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Part 2 of a 2-part series

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Buyers Shape Health Care Quality

Clinicians feel the pressure as absentee costs rise

Companies tighten up on sick leave, disability care

In the health care arena, where providers traditionally have called the shots, another stakeholder's voice grows louder each year. More employers are actively managing the amount of time their employees are off the job from workplace injuries or other health problems. Companies continue to track the cost of care as in the past — but with an added twist. Now they measure performance when employees return. All too often, this produces prickly relationships between corporations and clinicians.

Driving this corporate activism are the direct and indirect costs of absenteeism. They're rising on both fronts, according to the fourth annual (1999/2000) Staying@Work survey. Staying@Work is conducted by the Washington Business Group on Health (WBGH), a nonprofit organization in Washington, DC, devoted to analyzing health policy and work site issues from the large employer's perspective; and Watson Wyatt Worldwide, a financial management consulting firm based in Bethesda, MD.

The latest findings reveal (compared to the previous survey):

- **Total average costs for health and injury-related absence: 6.3% of payroll (vs. 6.1%).**
- **Indirect costs, including overtime, replacement employees, and workstation/job accommodations: 8% of payroll (vs. 6.7%).**

"In the tight staffing and full-employment climate, companies want to avoid hiring temporary workers who are apt to make mistakes. And they

Continued from cover page

Quality Talk

News Briefs

Grass Roots QI

COMING IN FUTURE ISSUES

- How well do elderly patients function after cardiac procedures?
- Integrated outcomes — the only true quality measure
- Take care of employees and patient satisfaction takes care of itself
- Observation in the ED is good medicine
- Improve outpatient surgery by fixing perioperative glitches

Buyers Shape Health Care Quality

want to avoid postponing projects until key employees are able to come back to work," says **Jennifer Christian**, MD, president and chief medical officer of Webility.md of Wayland, MA. She and other experts who spoke with *QI/TQM* see opportunities for providers to be proactive, improving their professional expertise as well as organizational processes in enabling people to get back to work. The fix will take old-fashioned communication at the local level and, perhaps, resourceful use of Internet technology. Some suggest that quality specialists within health care systems could start the initiatives.

Employers rely on the attending physician to determine how long an absence should be and to restore a worker's ability to perform the job after the recovery period.

"While employers track the numbers, they report difficulty in managing provider relationships," states **Bruce Flynn**, WBGH's disability management director. One strategy that has gained some popularity is for employers to talk with physicians about their expectations for return to work. "The other side of that is that physicians often have a more difficult time managing disability than managing the actual symptoms of illness."

A WBGH survey confirms that physicians are relatively uncomfortable with disability issues. They lack training. They feel underpaid for the extra work and contend that somebody else should be doing it. At stake for employers are the costs of care as well as wages paid to sick or injured workers and possibly to a replacement. For most hospitals, the chief concern is the cost of care, Christian explains. However, that may change as employers ask new questions about the value of care their health providers deliver. They are beginning to question whether their employees are healthy enough to be at work and do their jobs. "That's the direction the market is moving," she says.

Another facet of this attitude shift is that employers are lumping the management of all health-related time off into one function instead of separately handling workers' compensation, sick leave, and disability leave in different organizational "stove pipes." A company representative could make unprecedented inquiries about the course of treatment and the expected return-to-work date — whatever the injury or wherever it occurred. It would not matter if the injury was a concussion from a bicycling accident or a broken

wrist suffered on a loading dock.

If that's not enough, the employees stir the pot with personal agendas. Workers who suffer non-work-related injuries are motivated to return to work so they won't burn up too many sick days or push their insurance copayments too high. Those injured on the job, however, "get paid to stay at home, so we sometimes see a blunting of their incentive to comply with treatment requirements to expedite their return to work," Christian explains.

As employers become more aware of the connection between health and productivity, they want providers to join them in mitigating and preventing disability. **Liza Greenberg**, vice president of research at the American Accreditation HealthCare Commission / URAC in Washington, DC, describes an additional contributor to employer urgency to reduce lost time, especially on workers' compensation cases. "Statistics show that the longer people are out, the less likely they are to come back to work," Greenberg says. "It used to be that employers imposed a 100%-fit criteria. Could the laborer push a wheelbarrow and lift a load of cement? But now, companies use modified-duty criteria. They want workers to stay fit and keep the work mentality."

Providers, on the other hand, are trained and paid to do acute treatment. "They have no tools in their hands and receive no rewards for doing the job of helping people recover from disabilities and get back to work," Christian says. "Historically, it's been a courtesy to give a note to the employer and disability carrier on the extent of the worker's injury and the expected return-to-work date." It's a low-priority task.

