

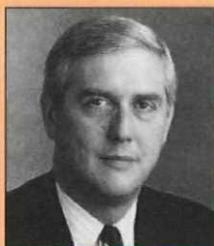
Patient-focused Delivery Promises to Reshape Hospitals

A revolutionary way of providing hospital care promises to improve quality and control costs. The concept, known as "patient-focused delivery," is a decentralized approach that significantly changes the structure of hospital operations and jobs.

Patient-focused delivery is being explored as a way to effectively respond to the dissatisfaction of legislators, business leaders, and patients with the continually rising costs of inpatient and outpatient care and the deteriorating quality of service. The concept complements plans—such as the Catholic Health Association's—for restructuring the nation's healthcare system. Like CHA's plan, patient-focused delivery makes patients' needs the driving force in the design of delivery methods. Reforming care delivery requires a sea change in traditional systems, said speakers at a February conference sponsored by the Healthcare Forum, Abbott Laboratories, and Hill-Rom. They shared their experiences with patient-focused models and their reasons for undertaking a difficult but rewarding process.

WHY PATIENT-FOCUSED DELIVERY?

Why should providers be concerned about changing their delivery methods when clinical care continues to be good? One reason is costs. Government sources are predicting healthcare spending will rise 12 percent to 13 percent annually for the next five years. Another problem is service. "By most measures the customer service we provide is lousy," declared J. Philip Lathrop, vice president, Booz, Allen & Hamilton (BAH), Chicago. During a typical three- to four-day inpatient stay in a typical large hospital, a patient interacts with 50 to 60 employees, he said. "An outpatient typically spends a half day obtaining an x-ray or lab test." Care givers are as frustrated as patients, Lathrop said. On average, a nurse spends about two hours a day documenting work. Lathrop estimated that an hour or more of this time could be reclaimed for direct patient care.



"We won't fix things by working harder or faster," said J. Philip Lathrop.

WORKING HARDER NOT THE ANSWER

Lathrop reported that six major hospitals, with assistance from BAH, have one or more pilot restructuring projects under way. Eight other hospital pilots are at various stages of planning and design. Most hospitals elect to pilot one restructured unit to demonstrate credibility before undertaking patient-focused care throughout the hospital.

The projects have been based on the concept that operational improvement must focus on structural change, he said. Lathrop pointed out that most cost-containment efforts have concentrated on improving productivity—how well a job is done—with limited success. "We won't fix things by working faster or harder," he maintained. "How fast the pharmacist fills the prescription isn't the issue. It's the number of staff and the organization of the pharmacy."

Hospitals are labor intensive, not capital intensive as many think, Lathrop pointed out. Hospitals must find ways to control staffing costs if they are to reduce expenses. For example, at a client hospital of BAH, 53 percent of costs are for salaries, wages, and benefits.

FRAGMENTED SERVICE

Generally, hospitals are highly compartmentalized, with centralized support services such as transportation and phlebotomy serving small, specialized patient units. A goal of patient-focused restructuring is to reduce time spent on scheduling, documentation, and duplication of services, ultimately generating savings.

Hospitals have many positions with only one incumbent, Lathrop said. He noted that the average 500-bed hospital has 350 job classifications, 275 of which have fewer than 10 employees. This specialization leads to fragmented, costly service, he explained, describing the process for obtaining an electrocardiogram (EKG) for "Mrs. Jones": The physician tells the nurse that Mrs. Jones needs an EKG; the nurse tells the ward secretary, who calls the EKG department. The clerk there

notifies the transportation department. The transporter calls the unit clerk to see if Mrs. Jones is there and then takes her to the EKG technician. By this time five or six employees have been involved, but essentially nothing has happened that serves the patient.

Hospital jobs, he continued, have lots of "structural idle time" when employees have nothing to do. In summary, for every \$1 spent on direct patient care, \$3 to \$4 are spent waiting for care to happen, arranging to do it, and documenting it, according to Lathrop.

In his view the "one-size-fits-all approach" for the organization of departments in traditional hospitals fails to take advantage of potential operating efficiencies that can result from concentrating on similarities of groups of patients. For example, medical patients usually have longer stays than general surgery patients, their visits are generally unscheduled, their care is less predictable, and they use more ancillary services.

In the "vision" guiding the pilot projects, resources are concentrated in operating units that are organized around patients with similar needs. Only 15 percent to 20 percent of services are centralized—those requiring expensive equipment or highly skilled personnel, those exhibiting economies of scale, or those related to the whole facility. All other services are provided on the units. These include:

- Nursing care
- Operating and recovery rooms and personnel
- Routine ancillary procedures
- Patient-support functions
- Patient-related clerical and administrative activities such as admissions

Lathrop said one hospital has organized into the following five operating units:

- *General surgery and specialty services.* This unit has highly schedulable patients, many outpatients, short inpatient stays, and less night and weekend personnel demand.

