

# Hospitals with TQM Offer Good Value to Payers

**I**n their efforts to attract payers, hospitals that have adopted total quality management (TQM) systems may have a distinct advantage over their competitors. Hospitals with TQM have evaluated and improved their processes to maximize quality and cost efficiency—important issues to payers in search of good value.

But hospitals must do more than say they can provide good value for the money. They must have the data to back up such claims. TQM experts at a March meeting of the American College of Healthcare Executives (ACHE) described how hospitals can prove the value of their services and secure the commitment of physicians and staff to TQM.

## MARKETING TQM

Hospitals and physicians should emphasize the value of TQM when they market themselves to major employers in their areas, suggested William C. Mohlenbrock, MD, a practicing orthopedic surgeon and medical director of San Mateo, CA-based Iameter, Inc. "Your hospital must differentiate itself as the value provider for certain services," he said.

**Attracting Payers** To attract payers, Mohlenbrock advised hospitals to do the following:

- Give the physicians quality and cost data so that they can see where improvements in clinical processes are needed.
- Begin marketing processes or services that are already efficient.
- Look at competitors' efficiency and ask, Can we do better?
- Establish ongoing monitoring. Physicians and hospitals need to know whether the changes they have implemented make a difference. One way to keep physicians up-to-date is by giving them monthly quality and cost data to be discussed in quality teams at short (15-minute) monthly meetings.

**Providing Data on Value** A good value means "predictable outcomes at predictable prices," said



*Hospitals can do clinical benchmarking to determine "what procedures the best-of-the-best are following and how their own facility can follow them," said Borden.*

Mohlenbrock. "Payers simply want to know what their healthcare dollars are buying."

Large employers and payers therefore seek three types of data, said Stephen L. Ummel, president and chief executive officer (CEO), Lutheran General Health Care System, Park Ridge, IL. They want patient satisfaction data, prices, and clinical outcome data on patient morbidity and mortality, he noted.

Hospitals usually collect data on observed versus expected mortality rates because they want to know where they stand compared with other facilities, said Spencer Borden IV, MD, medical director of Westborough, MA-based MediQual Systems. Hospitals must look at key clinical factors (KCFs) associated with death, he suggested. For example, conditions such as low systolic blood pressure, high blood urea levels, and lethargy are KCFs associated with death for persons who have pneumonia. Patients who exhibit few KCFs associated with death have lower mortality rates than those who have many. Obviously, hospitals would not give these patients the same treatment. Hospitals therefore can do clinical benchmarking to determine "what procedures the best-of-the-best are following and how their own facility can also follow them," said Borden.

Borden defined benchmarks as "performance measurement standards derived from definition or quantification of best practices." He said hospitals should analyze benchmark data each year because:

- Breakthroughs in quality and cost are required *now*.
- Comparing against best industry practices creates commitment to change.
- Hard clinical data are required for rigorous statistical and clinical analyses of variations in hospital outcomes.
- Hospitals with benchmark results have consistent processes that others can learn from.
- Benchmarking ensures a return on the organization's investment in quality improvement.

**Using the Acuity Index Method** Mohlenbrock

described a quality- and cost-analysis system based on information physicians have already gathered about their patients. By considering such factors as age, sex, and diagnosis, the system can calculate how sick the patient is and compare

patients' lengths of stay, charges, and mortality rates in one hospital's department or in different hospitals.

Mohlenbrock's system, the Acuity Index Method, establishes a five-point scale, assigning

## APPLYING TQM IN THE NURSING DEPARTMENT

As the U.S. health-care delivery system works to save costs, nurses' roles may focus more on pre-admission and post-discharge duties, said George Whetsell, principal and national director of health care operations improvement, KPMG Peat Marwick, Pittsburgh.



Whetsell

### A GOOD PLACE TO BEGIN

Whetsell explained that the nursing department is a good place to begin implementing TQM for many reasons:

- The nursing department is the hospital's largest department in terms of labor and total costs.
- Almost every process begins with nursing, passes through nursing, or ends with nursing.
- Nurses do not always see how their duties fit into the overall process, which can lead to duplications of services and delays. Nurses have a functional perspective but need to develop a process perspective.
- Inefficiencies in nursing may have a negative effect on things such as length of stay, quality of care, and receivables.

### USING BENCHMARK DATA

The hospital can look at benchmark data on current nursing task allocation and cost. Whetsell pointed out that Peat Marwick has information (activity, annual hours, full-time equivalents, and annual cost) on 900 nursing activities. A hospital should track its own data and see how they compare with others', he recommended. A hospital may find it is not offering some nursing services

that other facilities offer. Depending on its philosophy of care, the hospital may not need to offer those activities or it may decide to drop some unnecessary activities.

After asking who needs to perform a particular task, many hospitals find that they need fewer registered nurses, noted Whetsell. Once the hospital knows how its nurses spend their time, it can reallocate nurse assistants or clerical staff to perform tasks formerly done by registered nurses. In turn, the registered nurses can concentrate more on the care giving for which they were trained.