Employers have big money at take regarding doctors' decisions, however. Some companies have even held training sessions for providers with the hope of achieving better compliance with paperwork completion and timely reporting. "But often physicians won't come, and the information employers get back from them is still meager, sloppy, and late," Christian adds.

What's the incentive for a clinician already working 12-hour days? "Neither employers nor insurers have traditionally paid providers for the paperwork involved in disability cases," Christian says. "But it may make more sense for an employer to pay $35 for on-time documentation because a late report would mean an employee is going to be out of work an extra five days at $100 a day. On the other hand, it's silly for physicians to expect to get an employer's business when they turn in late and incomplete reports."

The right training and incentives could quell the adversarial quality of relationships surrounding disability. "The problem is that the medical community is not perceived to be responsive to the duration of disability," says **Peter Rousmaniere**, of Rousmaniere Designs in Little Rock, AR, a consultant to insurers and employers on disability prevention and management in the work force.

But in truth, they need training on return-to-work issues, he observes. "Clinicians have the right to be compensated for the extra work involved in helping people who are disabled get back to work."

As Flynn sees it, "those efforts are probably best conducted locally rather than through any national grand plan. Where we've seen the most successful partnerships between employers and

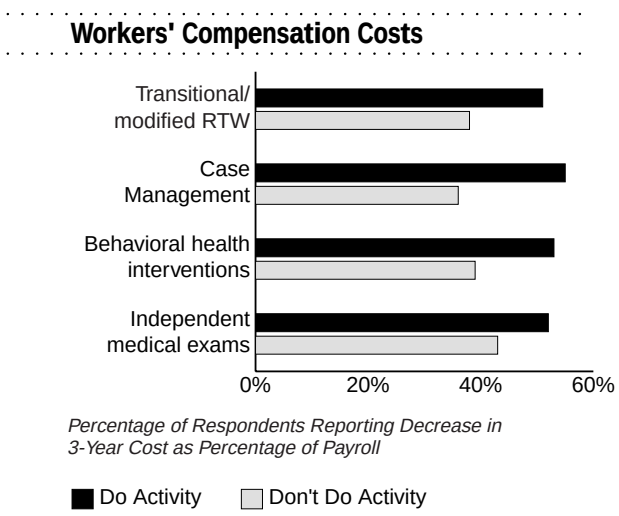
Key Points

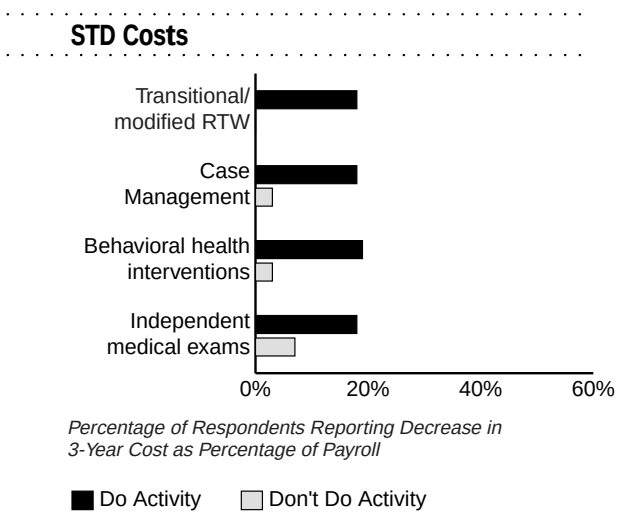
As noted last month in Part 1 of our two-part series "Corporate Buyers Shape Health Care Quality" exploring corporate influence on health care and quality measures, buyers of employee benefits often question the validity of provider-based quality and outcomes measures. This corporate activism, driven by the rising costs of absenteeism, is spreading to include the care that workers receive when they are out due to health problems.

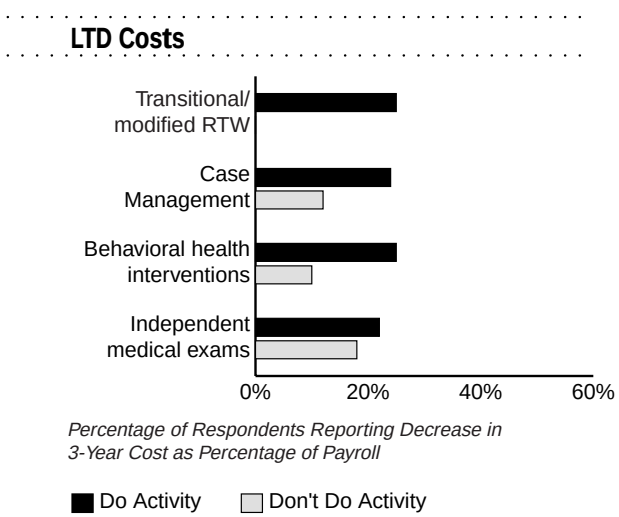
- Employers often report difficulties in building communication links with providers who take care of workers who are on sick leave or workers' compensation leave.
- Most clinicians in hospitals and outpatient settings are not trained or compensated for the extra care and paperwork required in work-related absences.
- Experts say that provider compensation for work-related absences should be redesigned to match the work involved. Similarly, providers should tune in to employers' concerns regarding the cost of hiring replacement workers and the importance of maintaining workers' fitness throughout the rehabilitation period.
- The quality specialist could be a catalyst in improving a facility's system of employment-related care.