- *Orthopedic and neurologic care.* Patients require physical assistance, have relatively lengthy stays, and have predictable clinical requirements.

- *Cardiovascular center.* A full range of services is needed around the clock, seven days a week in this unit. Patients have high acuity, and work loads are unpredictable.

- *Family care services.* Patients generally have low acuity, and most are ambulatory.

- *Oncology and diagnostic medicine.* Medical

Each hospital has to determine its own operating units based on similarities in patient care.

diagnostic services are available on this unit, which serves many elderly patients with diminished physical abilities. Care is generally unpredictable, and stays are longer.

Lathrop stressed that each hospital has to determine its own units based on similarities in patient care (schedulability, predictability, length of stay, ancillary service needs, etc.).

ANCILLARY SERVICE REDEPLOYMENT

A key factor in setting up the units is redeployment of ancillary services. The goal, Lathrop noted, is to meet most patients' needs for laboratory, x-ray, pharmacy, and respiratory services within the unit. He suggested that many physical changes to the facility can be made fairly easily—taking one patient room for an x-ray machine, for example. Administrative and support services such as admitting, housekeeping, and coding are also contained in the unit.

CROSS-TRAINING PERSONNEL

Another major implication of moving these functions to the units is that many employees must be cross-trained to do multiple tasks, Lathrop said. Cross-training is straightforward with unlicensed jobs (e.g., admitting, housekeeping, transportation, inventory, distribution) and with midlevel unregulated jobs (e.g. phlebotomy, EKG technician, basic respiratory and physical therapy). But regulations and licensing requirements, which vary from state to state, affect cross-training and work arrangements in areas such as radiology and pharmacy. "The issue," Lathrop emphasized, "is finding a full day's work for people—not doing away with specialties."

Cross-training raises many questions and concerns, but Lathrop reminded providers that it is necessary to carry out a vision of coordinated care given by a person who can provide a range of services and address patients' needs quickly.

In a restructured unit at one client hospital, about three-fourths of the staff are in "care pairs" (generally, a registered nurse plus another care giver). They are responsible for all aspects of a patient's care, ensuring continuity. All unit staff working together can anticipate work loads and plan their work accordingly. Exception charting, in which only exceptions to standard care protocols are charted, is used to streamline work.

When persons providing ancillary services are based on units, reporting arrangements change.

For example, a pharmacy employee would report to the head of the unit rather than the pharmacy director, Lathrop noted.

Lathrop said no pilot projects have yet been tried in a union environment. In conversations with labor representatives, however, Lathrop has detected more fear about management not being willing to empower employees to work in new ways, rather than about jobs being eliminated. He said that unions may find the opportunities for job mobility appealing.

Patient-focused care affects all levels of hospital employees, Lathrop stressed. "Executives of the future will run units rather than collections of departments," he said. "They will get into operations and be more active managers."

HOW TO COMMUNICATE THE CONCEPT

The sweeping changes of patient-focused care can be highly threatening to staff. How managers communicate with employees can affect the success of restructuring plans. Employees' work values influence how they adapt to new situations and the satisfaction they derive from various work arrangements.

Jim Velghe, president, Management Science Associates, Inc., Independence, MO, said knowing employees' work values, or orientations, can help planners of patient-focused care to communicate the concept, address employees' concerns, and help them see the benefits of the new arrangement. Planners can also identify employees who will be most likely to support the new work environment, Velghe said. His company has identified the following six basic work orientations.

Task In an average hospital, about 17 percent of nonsupervisory personnel are task oriented, Velghe said. They prefer routine, secure jobs where they can follow orders and take on few responsibilities. They want to be treated fairly and prefer a boss who is directive and works closely with staff. They are not "initiators," and they feel threatened by change. Verbal communications are effective with task-oriented employees, according to Velghe. Communications should come through the boss and acknowledge these employees' needs for stability and security.

Self About 9 percent of nonmanagement employees are self-oriented. These "rugged individualists" do best in jobs where they work alone. Velghe said this group is likely to be the most dis-



Jim Velghe said

knowing employees' work values can help planners communicate the concept of patient-focused care.

satisfied with the boss, the work, and the organization. Self-oriented individuals may engage in disruptive behavior, including chronic complaining. They are creative and will break tradition. They respond best to a tough, autocratic boss.

