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FEBRUARY 2000
VOL. 8, NO. 2 (pages 13-24)
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Persistence can overcome resistance to hospital immunization program

But you need a physician or nurse champion

Every winter, the media bombard their audiences with stories about influenza and flu vaccines. Yet, not all those who should get the shot do. For the elderly, getting a vaccine can mean the difference between life and death. It is with this in mind that many hospitals are opting to start inpatient flu immunization programs.

With a large state immunization program, **Cindi Welch**, RN, CIC, infection control specialist at the 300-bed St. Mary's Medical Center in Duluth, MN, says starting an inpatient flu shot program was an obvious idea.

"The concept is hot here," she says. "And when we talked about it, it seemed the right thing to do. It is well-studied and documented that we have an opportunity to provide care to patients that they might not seek elsewhere once they leave the facility."

A boost in screening and shots

The hospital began its program in 1992, and redesigned it in 1995. The team included nurses, pharmacists, infection control experts, and health unit coordinators. There was also participation from the information system team to deal with order form issues and business services, and was also responsible for dealing with billing and reimbursement. A physician epidemiologist served as liaison for the hospital physician staff.

The results of the redesigned program included an

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COMING IN FUTURE ISSUES

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increase from 33% to 80% of the inpatient population being assessed for shots between 1995 and 1997, and an increase from 191 to 900 immunizations given between 1995 and 1997.

Frank Runfola, MS, RPh, pharmacy director at Eastern Long Island Hospital in Greenport, NY, says common reasons that used to be given for not starting such programs no longer exist. "We weren't doing it before in part because we feared we were encroaching on physicians' business. Another problem was that you couldn't get reimbursed for doing it."

When Medicare began to pay for inpatient flu immunizations in the mid-1990s, Runfola's 80-bed hospital revisited the idea. After discussions with a few physician leaders, administrators learned that they had absolutely no objection to their patients getting shots while they were in the hospital.

Minimize paperwork

The program at Eastern Long Island Hospital started in 1997 with the inpatient population, and was quickly expanded to include emergency room patients and walk-ins. All patients over 65, and younger patients with chronic conditions were considered eligible for immunization. The program quickly showed results, with an increase in total shots given rising from 807 the first year to 854 in 1998.

Not that inpatient immunization programs can be implemented without hitches. Runfola says his nurses initially viewed the program as more work. "We had to work with the nursing department to see what they could do to make it more acceptable to them."

That led to the creation of a simple one-page, multicopy assessment form. It was easy and quick to use, and because it had multiple copies it would not require support staff to stand over the copier.

St. Mary's also identified barriers. Among them:

- **The flu season is short, and procedures can be forgotten.**
- **Many staff are part-time employees or casual staff, and some of them were not supportive of immunizations.**
- **There was limited physician buy-in, especially from specialists who worried that reactions might mask post-operative wound infections.**
- **Transfer patients from nursing homes didn't always include information on whether**

the patient had been immunized previously.

The first year was the worst, recalls Welch. "The nurses wanted to know why we were doing it here. But by the second or third year, they were gung-ho on it. It shows a real culture change. That just fits in with all the other changes we are seeing in health care. We are more accepting of stepping out of our boxes."

Easier to do it than not

Getting physicians to agree to it was as simple as creating a standing order. At the start of every flu season, the hospital sends out a memo to all physicians. It says that the shot will be given to all patients unless there is an allergy or the vaccine was already given. "If they don't want their patients to have it, they have to provide an order *not* to give the shot," Welch explains. "We make them work to not do it."

Further acceptance of the idea came from having the physician epidemiologist act as a promoter. "He is well-respected in the physician community," says Welch. "In larger facilities, the physicians will listen to another physician when they have questions or if they want to know if it's still okay to vaccinate a patient who just had surgery. They have an expert they can go to with questions."

Even after the program started, there were still bumps at St. Mary's. Initially, the assessment form was attached to the admissions form. "This just didn't work," Welch says. "There is just too much going on at the time." Now they wait until the patient is stable. That removed the program from the six intensive care units, too.

The hospital also moved to a system of unit-based pharmacists. That eased problems of educating large numbers of people every year. Instead, you can remind the pharmacists, and they can spur the program forward. "They also assist in patient education," Welch says. "In smaller settings, it might be someone in the nursing department who takes on this role."

Both Welch and Runfola believe another key obstacle to success for inpatient immunizations is trying to maintain the program when the flu shot season runs only about three months of the year. "It would be a lot easier if it was year-round," Welch says.

If you need proof that even such obviously beneficial programs need an active champion, ask Runfola. His biggest problem with the program occurred a few weeks ago, when the nurse who was a driving force behind the program retired just before the flu season started. She was replaced with a part-time consultant. Without the constant input and presence of that nurse, Runfola says, his inpatient immunization rate suffered. It went from a high of 177 patients in 1996 to only 86 in 1999. Even the rate of immunization among hospital physicians, volunteers, and other staff dropped. "She's not there on the ward to reinforce these good ideas."