(See "Who's measuring, and what do they measure?" p. 53, and "Employer rehabs its own workers back to health," p. 54.)

Effectiveness of Top Four Disability Management Activities in Decreasing…







Source: Washington Business Group on Health, Washington, DC; Watson Wyatt Worldwide, Bethesda, MD.

hospitals is on a regional basis where the interests are mutual. They sit down and talk about what it means to manage disability issues."

Greenberg suggests that quality or outcomes management specialists within health care systems could precipitate the kind of talks Flynn describes. She notes that much of the work will take place in the system's outpatient clinics since the vast majority of cases are treated there.

A natural contact point with self-insured employers is the company case managers who coordinate care of employees on sick leave. In many instances, they coordinate treatment of workers' compensation recipients as well.

Christian says that the tone of conversations between health care systems and corporations will be more constructive if both sides couch their discussions in terms of "Why I need this," instead of "I want this." Too often, each side is more interested in talking than in listening. When people focus on helping each other get their needs met, they have a baseline for collaboration and problem solving, she adds.

Corporate case managers will look for local providers willing to join employers in efficiently managing disability cases, Greenberg says. She has a few suggestions for how QI specialists can help their institutions become centers of excellence in restoring worker productivity:

❒ **Repair or strengthen communications.** "Quality managers could work with the appropriate staff in their institutions to contact employers, learn the criteria for a modified back-to-work schedule, and make appropriate care plans," she says.

❒ **Help providers understand that medical costs are only one piece of the employer's problem.** The other is lost wages. So even resource-intensive services from physical or occupational therapies could be cost-effective from the employer's point of view.

❒ **Look for value-added service opportunities such as assessments of workers' recovery in light of job requirements.** This might be especially attractive for employers who are not staffed to conduct assessments in-house.

Christian suggests that Internet technology could hold solutions to communication and paperwork problems. Her firm, Webility.md, is building a system to connect doctors with employers and disability / workers' compensation insurers on the

Internet to communicate about patients' ability to work. The purpose is to reduce medically unnecessary absences.

Webility will streamline communications by creating an electronic in-box that consolidates all requests for disability reports from multiple employers and insurers. It will use scripted dialogue to standardize the questions doctors are asked and to provide clinicians with an easy way to answer through multiple-choice questions and check boxes.

She explains that employers or insurers will be able to post their forms on a secure Web site along with instructions for physicians to write and file reports electronically. Employers also can post full and modified return-to-work criteria as well as the e-mail address and phone number of the company's contact person.

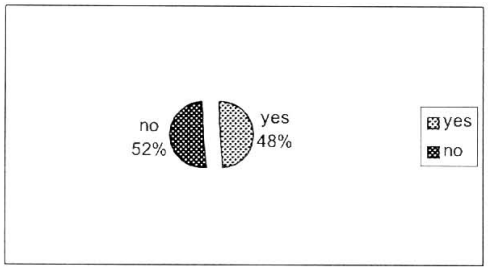
"The employer will be virtually present in the exam room, expediting the physician's reporting burden, and most physicians will love to be rid of the paperwork," Christian adds. ■

Who's measuring, and what do they measure?

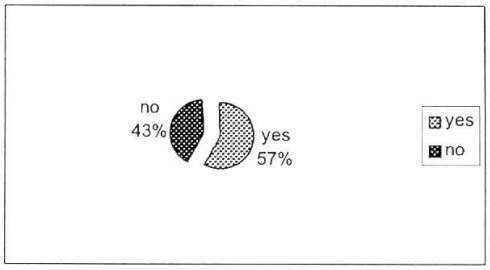
Employers used to keep tabs on the costs and outcomes of workers' compensation care for employees injured on the job. Today, however, more and more companies monitor the costs and outcomes of care for all health-related absences including long- or short-term disability and extended or chronic illness.

