielded a 7% injury reduction.

"There are still user issues," Howell admits. "It's like convincing people of the need to wear latex gloves a few years ago. It's a mindset thing." Some safety products are cumbersome and incident reports reveal that caregivers don't always activate them. Persistent trouble spots: (1) phlebotomy needle disposal; (2) butterflies, ultra-fine needles for pediatrics, and frail patient veins.

Phase 2. Shift from supervisory instruction to peer reminders.

Ideas under consideration:

• instructional video and skills verification;

• GASI progress newsletter;

• testimonials from clinicians who confess they chose not to use safety devices, their accounts of personal health consequences, and time spent for ongoing disease monitoring.

Projections for Phase 2 solutions.

Goal: 70% decrease in needlesticks. "We feel we have a handle on the problem and I'm predicting that, in a few months, when we see our data, we will see the 70% decrease," Howell says. Based on Phase 2 outcomes, GASI will collaborate with vendors on improved needle designs.

✔ CONTACT

Kathy Howell, SwedishAmerican Health System. Telephone: (815) 489-4687. ■

cooking, and taking medications.

The study followed two groups of patients ages 70 years or older. "The contributions of functional and burden of illness measures were substantive and interrelated," write the investigators, some of whom are based at the Yale University School of Medicine in New Haven, CT. The study population comprised 207 men and women with a mean age of 79.

The median length of hospital stay was eight days. Eighty-one patients died during the two-year follow-up, with 17 in-hospital deaths, 29 deaths within 90 days, and 52 within one year. Demographics, including age, sex, race, education, marital status, living arrangements, and admission source, had no statistically significant impact on mortality.

A potential limitation of the study is the difficulty in obtaining information on functional variables. The researchers caution, "A first priority for future work will be to find feasible and practical ways for measuring functional status across health care settings."

(See: Inouye SK, Peduzzi PN, Robison JT, et al. Importance of functional measures in predicting mortality among older hospitalized patients. JAMA *1998; 279:1,187-1,193.)* ■