Pneumonia targeted next

Another problem Eastern Long Island Hospital faced this year was the departure of the nursing care coordinator for the medical/surgical unit. "The new person just hasn't had the time to get really involved in the program," Runfola says. He hopes that the coming year will allow him time to develop rapport with the new coordinator prior to the 2000 flu season. He might have that opportunity as Eastern Long Island Hospital continues a new inpatient pneumococcal vaccine program.

"That program is the same story only worse," he says, explaining that since the shot is only given once or twice in a lifetime, the nurses have a much harder time establishing whether a patient has had the vaccine or not. "Our statistics on it were low last year, but we didn't promote it at all."

This year, there was more promotion, and although the numbers of pneumococcal vaccines still aren't high, they have improved. And since that program can continue throughout the year, the improvement should be much more evident next year.

St. Mary's is also toying with the idea of an inpatient pneumococcal vaccine program. Also, the idea of giving patients the chance to take care of vaccinations while they are in the hospital is expanding to other areas. Part of a new wound care protocol at St. Mary's includes providing tetanus and diphtheria shots to patients who

SOURCES

- **Frank Runfola**, MS, RPh, Director of Pharmacy, Eastern Long Island Hospital, Greenport, NY. Telephone: (631) 447-1000.
- **Cindi Welch**, RN, CIC, Infection Control Specialist, St. Mary's Medical Center, Duluth, MN. Telephone: (218) 786-4696.

need it. "I think the flu shot program heightened general awareness of immunizations in inpatient setting," says Welch.

But regardless of the program, Welch says you have to have a consistent core group of people who are committed to the project. Runfola agrees, pointing to the experience he had the last flu season. "The loss of two key players in the inpatient program proves how important having a driving force behind a program is. It proves that the turnover of key people can affect you. You really have to have someone there who wants the program to work. You have to have a champion available to be the motivating force." ■

Wound care program saves $142K, wins award

System gets lower LOS and improved outcomes

Ask any physician or nurse from a large health care system and you'll hear the same thing: Wound care is always a problem. It is no different at the North Shore Long Island Jewish Health Care System, a group of 13 institutions, two nursing homes, four home care agencies, and some 100 ambulatory care sites in Great Neck, NY.

"I've been in this business for 20 years, and wound care is always an issue," explains **Yosef Dlugacz**, PhD, senior vice president for quality management for the system. But with a large database, he was able to determine that across the system that nurses were using different methodologies to deal with pressure wounds. In some institutions, care seemed to work better. "The variation between institutions was too big to ignore," he adds. It put wound care at the top of an annual list of quality improvement projects.

Fewer days, fewer dollars

The resulting project was able to help the system decrease median length of stay (LOS) for those patients by one day, improve patient outcomes, and save more than $100,000 in costs associated with the specialty beds that patients with advanced pressure wounds use. And the project won recognition from the Joint Commission for Accreditation of Health Care Organizations (JCAHO), which awarded the system the Codman Award for the project last November.

"It was a problem that occurs a lot with the elderly," explains Dlugacz. "It costs a lot, patients are in the hospital a long time. They often have gait deterioration. Although they don't usually die from their wounds, they have a high mortality rate, and the decubiti can't help."

While the project didn't measure pain, he adds that there is probably some pain associated with those injuries, as well. For patients who have to have surgery on their wounds, there is post-surgical pain at the very least.

"We wanted to create an organized way of providing care to the patients across all the institutions," he says. "The challenge was enormous. But this gave us a unique opportunity to bring the system together through a particular task. This is a tangible thing for administrators, medical staff, and nurses to do. And as the demographics of the patient population changes and they grow older, this will be an increasing problem."

Bringing the team together

Lori Stier, RN, EdD, assistant director of quality management, put together a team in August 1996 that included nutritionists, physical therapists, physicians, and nurses. Nursing education and quality management staff were also involved. "We wanted to look at all policies and procedures and see what we could standardized and where we could use the AHRQ [Agency for Healthcare Research and Quality] guidelines," she explains.

The group also wanted to standardize the way they measured wounds, the definitions used, and what products they used. "When we inventoried our products, we found we used about 160 different ones." That was eventually reduced to 24 products that all facilities could use.

The team members, says Dlugacz, reflected different specialties and leaders of the system's various organizations. Nurse executives from the nursing council gave legitimacy to the process.

The system created a uniform standard of skin care across the continuum. Team members developed a risk assessment methodology with a score given to patients based on wound size and depth. It provides nurses and other members of the care team with an objective measurement that can be related to specific interventions. Stier says they went one step beyond teaching nurses simply to quantify wounds in terms of depth, size, and color. "What made it even better is that we attached outcome. If there is redness and the wound scores a one, we incorporated it into care

map: How do we get rid of the redness?"