Velghe recommended one-on-one communications with self-oriented persons and firm explanations of the consequences of noncompliance with policies.

Structure Many employees—about 22 percent in nonsupervisory positions—are structure oriented. They have the "classic work ethic," Velghe said, and value a secure job that rewards loyalty, hard work, and honesty. They like an environment in which their boss is decisive, fair, and consistent in applying policies and rules. They think pay and benefits should be related to seniority and longevity, and they prefer clear, written job descriptions and personnel policy manuals. This group has the least turnover and absenteeism.

To sell the concept of changing job responsibilities to structure-oriented workers, Velghe said communications should reassure them that they will have time to learn jobs they are not trained for and that compensation systems will in some way reward seniority. Written communications are essential.

Success Many top managers and about 14 percent of nonmanagers fit into the success-oriented category, Velghe noted. These employees are goal oriented and motivated by a system that rewards achievements with dollars, including bonuses. They like jobs that offer variety and the opportunity to "wheel and deal." Believing they are responsible for their own success, these individuals want to be able to control their career paths.

To appeal to success-oriented people, Velghe said it is important to communicate the big picture so that they can see how they can maneuver within the new structure. Compensation systems that include bonuses and incentives are also important, Velghe said.

People Workers who are people oriented are more concerned with getting along with others than with getting ahead, according to Velghe. He said that about 18 percent of nonmanagers and as many as 50 percent of staff nurses are people oriented. They prefer a work environment that encourages cooperation with others and group decision making. Helping other people and working with a boss who encourages team participa-

HOW IT WORKS: CASE STUDIES OF PATIENT-FOCUSED RESTRUCTURING

SAINT VINCENT HOSPITAL AND HEALTH CARE CENTER, INDIANAPOLIS

Seton Surgical Unit, Saint Vincent's first pilot project, opened in January 1990, with 44 beds and 195 surgeons. A second pilot, 4 East Medicine, opened in April 1991, with 34 beds and 111 surgeons. The physical changes to the units included decentralized nursing stations, bedside terminals, laboratory and radiology facilities, and satellite pharmacies.

In communicating the vision for the project, Bain J. Farris, president and CEO, stressed the importance of following the principles of this new approach to care. "Efficiency and effectiveness, simplicity, and creating an environment for change must be considered at every level of the organization." He went on to say, "Silence is not golden." Experience with the pilots taught Saint Vincent the importance of communicating the "Care 2001" vision to staff. He cautioned against assuming that staff will be committed or that empowerment can be legislated.

Patient surveys indicate satisfaction with care; physician satisfaction has been mixed. Farris said surgeons were the most positive, probably because the hospital involved them more than it did the physicians in the medicine unit. Staff satisfaction is demonstrated by lower turnover in the unit than in the hospital as a whole. Hours of daily bedside care have increased from 6.2 to 8.2 per patient. Care team members indicate satisfaction with the continuity of patient care, decreased delays, and coordination of patient placement made possible by their knowing the patient mix, not just numbers of patients.

Staff training is among Saint Vincent's continuing concerns, although issues of professional standards and regulations have not been as difficult

as anticipated. Farris is convinced that cost savings are significant enough to warrant redirecting the whole hospital to patient-focused delivery.

NEW ENGLAND MEDICAL CENTER, BOSTON

In choosing units to participate in its three-year Care Redesign Project, the 492-bed teaching facility sought clinical areas in which patients needed treatment over a long period and staff were experienced in working as a team. The medical center's guiding principle was that care should be integrated across an episode of illness and maximize support and continuity for the patient and family, explained Deborah Szmuszkovicz, senior project director. Three units are participating in the project: pediatric hematology/oncology, cardiac care, and adult hematology/oncology.

Based on findings that typical patients in the adult hematology/oncology unit interacted with many different physicians, nurses, and other providers during lengthy treatment, the unit's key priorities included coordination between inpatient, outpatient, and home care, said Patricia Swanson, RN, the unit's assistant nurse manager. A new information system will allow providers in physician offices, the outpatient clinic, the home care department, and inpatient units to access patients' records throughout an episode of illness, she said.

To reduce variation in care, unit staff prepared teaching guides for inpatient, outpatient, and home care and standardized instructions for families and patients, Swanson noted. Working with a home care agency, the staff prepared standardized order forms and reporting regimens.

PRESBYTERIAN HOSPITAL OF DALLAS

The oncology and medical units pioneered patient-focused care at 938-bed

Presbyterian Hospital. Executive Director William Haire explained that although the hospital was financially successful, he knew that high-quality care was essential for continued success. Convinced that the patient-focused model would improve patient outcomes and patients' and physicians' perceptions of service, reduce operating costs, and use professionals' time more effectively, the hospital launched pilot projects about 18 months ago, he said.