### DETERMINING WHICH PROCESSES TO CHANGE

When first trying to implement TQM, nursing departments should choose processes that will cause positive changes quickly, Whetsell advised. This may spur nurses to take on processes that are more unpleasant or difficult to change.

Although changing interdepartmental processes is more challenging than changing intradepartmental ones, the returns are bigger on the former, noted Gail A. Currie, director of quality strategies, Opinion Research Corporation, Princeton, NJ. To study an interdepartmental process, a nurse quality group must first specify where it will begin and end its study, said Currie. For example, the quality team must decide at what point they will begin tracking a medication-ordering process (e.g., when the physician writes the prescription) and

when they will stop tracking it (e.g., when the patient receives the medication).

The quality team should do a flow chart to determine step-by-step how the process is completed, recommended Currie. When branches on the flow chart go haywire, this is a strong indication that the process needs to be changed, she explained.

### STANDARDIZING CLINICAL PROCESSES

Medical staffs have established standard treatment plans for certain procedures like a routine birth. Nurses can help standardize clinical processes as well, according to Whetsell. For example, he suggested that nurse clinical specialists could initiate the patient discharge process, and the physician could then follow through. This procedure could be more cost-effective than having the patient wait for the physician to initiate discharge.

Whetsell explained that many facilities are grouping services into preadmission and postdischarge activities. For example, nurse clinicians may visit orthopedists' offices to educate patients on what to expect after knee replacement surgery. This education usually cuts the patients' length of stay by one day.

Physicians and nurses need to work together, concluded Whetsell, always asking:

- What are we doing?
- Are we duplicating services?
- Are we delivering unnecessary services?
- Who is doing what?

By keeping these quality questions in mind, nurses and physicians can help the hospital reach total quality.



Currie

level 1 acuity to patients who are mildly ill and level 5 to severely ill patients. It also subdivides the diagnosis-related groups (DRGs) into five acuity indexes. To test the system's validity, the physician must know mortality rates because the patients rated 5 should have a higher death rate than the patients rated 1. As patients get sicker, length of stay, charges, and mortality rise.

Hospitals and physicians may find the data useful if, for example, a payer criticizes the hospital for losing 118 cardiac patients last year, Mohlenbrock said. The hospital, using its own data, could confirm this but point out that because most of its cardiac patients were at acuity level 5, it should have lost 120. Two that should have died lived.

### GETTING PHYSICIANS TO BUY IN TO TQM

Physicians need and want data, such as the diagnoses and ages of the most ill patients, according to Mohlenbrock. For example, some states publish data on how much certain treatments cost in all hospitals in the state, Mohlenbrock said. He noted that unsophisticated payers will look at the data and say, "It's cheaper to treat patients in hospital X; we'll send them there." But often those payers will not know whether those hospitals treat high-risk patients. Hospitals need to provide physicians with more sophisticated information than what the payers have because payer data are all based on DRGs.

**Modifying Behavior by Department** How can a hospital get physician X to look at her own data so that she modifies her behavior to reduce the variation between her clinical outcomes and those of physician Y? asked Mohlenbrock. When asking physicians to examine their data on length of stay and charges and assess their quality of care and the economic ramifications of such care, hospital administrators must approach them in a non-threatening manner, said Mohlenbrock. Administrators must tell physicians that they are trying to find out how the hospital and the physicians can work together to improve quality and increase cost efficiency, he advised.

Mohlenbrock recommended that hospitals focus on the process, such as knee replacement, rather than the individual physician. For example, administrators might present information to all the physicians in the orthopedics department on all the different services performed in the department. The physicians can then compare their department's data with those of other hospitals in the state that provide the same services to patients with similar severity ratings. "The hospi-



*Mohlenbrock recommended that, in attempting to get physicians to modify behavior, hospitals should focus on the process rather than the individual physician.*

tals and physicians who do this are going to win big because the payers are dying to know who the high-quality, cost-effective providers are," said Mohlenbrock.

**Maintaining Anonymity** Mohlenbrock warned that, in offering these data, hospital administrators should never use physician names or numbers. "There is absolutely no reason to get into a fight with physicians," he explained. "This is a TQM and cost-efficiency improvement process." Each physician should receive a printout of where he or she stands in comparison to other physicians in the department in terms of quality and cost efficiency, said Mohlenbrock.

**Emphasizing Shared Interests** Mohlenbrock added that hospital administrators should emphasize that it is imperative for physicians and the hospital to be familiar with their individual performance, the performance of the group (or department), and the hospital's performance. In addition, he said that hospital administrators must tell physicians that if they do not modify their behavior, the hospital will be in financial trouble, and the physicians will not be marketable.