Another goal for the team was to adopt best practices and measure patient outcomes. That in turn would be measured against internal and external benchmarks. Using AHRQ guidelines, Stier says the system didn't do too badly — AHRQ has a rate of 2.7%, while the incidence in the system was about 2.2%. "But when we looked internally at our more aggressive benchmarks, we didn't do as well. And we found that some of our hospitals were doing better than the system average, and some had room for improvement."

The goals were primarily to improve quality and improve care processes, Stier says. "This was not a cost-cutting program. Saving money was just a secondary benefit."

Using external guides as a template

Stier explains that using existing guidelines as a template helped save time. "There were some practices that we used across the system, though, that shouldn't be scratched. We incorporated them with other guidelines. We wanted to merge what was out there together and create our own guide."

One benefit of that process was the ability to adapt the guideline to other parts of the system. For example, AHRQ doesn't have different pathways for nursing homes and acute care facilities.

Creating their own guideline also enabled the health system to incorporate practical aids, such as the well-known Braden scale of wound risk into their care map. "AHRQ may give us numbers and supporting literature," says Dlugacz, "but we brought the practicality to it."

The resulting program includes the following steps:

- **complete a risk assessment on all patients;**
- **determine appropriate stage for patients with skin breakdown;**
- **perform chart review for relevant data;**
- **record data (using palmtop computer);**
- **conduct benchmark prevalence studies compared to national statistics to identify strengths and weaknesses;**
- **complete follow-up prevalence studies to identify areas for improvement and analysis.**

The program was implemented through a teleconference program that allowed the staff to learn about the new program in the most efficient way. Using a train-the-trainer scenario, the team introduced the new guidelines to system educators, wound specialists, and some nurse managers. They, in turn, took it to their own people.

The new program puts everyone in charge of intervening in a wound case, says Dlugacz. "Where there was a wound specialist in every department who would be in charge of intervention, education, and data collection, now there is no such sacred cow. Now, intervention is universal. Everyone can help take care of the patient."

And, adds Stier, the system has provided the staff with the tools, material, and resources to make the program a reality. "Before, there were some units that had programs in place, while others were rudimentary. This elevates the standard of care across the system."

No such thing as a good wound rate

The results of this particular project were impressive: annual savings for use of specialty beds were nearly $142,000. Length of stay (LOS) decreased from 13 days to 12 days. Stage III pressure injuries decreased from 7% to 5%; and Stage IV wounds declined form 5% to 1%. Staff competency has improved, and the system has standardized guidelines and measurements to use.

But the program still has further to go, Dlugacz says. "We think we can reduce LOS further if underlying diseases don't interfere. We are going to do a new study to see if nutritional supplements help these patients."

Other steps for the future include improving surveillance, communication, and transfer of patient information across the continuum of care, monitoring readmission of patients with pressure injuries, and establishment of a demonstrated best practice within the system.

Dlugacz says the biggest obstacle in implementing the program was convincing 12 hospitals to do it. "The nurses felt that a 4% or 5% wound rate was OK. We had to convince them it was not."

The key to getting buy-in was to give them a sense of ownership. There was some solid data that showed the system needed to provide better patient education; since New York has a higher LOS than other parts of the country, there was pressure from managed care organizations to reduce that number.

Dlugacz knows that having a commitment to quality from the chairman and the board is vital to making a project like this one work. "This takes money, time, and resources to work. You have to have trust between your administration and your quality staff so that quality is always on the agenda. Some people think quality is just about JCAHO accreditation. But it is a permanent

SOURCES

- **Yosef Dlugacz**, PhD, Senior Vice President of Quality Management, and **Lori Stier**, RN, EdD, Assistant Director of Quality Management, North Shore Long Island Jewish Health Care Systems, Great Neck, NY. Telephone: (516) 465-2600.

topic for us, part of our culture."

"One of the things that has been helpful for us is a strong communication structure among our facilities," says Stier. "Initiatives like this have the opportunity to be recognized throughout the system. We can keep the leadership informed of our progress so that our committee is known to do work and people understand that we are getting somewhere with the time we have invested."

She also believes that having the right people on your project team is vital for success. "Everyone involved has to have a voice in the decision making," she warns. "If you try to it do top down, it doesn't really work." ■

Shortage spurs hunt for hospital staffing ratios

State legislatures codify standards

From protests in Massachusetts to legislation in California, from federal measures in Washington, DC, to sign-on bonuses in Texas, the nurse staffing shortage has made the big time and grabbed the uneasy attention of health care administrators, lawmakers, and nursing professionals nationwide.