In the most recent Staying@Work survey, companies report nearly two dozen cost management strategies such as case management, transitional return-to-work programs, and independent medical exams. **(See "Effectiveness of Top Four Disability Management Activities," p. 52.)** The strategies work, according to survey results, which suggest that employers will use them until they find better ones. The 1999 / 2000 version is the fourth annual Staying@Work survey conducted by

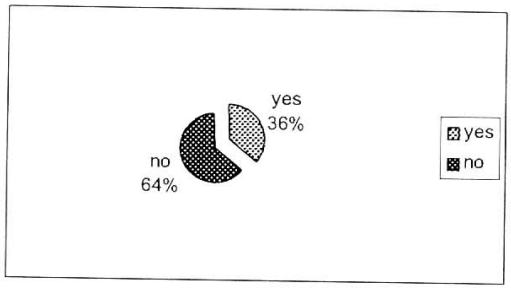
MCOs that Measure Disability-Related Performance or Outcomes



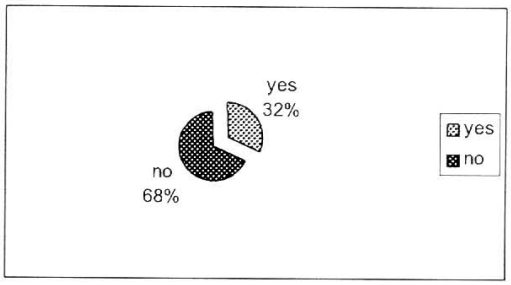
MCOs that Collect Data on Patient Satisfaction



MCOs with a Method to Monitor Patient Access to Health Care Services



MCOs that Collect Functional Status Information on Patients (SF 36 or the like)



Source: American Accreditation HealthCare Commission/URAC, Washington, DC.

the Washington Business Group on Health in Washington, DC, and Bethesda, MD-based Watson Wyatt Worldwide. **(See cover story for additional survey findings.)**

Generally, employers cover their disability and workers' compensation costs through self-insurance or through benefits packages purchased from insurance companies or managed care organizations (MCOs). Either way, the expectations for provider accountability are becoming more sophisticated.

The American Accreditation HealthCare Commission / URAC is in the process of determining which data sources MCOs should use to design standardized measures of performance. URAC, based in Washington, DC, issues various accreditation certificates nationwide, including one for workers' compensation networks.

In a survey last year, URAC found that the majority of MCOs measure quality in disability and workers' compensation care. **(For details, see box, p. 53.)** Indicators include:

- disability-related performance or outcomes;
- patient satisfaction;
- access to health care services;
- functional status information;
- appropriateness of clinical care.

Liza Greenberg, URAC's vice president of Research and Quality Initiatives, describes the findings as a snapshot of the data collection and analysis capacity among MCOs. However, standardized quality data on disability or workers' compensation care are still a goal rather than a reality. "URAC wants to persuade employers to consider providers that deliver the best results on cost as well as return-to-work results," she notes.

Instead of relying on subjective clinical judgments, employers now turn to best practice data for expected length of absence in work-related injuries, according to **Peter Rousmaniere** of Rousmaniere Designs in Little Rock, AR. He is a consultant who works with insurers and employers on disability prevention and management in the work force. He notes that discrepancies between typical and best practice return-to-work cycles leave considerable room for improvement:

- Typical cycles: 50% return to work within 30 days, 90% within 180 days.
- Best practice cycles: 85% return to work within 30 days, 98% within 180 days.

There's little doubt that employers who don't currently require providers to practice outcomes will do so in the near future. Rousmaniere explains that short, nonwork-related absences are less rigorously tracked than those for disability and work-related injuries. But given the growing concern about absenteeism in general, that could change. ■

Need More Information?

For more on employer expectations and preparing providers to better handle health care involving absence from work, contact:

- ❒ **Peter Rousmaniere**, Rousmaniere Designs, 501 N. University, Suite 206, Little Rock, AR, 72207. Telephone: (501) 666-0556.
- ❒ **Jennifer Christian**, MD, President, Chief Medical Officer, Webility.md, 95 Woodridge Road, Wayland, MA 01778. Telephone: (508) 358-5218. E-mail: jennifer.christian@webility.md. Web site: www.webility.md.
- ❒ **Bruce Flynn**, Director, Disability Management, Washington Business Group on Health, 7777 N. Capitol St., N.E., Suite 800, Washington, DC 20002. Telephone: (202) 408-9320. E-mail: flynn@wbgh.com. Web site: www.wbgh.com.
- ❒ **Liza Greenberg**, Vice President for Research, American Accreditation HealthCare Commission/URAC, 1275 K St., N.W., Suite 1100, Washington, DC 20005. Telephone: (202) 216-9010. E-mail: lgreenberg@urac.org. Web site: www.urac.org.
- ❒ **Watson Wyatt Worldwide**, Bethesda, MD. Web site: www.stayingatwork.com.

