Proactive Healthcare Organizations Strengthen Key Relationships

Healthcare organizations today face the challenge of watching reform occur or of influencing inevitable change. Many providers have already become facilitators of reform by enhancing their organizations' key relationships—with patients, physicians, and the community.

Healthcare professionals recently gathered in Chicago at a conference of the Academy for Health Services Marketing to discuss their organizations' efforts to reform the U.S. healthcare delivery system.

One healthcare organization has transformed its relationship with its patients through patient-focused care; another is working more closely with its physicians to involve them in administrative issues.

Patient-focused Hospitals

Healthcare providers are accustomed to doing things their way—designing equipment and implementing procedures to meet their own needs. Many say they know what is best for patients, but only the provider finds it convenient to admit patients at 5 AM or shuffle them from place to place for various laboratory tests.

Two hospitals in the Norfolk, VA–based Sentara Health System are changing this. They believe patient-focused care is the key to healthcare delivery reform.

Sentara Norfolk General and Sentara Leigh (also in Norfolk) hospitals are part of this multi-institutional healthcare system, which sustains nursing homes, health maintenance organizations, ambulatory care, urgent care, and other health and wellness services in Virginia's Hampton Roads region.

In focusing on the patient, the system had to make changes. "We had to rededicate ourselves to continuous quality improvement [CQI] and what it meant in our organization," said Karen Corrigan, who is Sentara Health System's director of system development. "The patient-focused hospital is just one aspect of our CQI basket, but a very important aspect."

"The patient-focused hospital is a philosophical and cultural change—a different way of doing things," Corrigan explained.

Sentara Health System committed itself to patient-focused care after banding together with four other healthcare organizations and Booz, Allen & Hamilton in 1988 to uncover shared patterns in healthcare operations and delivery. They found the following bleak facts:

- Only a small portion of a hospital's resources are directly related to the delivery of care.
- Scheduling and documentation are a hospital's primary operating functions.
- Downtime has increased.
- Delivery of care is difficult because of the variety of interactions.

In short, hospitals have very complex systems. For example, a chest x-ray could take 38 discrete tasks (79 percent of which are process related).

Sentara Health System administrators knew they had to reform their organization. The old, convenient ways of doing things did not appear so convenient—for the patient or the care giver. The system therefore began transforming two of its facilities into patient-focused hospitals.

What Is the Patient-focused Hospital? Corrigan described the patient-focused hospital as a *concept* that:

- Gives employees a framework for providing high-quality healthcare
- Places resources closer to the patient
- Increases employee responsibility to better meet customers' requirements and expectations

"The patient-focused hospital is a philosophical and cultural change—a different way of doing things," Corrigan explained. Shifting to the patient-focused hospital philosophy affects employees, physicians, patients and their families, board members, other divisions of the healthcare organization, selected businesses such as universities, state professional organizations, the public, and the media, noted Corrigan. She said that a healthcare organization transforming to patient-focused care must alter the way it trains employees, delegates employee responsibility, and configures processes.

Communication Process Corrigan emphasized the importance of involving employees at all levels in planning this change and focusing on communication to facilitate it.

Employees often feel anxiety when organizational changes are in the works. Open lines of communication helped keep Sentara employees' anxiety at bay, Corrigan said. And because transformations like this can mean the elimination of some levels of management, Corrigan emphasized that administrators must keep managers informed. "This change can be very frightening to managers because they must approach it with the knowledge that it will change their lives," she said.

Implementing New Operating Principles Mary Ellen Bachas, project leader, Sentara Leigh Hospital, described how the system implemented the patient-focused hospital concept. The first new operating principle, she said, is to identify patient populations based on their diagnosis and service needs. Administrators at Sentara Health System looked at Leigh's and Norfolk General's major product lines. They then matched medical specialties within each line with common care patterns among patients.

Sentara established operating centers on the basis of common care patterns.

Operating centers, ideally of 40 to 100 beds to enhance teamwork, were established on the basis of these common care patterns. Sentara Leigh Hospital's operating centers are surgery–women's health, medicine, and outpatient-support services. Sentara Norfolk General's eight operating centers are cardiac, women's health, trauma–rehabilitation–orthopedics–neurosciences, vascular-renal, cancer, medicine-psychiatry, surgery, and outpatient.