The federal Bureau of Labor Statistics projects that during the next six years, the need for RNs will grow by 21%, while the growth for all occupations will be 14%. Demand is expected to exceed supply by 2010, and statistics suggest that by 2015, the deficit will reach 114,000 full-time RN positions. In other words, left to its own devices, the nursing shortage is going to get worse, not better.

Some key factors at work:

- **About half the RN work force will reach retirement in the next 15 years.**
- **The average age of new RN graduates is 31; they are entering the profession at an older age and will have fewer years to work than nurses have had traditionally.**
- **RN enrollment in schools of nursing is down. Entry-level BSN enrollment has fallen 6.6% from a year ago, dropping for the third year in a row, according to the Washington, DC-based American Association of Colleges of Nursing.**
- **Modifications in managed care and a new push for competitive quality are increasing acuity in many units, as well as patient days, hours of nursing care, and the recognition of the role of the RN.**

The future is here

But the industry need not wait 15 years to see fallout from all those factors. Problems are starting to show up now. **Mary Lee Mohr**, director of nurse recruitment at University Hospital in Denver, has been wrestling with staffing shortages since she started her job there three years ago, and she points out how frustrating the economics of the situation can be. "I use outside agencies," she says, "but it costs a lot of money. We float nurses when we can, and if we simply can't staff the unit then we hold beds. That means sending patients to other hospitals, which also costs money."

Because of the proliferation of managed care and the subsequent reduction of professional staff, consumers are showing concern about the quality of care available in hospitals, and state legislatures are taking action. In 1998, staffing bills were introduced in 24 states. In 1999, bills were brought to the legislatures of 15 states. Bills that have passed include:

- **Kentucky's new law that mandates all licensed facilities to provide an appropriate mix of licensed and unlicensed personnel;**
- **a New Mexico appropriation of $150,000 to fund a nursing work force study;**
- **a law in New Hampshire that requires hospitals to report a number of variables, including rates of RNs per bed, to a newly established Health Care Quality Commission.**

California recently became the first state in the nation to pass and sign into law a measure requiring minimum ratios of nurses to patients in all acute hospital and psychiatric hospital units. **(See box, p. 20.)** The bill does not use actual numbers, since the needs of any particular unit varies from day to day, even hour to hour.

Beverly Malone, RN, PhD, FAAN, president of the American Nurses Association in Washington, DC, objects strongly to the idea of prescribed numbers for nurse-to-patient ratios. "The idea that 'a nurse is a nurse is a nurse' — that one can

Matrix for Staffing Decision Making

Items	Elements/Definitions
Patients	Patient characteristics and number of patients for whom care is provided
Intensity of unit and care	Individual patient intensity; across the unit intensity (taking into account the heterogeneity of settings); variability of care; admissions
Context	Architecture — geographic dispersion of patients; size and layout of patient rooms; arrangement of entire patient care unit(s); technology (beepers, cellular phones, computers); same unit or cluster of patients
Expertise	Learning curve for individuals and groups of nurses; staff consistency, continuity, and cohesion; cross-training; control of practice; involvement in quality improvement activities; professional expectations; preparation and experience

Source: American Nurses Association, Washington, DC.

just count nurse bodies and patient bodies and state the ratio between them — just doesn't hold," she insists. "Clinical knowledge, knowledge of the unit, and getting enough downtime between shifts also influence the quality of care."

So does the availability of skilled aides who can help cut down on the nursing staff responsibilities for cleanup, paperwork, and other nonclinical duties.

"Staffing decisions should be based on real patient conditions and real provider competencies," adds Malone, "not on a cookie-cutter approach that treats patients and their nurses as widgets on an assembly line." **(See decision-making matrix, above.)**

Late last year, nurses at St. Vincent Hospital in Worcester, MA, demonstrated to protest a situation in which one nurse was caring for nine critically ill patients on a single shift. Other hospitals in Massachusetts have been the object of nursing strikes and protests related to dissatisfaction with staffing levels. It's a widespread problem that also affects much of Europe, Australia, and the Philippines. In the United States, it stems from combined issues that include steep population growth in some states, a diminishing supply of new nurses, an aging work force, and a baby boom bubble that will require intense health care services just as the majority of nurses are retiring.

So, what are the solutions? "The big thing for us right now is retention," says Mohr. And she notes that a lot of the motivation for a nurse to stay on comes from the top down. "Money isn't the issue. A veteran nurse can earn more than $23 an hour for a straight shift and more for overtime and weekends. The big thing is work satisfaction. Our management incentives include turnover levels, and I have some great directors here who make a big difference in our retention efforts."