Employer rehabs its own workers back to health

Back-to-work time down 80%

When an employee of the Coors Brewing Company in Golden, CO, suffers a heart attack, he or she usually goes back to work in just over a month. While most don't return to full duty at that point, the cycle is still an 80% improvement over the pre-1982 cycle. That year, Coors created the country's only workplace early post-hospitalization (Phase 2) cardiac rehab program. One of the company's top managers, Bill Coors, established the program after an employee suffered an

anxiety attack upon returning to work following a heart attack. Rehab activities take place in the Coors Wellness Center (CWC), a 36,000 square-foot facility housing exercise equipment, workout rooms, and classroom space. A number of full-time and contract health care providers staff the center.

The success of Phase 2 rehab depends partly on the quality of communication between CWC and community health care providers who take care of employees during the acute stage of a cardiac episode. For its part, Coors has designed communication links into its program, but the staff would like to see more reciprocity from the community providers.

The handoff between the attending physician or hospital and CWC's consulting cardiologist takes place as soon as possible after a cardiac event such as angioplasty or cardiac surgery. "Our goal is to prevent further problems and help employees get back to work as quickly as possible," explains **Joan Miller**, MA, a wellness specialist. And who would quibble with this, given the Phase 2 rehab record? Current return-to-work rates average 1.4 months compared to pre-Phase 2 rates of 7.5 months. The company pays whether employees participate during sick leave or after they return to work.

To fulfill the handoff, CWC requests a referral from the attending cardiologist to the Phase 2 program. If the employee was treated in an ambulatory setting, CWC sends a letter and treadmill results to the personal physician along with a request for a referral and description of the Phase 2 rehab process.

A signed release by which the patient authorizes the community physician to send medical information to the CWC cardiologist allows further communication between the doctors. For patients who were hospitalized or treated through a hospital outpatient clinic, Miller says, "we need a communication channel with medical records departments so our staff can be informed of the prior surgery and tests the employee has received."

To lay the groundwork, the CWC staff meet each year with community cardiologists who take care of Coors employees. The point is to show physicians what Coors provides and to convey the company's expectation that employees receive their rehab care through CWC. "We explain that after they refer our employees to the Phase 2 program, our rehab physician will facilitate the return-to-work process through communication with the rehab team, employee, and employee supervisor," Miller says.

But too often, effective communication is more a wish than a reality, observes **Robert Gibson**, MD, Coors' director of occupational health services and a primary care physician. Gibson is also director of occupational health at Liberty Health Care, also in Golden, CO. "We can't achieve optimal productivity for people in their life and work unless all the providers communicate. The biggest problem with hospitals is their communication with people outside of their system. Some are very good at it, and some are very bad at it."

Gibson describes Coors' expectations as standard for any employer. "We don't want to waste time getting our people back to work. On the other hand, we monitor to be sure they're ready and that we're not pushing them too far." The employer's rehab staff and community clinicians have to talk to each other to make that happen, he notes. Spotty feedback "is like a doctor doing an MRI on a football player who injures his shoulder in the Sunday game and not reporting the results until Saturday afternoon!"

Throughout the 12-week program, participants are routinely monitored by the company's consulting cardiologist. They attend three sessions a week for 90 minutes of exercise and

Key Points

Location: Coors Brewing Company, Golden, CO

Situation: Prior to 1982, Coors employees who suffered heart attacks would miss approximately 7.5 months of work.

Solution: In 1982, the company established an on-site early post-hospitalization (Phase 2) cardiac rehab program. Coors contracts with a cardiologist to supervise a 12-week regimen of wellness activities including exercise, dietary changes, and stress management. Return-to-work cycles currently average 1.4 months. The vast majority of employees resume full duties following a modified work schedule. However, Coors staff note that one critical part of the effort could bear improvement — the handoff between community-based providers and the company's physician.

Need More Information?

For further background on employee wellness programs, contact:

- **Joan Miller**, MA, Wellness Specialist, Coors Brewing Company, P.O. Box 4030, WC707, Golden, CO 80401-0030. Telephone: (303) 277-5351. E-mail: joan.miller@coors.com.

receive one hour of stress training.

Phase 2 program components include:

1. check-in with Coors consulting cardiologist;
2. entry and exit treadmill tests, blood pressure readings, lipid levels and weight monitoring, as well as employee and family counseling by Coors' employee counselor;
3. relaxation and stress management techniques such as yoga and meditation;
4. smoking cessation techniques;
5. nutrition education;
6. fitness exercise, including aerobic conditioning and strength training for job-specific activities;
7. phased return to full duty following a jobsite analysis by the CWC rehab team.