During that time the hospital has confronted personnel problems caused by restructuring work roles, including designing a new compensation system, clarifying managerial roles, determining the role of nurses on the multidisciplinary team, involving the medical staff in coordinated care, and developing a model for education and professional development.

Haire said the patient-focused model also raised operational issues, including the need for coordinated information systems and quality-monitoring tools.

Haire advised managers contemplating patient-focused efforts to ask themselves the following questions:

- Do you have the right management team?
- Have you clearly defined expectations? (The hospital's vision and mission "saved" it as it struggled with restructuring, Haire said.)
- Will you allow employee involvement, feedback, decision making, mistakes, fun, and recognition of both successes and failures?

Haire said Presbyterian's accomplishments at this stage include strategic plans for medical information and the medical staff, a compensation program based on performance and skills, and a clearly defined employee education program.

tion is important to people-oriented employees.

Velghe advised communicating to these employees in small groups and discussing employee retraining or displacement so "there are no surprises" in how personnel concerns are handled. Communications should stress how the patient-focused approach enhances the quality of care and patient satisfaction. Velghe cautioned that the challenge for management is not to allow consensual decision making to block implementation.

Reality Like self- and success-oriented workers, reality-oriented employees are inner directed. Constituting about 20 percent of nonsupervisors, they value freedom and autonomy, but they are not disruptive. These "existentialists" try to understand the purpose of life and want a job that gives them responsibilities important to *them and to society*. They are able to see the big picture and solve problems creatively. Money is important to them for security and because it can buy freedom to do what they want. Reality-oriented workers, Velghe said, prefer a boss who provides needed information and then lets them do their job in their own way.

The best approach with these employees is to fully inform them and involve them in problem solving, Velghe said. He advised including as many "existentialists" as possible in pilot projects because they adapt well to multiskilled positions that provide autonomy and choice.

ORGANIZATIONAL "BUY-IN"

"You need to make sure you're ready to respond to the audience in the way they should be responded to," Lathrop said, advising careful preparation for introducing restructuring plans. "In many cases," he warned, "when you can't answer the questions they ask, they're either going to think you're lying or you're stupid."

Lathrop said managers must know the organization's culture—"its appetite for change and its preferred mechanisms for change." These will not be uniform across the organization because individuals' fundamental values are involved. Lathrop stressed that initiating patient-focused care is a three- to five-year undertaking, and the process is not completed even then. The organization will continuously strive for improvement, often through CQI (continuous quality improvement) processes that help to show "what needs to be fixed." Therefore the hospital must build credibility with employees over time. Staff members,

In the long term, hospitals will need to address patient groupings—"business lines"—by changing management structures.

many of whom may have witnessed unsuccessful attempts to change work patterns over the years, will be skeptical. Lathrop said they will not be persuaded by managers telling them "how wonderful it's all going to be after it happens. When they start to hear it from their compatriots, that's when it means something."

Top managers must make patient-focused care a high priority and provide constant reinforcement, Lathrop said. "We find that 60 percent to 70 percent of all job classifications will change in a significant way, and 60 percent to 80 percent of all jobs will then have different reporting relationships. That's scary."

Lathrop warned participants that they cannot blindly follow what others have done. He told them to get facts about their own patient populations ("how they present, what time of day they expect services"), staff, and facilities and "follow the facts where they lead you. Don't try to fight the revolution with someone else's bullets. Find your own truths."

LONG-TERM STRATEGIC GOALS

It is essential for managers to understand the cardinal values they want the process to support. Possible values, Lathrop suggested, could be continuity of care, customer service, increased market share in a specific area, staff retention and empowerment, cost reduction, or a combination of these. "Knowing this, combined with cultural issues, will help you guide the implementation path," he said.

Most important, according to Lathrop, is to know how the restructuring fits into a long-term strategic plan. If managers fail to think about how the business will run once it is restructured, the effort "will degenerate into a project on 3-West," he warned. For example, he said patient-focused delivery can be a "sustainable reason" for physicians to admit patients to the hospital—more important over the long haul than a parking place or a pleasant doctors' lounge.

In the long term, hospitals will need to address patient groupings—"business lines"—by changing management structures. Lathrop predicted that "restructuring means putting in a line structure that makes management accountable for specific groups of patients and gives them the structures to be held accountable through direct line relationships. That's the dominant management approach we see emerging." —Judy Cassidy