Laura Mahlmeister, RN, PhD, president of Mahlmeister & Associates, a California nursing consulting firm, agrees that the attitude of management is the biggest factor in nurse retention. "These nurses need to be treated like professionals," she insists. "Don't send nurses home without pay on down days. That reduces them to nothing more than clock punchers. There are alternatives for them when the census is down. They can go to the management pool and work on policies and procedures. They can go to a continuing education program for the day if one is available. If there is no viable option and they must be sent home, then send them home with pay or with comp time. But show that you value them as professionals."

University Hospital maintains strict staffing minimums. "There are never fewer than two RNs on a unit," Mohr explains, "and we seldom use LPNs because of the restrictions on their licenses." Does this mean nurses are asked to do more than should be expected? "I don't think they're asked to do more clinically," she says, "but they're certainly asked to work longer hours."

University Hospital also fills in with Canadian nurses for whom Mohr can arrange six-month work permits.

"The permit maximum was recently expanded to a year, and now the demand is such that we're

California passes first nurse staffing quota law

In October 1999, California became the first state to pass legislation requiring minimum nurse-to-patient ratios for all patient care units in hospitals. The bill requires nurse staffing numbers to be based on:

- ✔ the severity of illness;
- ✔ the need for specialized equipment and technology;
- ✔ the complexity of clinical judgment needed to manage the patient care plan;
- ✔ ability for self-care;
- ✔ licensed level of staff.

The bill also prohibits the use of unlicensed personnel for nursing functions when an RN is not available and prevents non-RNs from performing nursing functions such as:

- ✔ medication administration;
- ✔ venipuncture or intravenous therapy;
- ✔ parenteral or tube feedings;
- ✔ invasive procedures, including inserting nasogastric tubes, inserting catheters, or tracheal suctioning;
- ✔ assessment of patient condition;
- ✔ patient and family education and post-discharge care;
- ✔ moderate complexity laboratory tests.

The bill also requires that orientation be provided for an RN coming into a nursing unit or clinical area as well as for temporary personnel. ■

hearing it could be extended to two years," she says.

The need for additional nurses in certain areas is so critical that President Clinton recently signed a bill to provide up to 500 non-immigrant temporary visas per year to foreign nurses to help alleviate shortages for hospitals in the most affected areas, usually in rural or inner-city areas. The legislation is sensitive to the needs of domestic nurses, protecting their salaries and positions, and limiting the number of foreign nurses per facility.

In the meantime, hospitals are working with various incentives to recruit and retain their RNs. For example, hospitals in Texas, Virginia, and New York have instituted sign-on bonuses of up to $5,000. "In California, I've seen bonuses as high as $7,000," says Mahlmeister.

One important need that Mohr sees for many RNs is flexibility. They want family time, personal time, perhaps part-time work, and just plain breathing time. "Float pools are a big help," Mahlmeister says. "If recruitment and staffing offices can find enthusiastic float nurses, particularly in highly skilled areas like critical care and labor and delivery, it gives the float nurses the flexibility they need and the shift nurses the added RN support they may be missing."

Ensuring a strong work force

But some solutions that have been developed in response to the nursing shortage are opposed in a joint position statement from the American Nurses Association, the National Federation of Licensed Practical Nurses, and the National Council of State Boards of Nursing. The statement warns against solutions that are "expedient, inefficient, . . . and lead to unsafe delivery of nursing care," including:

- **delivery of nursing care by non-nursing personnel not under the supervision of a licensed nurse;**
- **substitution of licensed nurses with unlicensed personnel;**
- **unnecessary creation of new categories of health care personnel . . . [which] serves to fragment care;**
- **lowering of established legal standards [for] . . . the licensure of persons who have not demonstrated competence to practice nursing;**
- **lowering of professional nursing standards.**

Hospitals already face competition for qualified nurses from managed care, pharmaceutical, and nonhealth-related companies, according to a survey done last year for the American Organization of Nurse Executives (AONE) in Chicago.

With enrollment in four-year nursing programs dropping and the average age of nurses now at 44, hospital leaders must scramble to recruit qualified RNs. The AONE survey shows that flexible hours was the incentive most commonly used. Bonuses and child care also were noted.

But the larger question is: What can health care administrators do to ensure a strong work force in the years to come? Sigma Theta Tau, the International Honor Society of Nursing, based in Indianapolis, has a number of recommendations:

- Reposition nursing as a highly versatile profession in which young people can learn science and technology, customer service, critical thinking, and decision making.
- Construct practice environments that are

interdisciplinary and build on relationships between nurses, physicians, other health care professionals, patients, and communities.

• Create patient care models that encourage professional nurse autonomy and clinical decision making.

• Develop additional evaluation systems that measure the relationship of timely nursing interventions to patient outcomes.

• Develop career enhancement incentives for nurses to pursue professional practice.