Miller says most employees return to work within four to six weeks after the cardiac event. They often start with schedules of two to four hours a day for the first week. Most are back to full duty by the time they complete Phase 2 rehab, and 99% return to their original jobs.

Phase 3 rehab involves continued follow-up with services tailored to individual needs. Some employees work with the dietitians, and others require modified exercise prescriptions.

Generally, healthy lifestyle changes among Phase 2 and Phase 3 participants are permanent, Miller observes. Most continue to exercise at least three times a week and play volleyball with other Phase 2 participants. "They keep that group closeness," Miller says. "A cardiac event has an incredible impact on a person's perspective because it's life-threatening. People in this group do more sharing and develop a stronger support system than people in our orthopedic rehab group."

With a solid rehab record in place, Coors now addresses prevention. This month, CWC launches a cardiac risk factor screening. All employees are offered a comprehensive medical screening. Those who show a high potential for cardiac problems will be encouraged to participate in the Coors Health Intervention Program at the CWC. ■

QUALITY TALK

***Carolyn Boone Lewis**, newly elected chairman of the Chicago-based American Hospital Association (AHA), joins us to share her vision of hospitals as "prudent and ethical" institutions capable of resisting the "growth for growth's sake" mentality. Such was the challenge she issued in her acceptance speech as the first hospital trustee and African-American to be elected to AHA's highest office. She explains that even as chairman of the AHA board, her perspective is one of a community trustee.*

Her professional experience includes years of work with the U.S. Securities and Exchange Commission. She served in former President Jimmy Carter's administration and later directed a staff of analysts responsible for reviewing the emerging mutual fund industry. Lewis is currently president of the CBL Group, which serves clients in the health care and securities industries.

Lewis' long record of volunteer service includes involvement with the Joint Commission on Accreditation of Healthcare Organizations, the Health Care Financing Administration, and District of Columbia Hospital Association Board. In 1993, in recognition of her community service, then Mayor Sharon Pratt Kelly proclaimed Oct. 21 Carolyn Boone Lewis Day in the District of Columbia.

Q. From your trusteeship perspective, how do you see hospitals best dealing with the present pressure for improvement and seemingly slim chances for increased resources?

A. To be even more specific about resources, on a relative basis, they are shrinking and the needs are getting larger. I think hospitals best deal with it as a community-by-community kind of exercise, although there's a lot to learn one from the other. It starts with a hospital or group of hospitals looking to see what the need is in the community or communities they serve. It's sort of an inventory of needs and an inventory of available resources and services. Then you start to see where to place your resources.

You need to see where the gaps are, however. I think where you get into difficulty is where you don't go through that exercise. That's where you might create a lot of health care services that may

be excellent but that do not necessarily meet the community's needs.

Q. Are you implying that hospitals do better through collaboration than through competition with one another?

A. It absolutely implies collaboration. I think one of the best models is the Community Care Network Demonstration Program (CCN). It's a program funded by grants from the Kellogg Foundation and the Duke Foundation. It is administered by a collaborative group. Group members include the AHA; the Health Research and Education Trust, which is a component of AHA; Washington, DC-based Catholic Health Association; and the Irving, TX-based VHA, a nationwide network composed of physicians and community-owned health care organizations. It's an effort that looks to develop community care networks around the country. There are several demonstration projects.

It's grounded in four principles:

1. community health focus;
2. community accountability;
3. a seamless community of care;
4. management within fixed resources.

And there are some great examples in these demonstration projects of hospitals working collaboratively with other hospitals and other entities to address community health needs and to effectively spend community health resources in a way that hopefully stretches the dollars to where they are most needed.

Q. Are the collaborative networks going to be able to stay on their economic feet once the grant monies phase out?

A. The demonstration projects have been going on for some years, and part of the effort built into the program is to help the participating hospitals, the demonstration sites, transition into a self-supporting mode. It's the inventory of community services that starts to point out the gap. There's the obvious gap in the uninsured and the underinsured communities. But you may find a number of service gaps in your community, dental health services, school health programs, low immunization rates, absence or dearth of substance abuse programs. When you do the inventory, these things jump out at you. Not connecting your resources with your community's needs really sets a health care institution on the wrong path. **(For contact information on CCN, see the editor's note at the end of this column.)**

Q. What will come of institutions that don't follow the principles you describe?

A. A long time ago at a health care conference, I listened to someone say that he did his strategic planning by walking up and down the streets of his community. That was the core of this CEO's strategic planning. He made the point that if you are providing needed services, you'll always be there. If you're providing services that everybody else is providing, that represent a surplus of the high-tech services, for instance, then you're truly in competition with everybody else who's doing that. And that's a fight to the finish and everybody's not going to be left standing.