Another important new operating principle for patient-focused care is to broaden employee knowledge, skills, and abilities so employees can do more jobs, thus reducing the number of staff interacting with patients. During a four-day length of stay, patients could see as many as 50 different care givers. To reduce this fragmentation and promote continuity of care, the system identified three major role categories, but encouraged sharing of responsibilities. The three roles are:

- Clinical associates, including nurses, physical

REFORM THROUGH COMMUNITY COLLABORATION

Hospitals' biggest challenge is to improve access and contain costs, observed Thomas W. Chapman, president and chief executive officer, Greater Southeast Healthcare System, Washington, DC. But he emphasized that hospitals cannot meet this challenge on their own. Healthcare's underlying tradition of service and commitment to community means that "healthcare executives of the 1990s will be called on to lead the way toward collaboration and the development of strong relationships with physicians, patients, businesses, community groups, and other hospitals," Chapman added.

Greater Southeast Healthcare System serves low-income urban areas and high-income suburban areas. The system includes community outreach programs, medical office buildings, pharmacies, home care services, nursing homes, and hospitals.

Greater Southeast's goal for healthcare reform is to create a healthy community, Chapman said. Its mission is to improve the healthcare status of its community by:


Chapman

- Fostering the availability and the accessibility of high-quality, cost-effective healthcare and related services across the continuum of care
- Operating and refining responsive healthcare delivery programs
- Identifying, advocating, and serving as a catalyst for solving social and economic problems in the community and the areas served

"We embrace our entire service area and determine appropriate ways to provide service to this varied market. Instead of marketing the service area, we service the market," said Chapman. For example, Greater Southeast recently launched a small pilot program on AIDS counseling and education in two churches in its community. It hopes to expand the network in the future.

Chapman noted that three times a year Greater Southeast invites individuals and organizations from the community to an open forum to discuss what the system is doing, how well it is doing it, and what the community's interest and needs are. "One of the fascinating things that comes out of this is that we see groups talking with each other who have never talked with each other before," he said.

But collaboration can cause frustration, noted Chapman. He described Greater Southeast's attempts to introduce a primary care screening program in area elementary schools. It encountered difficulties because of parental consent requirements and other school board restrictions. Although cooperative ventures fall through at times, Chapman said, they are "an opportunity to learn and to come back and do it in another form."

therapists, and respiratory therapists

- Administrative associates, including admitting personnel and medical record keepers
- Service associates, including housekeepers, maintenance employees, and materials managers

The system identified potential shared activities among all three groups. These include simple bedside care, general cleanliness (e.g., everyone is responsible for emptying the trash), reception (e.g., service associates can answer the phone), transport, and discharge. "You don't hand off what you can do yourself," explained Bachas. For example, she noted that the radiology technologist on the surgical unit has also been trained to do phlebotomy, EKGs, and bedside care.

Training, a key element in expanding employee skills, accounted for a large part of the start-up cost for the patient-focused hospitals, Bachas said. Sentara employees receive three types of training:

- Two-day core relational training on CQI, team building, and conflict resolution.
- Core technical training on cardiopulmonary resuscitation, safety, and infection control.
- Job-specific training, which takes 2 to 10 weeks depending on the role and the person's experience. Administrative associates have needed the most job-specific education because of the insurance training.

Bachas said that another new operating principle in the patient-focused hospitals is to place patient services closer to the patient to eliminate delays and improve continuity of care. The equipment placed in each operating center should meet the specific needs of the patients admitted there so the patient can remain in the operating center as much as possible.

The types of services offered in each operating center depend on the needs of that patient population. Based on the needs of surgical patients, for example, Sentara Leigh Hospital placed a radiology room on the surgery unit.

The fourth operating principle necessary for the success of patient-focused care is to simplify processes. To achieve this, Sentara used a CQI model and completed work flow analyses. For example, at Sentara Norfolk General admission to obstetrics used to take 47 steps (90 minutes). Today it takes 17 steps (15 minutes).

Finally, Sentara Health System has dedicated itself to streamlining documentation, noted Bachas. The patient-focused hospitals have implemented charting by exception, in which employees chart only significant findings and exceptions to usual procedures and tasks. This is different from traditional charting in which if something is not charted, it was not done.

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Also, the system eliminated and consolidated many forms, saving $85,000. "Our vision at Sentara is a totally paperless system," said Bachas.

Measuring Success Bachas said that Sentara measures the success of the patient-focused hospital philosophy by looking at quality, service, and employee and patient satisfaction.

To measure quality, Sentara administrators review clinical outcomes and overall value (cost per case). To measure service, they conduct monthly patient satisfaction surveys.

Organizational assessments in the different operating units have shown that patient-focused care relieves frustration for both patients and employees. For example, in the past if a patient asked a housekeeping employee for a drink of water, the employee would have to deny the request because only specific employees were allowed to give water. In patient-focused care, any employee can give a patient water.