The bottom line: It appears that administrators must learn to understand what patients require for adequate professional care; what nurses want in the way of professional incentives, leadership, and assistance in their workplace; and what makes nurses love their jobs. Then they must address those issues on a consistent and generous basis. That seems to be the message nurses are sending, and the most realistic way to avoid what could be a potentially major health care crisis, boost the image of nursing across the board, and stimulate enrollment in schools of nursing. ■

Nurse-driven model gains elder lifestyle changes

For a good model for serving large numbers of people with chronic conditions, look to the Cardiovascular Disease Initiative in Minneapolis, says a physician affiliated with a locally based ambulatory care group.

For managed care patients, points out HealthSystem Minnesota internist **Anthony Woolley**, MD, seeking people less often is the goal. By contrast, the CVD Initiative achieves remarkable results by seeing them more often. He sees the program as a good model for serving large numbers of people with chronic conditions. "We can get closer to the goal levels of blood pressure and cholesterol management and smoking cessation."

Attention must be paid

For managed care patients, he observes, seeing people less often is a good thing, but the CVD Initiative achieves remarkable results by seeing them more often. "We pay close attention to their conditions until they reach goal levels," says cardiovascular disease prevention services manager **Linda Leimer**, RN. "After that, we schedule their visits and call to remind them of their appointments. We don't just say 'come back and see us in six months' and leave it to them." Eighteen months into the program, 14% of the smokers had stopped for over six months. "That's way over the national average," Leimer observes. **(For additional outcomes of the CVD Initiative, see the box "CVD Initiative — Pilot Site," p. 22.)**

Several other features distinguish the CVD Initiative from traditional acute care models:

• **Delivery revolves around the nurse.** "The nurses live in the primary care clinics, and they coordinate patient care with the specialists." While patients visit specialists as needed, their home base is the primary care clinic.

• **The focal point of service delivery for patients with multiple conditions is the one requiring most rigorous management.** For example, a person whose diabetes is out of control might visit the CVD Initiative programs once or twice but would remain in the diabetes program for ongoing care.

• **Information systems address many of the communication needs.** The electronic medical record (EMR) now encompasses all the documentation. Nurses write their notes by hand and later transcribe them to the EMR. However, that will change, Leimer notes. Soon, nurses will chart directly on the EMR.

Improvements in progress

1. Provider fact sheets will list clinic and community resources for chronic disease patients.

2. A visit planning process will help providers coordinate appointments for their chronic disease patients. For example, if a patient comes in for a hypertension appointment, she might also get a mammogram and have her feet checked for signs of diabetes-related circulatory problems.

While this model produces enviable results in health outcomes and patient satisfaction, it struggles to break even. "Medicare and managed care companies don't reimburse on outcomes or how well we control risk factors," Woolley notes. "In our system, the nurses might spend a half-hour educating patients when they need it, and the doctor might spend two minutes on a checkup. But reimbursement for the doctor is greater," he continues. "We've improved access to care by replacing doctor visits with nurse visits, but we

Healthsystem Minnesota

CVD Initiative — Pilot Site

Oct. 1, 1997 to March 31, 1999

Hypertension control rates

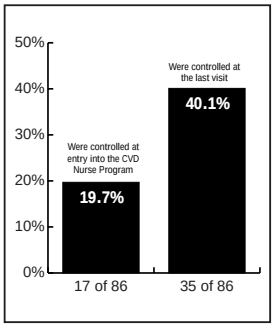
Aim:
Achieve blood pressure control rates of 50% in the pilot population within 6 months of entering the CVD Nurse program

Definition:
Patient Population: Any active patient with a Hypertension diagnosis who has been enrolled in the CVD nurse program for at least 6 months

Measurement:
Numerator: Number of patients with a B/P value < 140/90 on the last visit
Denominator: Total Number of patients

Analysis: Of the current active patients with a diagnosis of hypertension, 86 have completed at least 6 months in the program.

The increase in control rates is statistically significant.



Dyslipidemia control rates

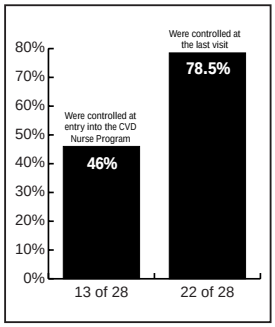
Aim:
Achieve LDL levels of < 130 in 80% of our population within 6 months of entering the CVD nurse program

Definition:
Patient population: Any active patient with a diagnosis of Dyslipidemia, who has been enrolled in the CVD program for at least 6 months.

Measurement:
Numerator: Number of patients with LDL level < 130 on last visit
Denominator: Total number of patients with diagnosis of Dyslipidemia

Analysis: Of the current active patients with a diagnosis of dyslipidemia, 28 have completed at least 6 months in the program.

Although the control rate at 6 months does not meet the 80% goal, we can conclude with 95% confidence that the increase is not caused by random variation, but is due to the effect of the CVD program.