It really comes down to the fundamental notion of doing well what you do best, and what is connected to your community's needs. In my mind, that takes you right back to collaboration because there are some things you do well, and others that someone else might take the leadership with. It's a process of pulling together resources across providers and across other kinds of service components in the community to meet the total needs.

Q. Economically speaking, what's the price of such collaboration?

A. I could flip it over and look at the price of not collaborating. It makes good business sense to pool resources. It's a leveraging of resources across institutions. It's a leveraging of the political clout of many rather than a few. It represents the real value a hospital can have as a convener of the resources. A hospital can be a powerful catalyst in bringing all the resources together and shaping policy and direction through that kind of collaborative process.

Q. Are there any lessons or principles from the business community that hospitals might turn to for instruction?

A. It's important for hospitals and businesses to be talking to each other on the front end. I'm a strong proponent of having people from the business community on hospital boards. In many industries, business has stepped forward and learned lessons in its management of information technologies and public relations. Even looking at the securities industry, where I was most involved

professionally, there is the example of learning how to work with the regulator, government, in a way that's more productive, more helpful, and less contentious. Those are lessons that a lot of industries have learned faster than we have in health care.

Q. What single difference do you want hospital patients to experience by the time you finish your term of office?

A. A restoration of the trust and confidence in the hospital system would make an extraordinary difference. I'd like to see patients and communities feel a stronger participation in the process of health management — a sense of participation with the health care providers at the hospital.

Q. Is that from the boardroom or from the hospital bed?

A. I'd like to see patients become more involved in their own health management. But again, it's grounded in the whole notion of restoring the synergy and the trust between hospitals and patients, between hospitals and communities.

I would take, for example, the kinds of programs that we've had at Greater Southeast Hospital in Washington, DC, which have been very imbedded in the community. I have been on the board for many years. The hospital went through a serious, devastating financial crisis over the last couple of years. But Greater Southeast Hospital sits in a community that would be without a hospital if it closed.

That hospital was able to manage through a period of financial crisis, largely because it had always been there for the community and so the community stood up for it during these crises. Together we were able to work our way through the crises. New ownership came in to take over and put financial resources into the hospital to save it from failure.

But I think the seed and the leverage and the ability of Greater Southeast to manage itself were really planted in the community relationships that were formed over time. The hospital did not just sit there to receive patients to provide acute care. It found many ways to identify and address community needs that nobody else was heeding:

• Neighborhood blood pressure programs in partnership with churches. It trained volunteers to become certified to take blood pressure readings and sent them out to places like barber shops and beauty shops where people would congregate.

• Breast cancer advocacy centers and a breast cancer education and screening program.

• A child development center and a high school adolescent health center.

There are some very clear and dramatic changes taking place around us — the aging population, the politically driven reimbursement system, advancing technology — that are going to change the way health care is delivered.

The environment around us is bringing dramatic changes to our doorstep. The challenge for us is to get ahead of that, to understand how that influences the delivery of health care and to take the leadership in making it work for us and the people we serve. It's an exciting challenge.

We could be doing things very differently, and we must! We will be doing things very differently, because everything is being done so differently around us, with the Internet and information processing and technology and the advances in science. It sparks a lot of interest on my part in getting out ahead of it and making it work for our patients and our communities.

[Editor's note: To learn more about the CCN, contact Health Research and Education Trust, American Hospital Association, One North Franklin, Chicago, IL 60606. Telephone: (312) 422-2612. Web site: www.aha.org/hret.] ■

Patients want the truth about tough choices

A study by Press, Ganey Associates of South Bend, IN, shows that people appreciate candor from their providers about life support options and organ donation decisions. "By bringing patients into the reality of health care, we're serving and satisfying them — not intimidating them," states **Irwin Press**, PhD, president of Press, Ganey Associates.

The findings come from data compiled from

250,000 patient surveys in 476 hospitals. Questionnaires asked patients if the facility provided information on organ donation and options and choices for continuing life.

The good news, according to Press, is that discussing life and death issues does not add negative stress to a patient's life. On the contrary, he says, "it creates an environment that contributes to patient satisfaction." Such findings should reassure health care providers who hesitate to discuss bad outcomes, for fear of dashing patients' hope of leaving the hospital cured.

Such communication can get everyone on the same page about care goals. It also can strengthen trust and confidence between the patient and his or her caregivers. Press notes, "Why should we be surprised that people respond positively to being empowered?

"These results should further remind us that the care of patients involves not only dealing with their illness and their condition, but also embracing them as a person and recognizing their authority. Patients can handle the truth."