### CEO AND STAFF SUPPORT

Making payers see that a hospital offers good value will not be possible unless the facility's physicians and staff are committed to total quality. To offer high-quality, cost-efficient services, hospitals must adopt TQM systems, emphasized the experts at the ACHE meeting. Implementing a TQM system is a challenge for even the most sound organizations, but without the support of the CEO, the hospital will not achieve it, said Borden.

Even if the CEO is committed to TQM, employee support is essential for success, added Ummel. He suggested that hospital managers gradually build up employee support for TQM.

**Key Factors for Successful Change** Launching a TQM system will mean major changes for physicians and hospital staff. According to Borden, for the switch to TQM to succeed, hospital administrators, physicians, and staff must:

- Believe in the need for change
- Determine what they want to change
- Envision what they want the hospital to look like after the change

**Ways to Approach Change** Gail A. Currie, director of quality strategies, Opinion Research Corporation, Princeton, NJ, offered three approaches to change: innovation without continuous quality improvement (CQI), CQI without innovation,

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## VOLUNTEERS

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be a problem, especially for the poor. Parish nurse programs in these communities could facilitate access to needed healthcare services.

### PROGRAM BENEFITS

Although it is too soon to evaluate program outcomes, anecdotal data indicate increased awareness of and interest in healthcare at the congregational level. Evaluation of the hospital's total outreach program is planned for 1992.

Throughout the history of Christianity, nurses have served the Church in various capacities—deaconesses, nursing sisters, and church nurses. Nurses who served in and through the Church have always brought a special sense of caring to the faith community. Today's parish nurse is no different in this respect. Because of their stability, congregations are becoming like extended families to which individuals and families turn in time of crisis and need. In this setting, the parish nurse helps families deal with their hurts and stress through presence, prayer, and counsel. The parish nurse brings understanding, caring, and support to individuals and families through personal sensitivity and skill in dealing with life problems.

As Catholic hospitals scrutinize their future roles in the Church's healing ministry, new models and partnerships are emerging. SEHMC believes that the parish nurse's role and health ministry in a congregational setting offer great potential for renewal of the holistic concepts of health, wellness, healing, and salvation. □

### NOTES

1. *Catholic Health Ministry: A New Vision for a New Century*, Commission on Catholic Health Care Ministry, Farmington Hills, MI, 1988, pp. 7, 11.
2. P. A. Solari-Twadell, A. M. Djupe, and M. A. McDermott, eds., *Parish Nursing: The Developing Practice*, National Parish Nurse Resource Center, Park Ridge, IL, 1990.
3. Solari-Twadell et al.

## ANALYSIS

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and TQM—the marriage of the big-bang breakthrough and CQI. TQM provides the best return on investment in terms of process improvement over time.

To achieve TQM, hospitals must learn to identify both the breakthrough opportunities and the incremental opportunities, said Currie. Hospitals need to create management systems that allow for major innovations while facilitating continuous fine-tuning, she added.

**Long-Term Commitment to TQM** What happens if a CEO committed to TQM unexpectedly leaves the organization after it has spent a lot of money and time establishing this innovative management system? To prevent a new CEO or the board of directors from discontinuing TQM, Ummel suggested the following precautions:

- Get total employee commitment.
- Get the chief of the medical staff to buy in to TQM and exploit that as a power center.
- Make the board believe TQM was their idea.
- Make TQM part of the mission statement.
- Add to the CEO's contract that he or she must continue an effective TQM program.
- Ask the board of directors to approve a covenant statement, adopting TQM as a board policy (e.g., "All senior executives must have TQM experience as a prerequisite to hiring").

### A WAY TO SURVIVE

Hospitals that have adopted TQM systems have evaluated and improved their processes to maximize quality and cost efficiency. They offer something payers seek—"predictable outcomes at predictable prices," said Mohlenbrock. He concluded, "Those hospitals and physicians willing to work together to implement TQM will survive." —Michelle Hey

## FINANCIAL MANAGEMENT

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## The payment changes present significant challenges.

of these constituencies must come to understand that normal economic relationships have been altered by these payment and tax changes. New relationships must be developed. Hospitals must help physicians understand that attempts to remove hospital services and the resultant revenues by transferring them to their own income stream may be positive in the short run, but in the long term will weaken the hospitals' financial and service position and eventually harm the physicians' ability to serve patients in most settings.

The outpatient bundling regulations may prove to be a point of intersection where all parties can evaluate ways a patient receives services. If discussions and educational opportunities are held without preconceived notions of what is the "right" approach, all may be able to see these services through the eyes of the patient who receives them. Then the contracts developed may represent the best possible way to meet patients' needs, rather than simply addressing disjointed economic objectives.

### SIGNIFICANT CHALLENGES

The payment changes for both physicians and hospital-based outpatient services present significant challenges. The Catholic provider community should strive to use them as a vehicle for improving the way it meets people's needs, rather than a time to introduce further fragmentation of services in an already fragile delivery system. □