Tobacco use control rates

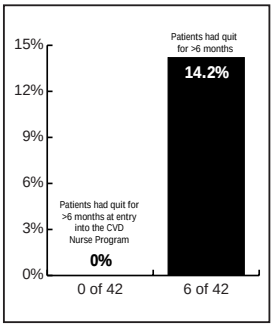
Aim:
Achieve tobacco cessation status in 20% of the pilot population tobacco users, who have stated a readiness to quit, within 12 months of entering the CVD nurse program

Definition:
Patient population: Any active patient with a personal history of tobacco use, who has been followed in the CVD nurse program for at least 12 months

Measurement:
Numerator: Number of patients who have quit using tobacco for > 6 months
Denominator: Total number of patients with personal history of tobacco use

Analysis: Of the current active patients with a personal history of tobacco use, 42 have completed at least 12 months in the program.

The cessation rate of 14.2% does not meet the goal of 20%, but it does show statistically significant improvement. If those patients who have quit for < 6 months were included in the numerator, the control rate increases to 28%.



Source: HealthSystem Minnesota, Minneapolis.

can hardly make ends meet." That challenge remains to be solved. ■

Managing Generation X in same-day surgery

They are surprising, frustrating, and our future

WANTED: Perioperative nurse for same-day surgery program. Must be willing to say no to working overtime or assuming additional responsibilities. Must express frustration with co-workers who are less technologically knowledgeable and should be prepared to question all policies, protocols, and requests from manager. Loyalty to employer and long-term commitment not required.

Recognize some members of your staff in that advertisement? Then you might be managing Generation Xers, a group of people born between 1964 and 1980, many of whom fit the above description, according to same-day surgery managers. **(See related story, p. 23.)**

For all of the negative descriptions of Generation X, the group brings a fresh look at the workplace and a creativity that will benefit all staff members, says **Jo Manion,** MA, RN, CNAA, FAAN. Manion is a senior consultant at Manion and Associates, an Oviedo, FL-based firm that specializes in helping health care organizations handle issues such as organizational structure, leadership, and change in the workplace. The key to tapping into the positives of these young people is to understand the generation, she adds.

Many members of this generation were latchkey children who had to become self-sufficient early in their lives, she explains. "Children who had to come home from school to an empty house, do their homework, and even start dinner have grown into adults who are accustomed to making their own decisions and finding better

Generation X: Who are they?

As baby boomers age, same-day surgery managers find themselves supervising and trying to motivate a group of people that seem to have completely different approach to life, work, and management.

This group born between 1964 and 1980 were first called "Generation X" in a 1991 novel, *Generation X: Tales for an Accelerated Culture*, by Douglas Coupland. Although Coupland's book is fiction, the characteristics of the generation he describes are different in many ways from baby boomers, says **Jo Manion,** MA, RN, CNAA, FAAN, senior consultant at Manion and Associates in Oviedo, FL.

"A big misconception about this age group is that they have it easy because their parents have given them everything," says Manion.

The reality is that 43% of Generation Xers are being paid minimum wage, she says. "Even those who are earning more, such as surgery program nurses, are spending as much as 40% of their income on their mortgages, compared to the 14% of income spent on mortgages by their parents."

The good news for Generation X is that it is easier for them to find jobs. Between 1946 and 1964, birth rates peaked at 25.3 births per 1,000 population, creating the age grouping known as baby boomers. This period was followed by a 16-year period during which the birth rate fell to 14.6 births per 1,000 population, creating a total of 44 million Xers, compared to 77 million boomers. This has created the smallest pool of entry-level workers since the 1930s.[1]

Because there are more jobs than people, Generation Xers can be choosy about where they work, says Manion. "One of the biggest complaints managers express to me about managing Generation Xers is their lack of loyalty," says Manion.

This lack of loyalty grew out of the Xers seeing members of their parents generation undergo the trauma of downsizing, re-engineering, and company closings, she explains. "An Xer is not going to look at any job as a lifelong commitment because he or she knows that the employer cannot make a long-term commitment to them."

What you can do is offer Xers a work environment that recognizes their technological knowledge, independence, and need for recognition, says Manion. And don't expect problems, she adds. "Managers must be careful not to create a self-fulfilling prophecy that Generation X staff members will be a problem to manage."

Manion suggests that managers learn as much as they can about this group. She suggests a book: *Beyond Generation X: A Practical Guide for Managers* by Claire Raines (Crisp Publications, Menlo Park, CA), as a source of information about how Xers think and what they expect from a job and a manager.

"Once a manager understands the generation's characteristics and why they act the way they do, the manager can create a work environment that is not only positive for Generation Xers, but for baby boomers as well," she says.

Reference

1. Loysk B. Generation X: What they think and what they plan to do. *The Futurist* 1997; 31:39-44. ■

ways to accomplish a task," she says.