To learn more, contact Press, Ganey Inc., specialists in health care satisfaction measurement, 404 Columbia Place, South Bend, IN 46601. Telephone: (800) 232-8032 or (219) 232-3387. Web site: www.pressganey.com. ▼

Glove offers safety in surgical procedures

Over the past decade, 60,000 nurses and physicians have contracted HIV or hepatitis from needlesticks, reports **Craig Maron**, president of Gimbel Glove, based in Phoenix.

To protect health care workers from this job hazard, the company recently introduced a puncture-resistant glove. Invented by **Neal Gimbel**, MD, a Phoenix-based orthopedic surgeon, the glove retains most of the flexibility and sensitivity required for delicate surgery. The latex gloves have special pads built into the fingers and thumb. "For years doctors have been doubling up their regular gloves or wearing cut-resistant liners to help prevent punctures," he says.

"This not only reduces sensitivity, but does little to prevent needlesticks," Maron says. The patented Gimbel Glove was FDA-authorized in 1994 for marketing as "puncture-resistant." It also complies with the Occupational Safety and Health Administration's bloodborne pathogen regulations. While the cost exceeds that of standard nonprotective latex gloves, the company says it is lower than the commonly used multiuse glove liners used by many clinicians.

For information about price and product availability, contact Gimbel Glove Company, 10640 N. 28th Drive, A-200, Phoenix, AZ 85029. Telephone: (888) 667-8425. Web site: www.gimbelglove.com. ▼

AHA to address interest in alternative medicine

The Chicago-based American Hospital Association (AHA) will address the growing consumer and practitioner interest in complementary or alternative therapies. Therapies including acupuncture and herbal medicine

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Editor: **Mary Kouri**, (303) 771-8424, (marykk@abwam.com).
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@medec.com).
Managing Editor: **Russell Underwood**, (404) 262-5521, (russ.underwood@medec.com).
Production Editor: **Ann Duncan**.

Editorial Questions

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

GRASS-ROOTS QI

When a ward coordinator in the child and adolescent psychiatric division of St. Francis Hospital computerized a paper patient census sheet, she saved resources and scored big points with internal customers. **Julia Downey**, CQI team coordinator for the 292-bed facility in Columbus, GA, reports a time savings of 45 minutes a day.

✔ IMPROVEMENT OPPORTUNITY

Daily census sheets document statistics — numbers of admissions/discharges, patients' names, admitting physicians, and attendance at therapeutic activities. Some data affect charges and billing, for example, whether the admission is for a half day, a full day, or longer. In the old system, the ward coordinator provided handwritten data from staff files and made copies for the intake, utilization review, pharmacy, and dietary departments. "Often the forms were delayed in the interoffice mail system or stayed in mail boxes, delaying the timely receipt of vital information," she says.

✔ SOLUTIONS

The ward coordinator designed an electronic census sheet, or "e-sheet," for e-mail distribution and other efficiencies. A one-week pilot involved:

1. dissemination of the proposed e-sheet to the regular recipients;
2. request for suggested improvements on the form and dissemination procedure.

✔ RESULTS

- **Time savings** — more than 34 staff days per year. "This gave the ward coordinator time for other duties such as devising an electronic census sheet for the adult program," says Downey.
- **Internal customer satisfaction** — high.
- **Resource savings** — elimination of hard copy filing supplies and space because e-sheets are processed and saved on disks.
- **Spinoffs** — adoption of the process and design of e-sheets by other units in St. Francis' psychiatric division.

✔ KEYS TO SUCCESS

"By empowering employees to make individual improvements, they feel a sense of ownership in what they do. Employees at St. Francis feel encouraged to make changes using the CQI principles," Downey says.

✔ CONTACT

Julia Downey, CQI Team Coordinator, St. Francis Hospital, P.O. Box 7000, Columbus, GA 31908-7000. Telephone: (706) 660-6020. E-mail: downeyj@sfhga.com. ■

are gaining credibility, particularly among consumers.

The AHA (www.aha.org) has signed a memorandum of understanding with the University Hospital and Medical Center at Stony Brook / State University of New York to help hospitals and health care institutions learn about and develop programs to meet the interest.

An AHA survey from 1998 reports that roughly 9% of the nation's hospitals offered complementary medicine. Larger institutions are more likely to offer the option than smaller ones. "I believe as we enter the new millennium, we will see a dramatic move toward complementary medicine because patients are asking for it," notes **Jonathan T. Lord**, MD, AHA's chief operating officer and quality expert.

Stony Brook is the home of the University Center for Complementary and Alternative Medicine. The goal of the joint venture is to develop services to enable hospitals to engage in responsible complementary or alternative medical services. That includes methods of quality assurance and record keeping, reimbursement issues, and professional education offerings. ■