Patients' satisfaction with the admitting process has increased from 80 percent to 95 percent. And a recent survey showed the percentage of patients who would recommend Sentara Norfolk General and Sentara Leigh hospitals to others has risen from 91 percent to 95 percent, said Bachas.

Patients' satisfaction with the amount of time their physician spent with them on the surgical unit also increased, from 84 percent to 92 percent, added Bachas. She said Sentara staff presume this is because chart racks are now placed outside patients' rooms. From their beds, patients can see their physicians looking at their charts and feel their physicians are spending more time with them.

The Physician-Facility Relationship

Many healthcare professionals view enhanced physician-facility relationships as essential for reform in the U.S. healthcare system. Kurt Sligar, MD, senior vice president, Medical Affairs, Sutter Health, Sacramento, CA, believes facilities and physicians must share a common interest and a common vision to create a system that works.

Elements of an Effective Relationship Physicians' training is different from administrators', explained Sligar, so the two approach their work or change differently. Administration has traditionally been a function of control and direction, and administrators must learn to share the control and decision making with physicians, he asserted. He suggested healthcare administrators practice the following:

• Exhibit genuine respect and liking for physicians.

• Communicate with physicians openly, honestly, and candidly.

• Share decision making by involving physicians early in the process.

• Develop physicians' leadership skills.

• Work with physicians as business partners. ("This is tough," Sligar noted. "Some physicians are extremely successful entrepreneurs"; others are neither adept at nor interested in business.)

• Manage the pace of change.

Physicians' Response to the Changing Environment Each physician has a unique approach to the changes taking place in the healthcare system, said Sligar. Some do nothing, hanging on and maintaining the status quo. These physicians may be close to retirement.

Some physicians feel angry and paranoid. Their anger with the healthcare delivery system is often targeted at administrators and institutions, explained Sligar. This frequently takes the form of institution-bashing, because physicians think that in some way the administrators control the external environment.

Physicians are also responding to the changing healthcare environment through internal competitions—turf battles. "Cardiologists and radiologists are battling over the peripheral blood vessels. Plastic surgeons, oral surgeons, and otolaryngologists are battling for the face," Sligar remarked. Many physicians are also battling external competition through advertising.

Physicians' and Administrators' Traits To help them understand physicians' attitudes toward change, facility administrators should become familiar with physicians' backgrounds, advised Sligar. While administrators are planners and designers, he observed, physicians tend to be reactors. Administrators are accustomed to interacting with groups, but physicians see one patient at a time.

Administrators understand that delegation is important, but physicians want to make their own decisions. Administrators value collaboration, whereas physicians value autonomy because their training emphasizes individuality, noted Sligar.

Administrators are organizational advocates. Physicians are patient advocates. Sligar pointed out that administrators identify most with their organization, but physicians identify first with their specialty practice. They have an intense bonding with their profession, rather than their organization.

Traditional Role of Medical Staff Traditionally, the facility's medical staff has been responsible for credentialing, privileging, and peer review, noted Sligar—tasks that do not prepare physicians to work with administrators. He suggested expanding physician education and involvement in hospital affairs through:

• Medical staff leadership training. Administrators must identify the medical staff's formal and informal leaders and then develop a program to develop their leadership skills.

• Strategic planning and clinical budgeting. Facility administrators need to involve physicians early in these processes and be sure they understand the compromises and trade-offs necessary in budgeting.

• Physician recruitment plan. Administrators must develop a succession plan, working with physician leaders to obtain their input and consensus on recruitment.

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Communication "One of the most difficult tasks facility administrators have is communicating to physicians what is happening in healthcare administration. Getting information out to the person who is not involved in the leadership structure, who spends 95 percent of his or her time seeing patients, is one of the main challenges in trying to move hospitals and physicians together," stressed Sligar.

Sligar advised hospital administrators to create the following systems for communication:

• Hospital medical policy committee

• Joint conferences

• Administrative and medical staff organization meetings

• Newsletters

• Bulletin boards in physicians' lounges that have photographs of department chairpersons so physicians know who to approach with questions and concerns

• Weekly bulletins on committee action in physicians' lounges

Dual-run Organizations Who will have greater influence or control over healthcare organizations at the turn of the century? Sligar envisions dual-run organizations with physician chief executive officers and lay chief operating officers. Both physician skills and administrative skills will be necessary, he observed.

The Challenge

Healthcare organizations are challenged today to help reform the system. Providers who are enhancing their relationships with patients, physicians, and their communities are meeting that challenge. —*Michelle Hey*