Because the group also witnessed their parents working 40- to 60-hour workweeks, only to be given a gold watch or a severance notice due to downsizing, Generation Xers are less likely to look at a job as a long-term commitment, says Manion. Managers who want to keep Xers within their program need to know the characteristics of the group and their expectations from a job, she adds. Key expectations of Generation Xers include:

• **Compensation for worth.** Generation Xers place value on their time, so asking an Xer to work overtime or spend time outside their normal job responsibilities on a special project means paying them for that time, says Manion. "Xers watched their parents spend much more time at work than at home with their families so they place a high priority on personal time and family time," she says. "They are not unwilling to take on extra responsibilities, they just expect to be paid appropriately."

You must respect Xers' personal time, advises **Diane Mamounis-Simmons**, RN, MSN, CNOR, CNAA, administrator for nursing in surgical services at Northshore Long Island Jewish Medical Center in Long Island, NY. "We create rosters of who is available for overtime, and my supervisors try to give staff members as much advance notice as possible."

• **Involvement in decision making**. Xers are accustomed to making decisions and solving problems. They are also likely to question managers about procedures and protocols, says Manion.

"I find that Xers are surprisingly self-motivated and willing to tackle problems," says **Laura Weinhagen**, RN, clinical director of El Camino Surgery Center in Mountain View, CA. A manager has to set goals and be available as a resource, but Xers don't want to be micro-managed, she adds.

"I find that Xers can be overwhelmed if the problem is too large, so I break it down into smaller problems to solve as we work our way to the larger problem," adds Mamounis-Simmons.

• **Professional development.** Although Generation Xers might not take a position with a same-day surgery program with the intention of staying 10 years, they are serious about developing their skills and their careers, says Manion. "These staff members understand that jobs can be eliminated with little notice, so they want to position themselves to find the next job. If a manager does a good job offering continuing education opportunities, responsibilities that enhance the job, and recognition that the Xer is an important part of the team, the staff member is less likely to leave."

One way to give Xers a chance to gain recognition and expand their job skills is involvement in special committees or task forces. Mamounis-Simmons says, "Not only does involvement on teams give the Xer a chance to demonstrate expertise but it also gives them a chance to gain recognition."

Remember, too, that Xers are extremely comfortable with technology, adds Manion. "Xers are very sophisticated in their knowledge." They can be a valuable resource as technology experts within the surgery program, she says.

• **Personal attention.** Another characteristic of Generation X is the need for personal attention. Mentoring is an important way for managers to help Xers develop and grow as key staff members, says Manion.

SOURCES

- **Laura Weinhagen**, RN, Clinical Director, El Camino Surgery Center, 2480 Grant Road, Mountain View, CA 99040. Telephone: (650) 961-1200. Fax: (650) 960-7041. E-mail: lweinhagen @ecsc.com.
- **Diane Mamounis-Simmons**, RN, CNAA, MSN, CNOR, Administrator for Nursing Services, Northshore Long Island Jewish Health System, Long Island Jewish Medical Center, Lakeville Road, New Hyde Park, NY 11040. Telephone: (718) 470-7404. Fax: (718) 962-6945. E-mail: Mamounis-Simmons@lij.edu.
- **Jo Manion**, RN, MA, CNAA, FAAN, Senior Consultant, Manion and Associates, 5725 Oak Lake Trail, Oviedo, FL 32765. Telephone: (407) 366-6506. Fax: (407) 366-6521. E-mail: jomanion@sprintmail.com.

"Whenever I spend time with an Xer, he or she blossoms," says Mamounis-Simmons. The time can be spent talking about career plans, specific projects within the surgery program, or recognition of the job the Xer is doing.

"One of my two key supervisors is an Xer, and she brings a lot of enthusiasm and creativity to my management team," says Weinhagen. "I believe that Xers can be terrific in leadership positions because they do look for better ways to do things." ■

Patient-Focused Care and Satisfaction™ (ISSN # 1097-9530) 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 at Atlanta, GA 30304. POSTMASTER: Send address changes to **Patient-Focused Care and Satisfaction**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours: Monday-Thursday 8:30 a.m.-6:30 p.m.; Friday 8:30 a.m.-4:30 p.m., EST.

Subscription rates: U.S.A., one year (12 issues), $499; outside U.S., add $30, total prepaid in U.S. funds. One to nine additional copies, $299 per year; 10-20, $200 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 $83 each. (GST registration number R128870672.)

Editor: **Lisa Hubbell**, (425) 739-4625.
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Elizabeth Connor**, (404) 262-5457, (elizabeth.connor@medec.com).
Production Editor: **Nancy McCreary**.

Editorial Questions
For questions or comments, call **Elizabeth Connor** at (404) 262-5457.