Managing Quality for Healthy Outcomes

By Stefanie Condie

In the cavernous Leningrad Hall, ideas bounced off the walls, ricocheted between participants and hit some panelists smack in the face. Literally. Participants at the general session of the conference scribbled down problems--from the paucity of funding for health care in the NIS to the illegibility of doctors' handwriting-- on scraps of paper, attached them with rubber bands to yellow foam balls and let them fly.

"It's impossible for you to catch all the problems thrown at you, so relax. But you can catch some," Tanya Kotys, director of international affairs at Magee-Women's Hospital in Pittsburgh, PA, said in introducing the concept of continuous quality improvement (CQI). Kotys was one of three quality improvement specialists who moderated general sessions on the theme of this year's conference, "Managing Quality for Healthy Outcomes."

Leaders must begin by establishing priorities, Kotys stressed. Rather than examining numerous problems at a superficial level, she encouraged leaders to choose one problem to look at in depth. Kotys described recurring problems as ricochets, adding that people often adopt short-term solutions to deal with such problems. Although that may correct the immediate mistake, it allows the problem to keep coming back. By using CQI strategies, leaders can create a permanent solution to the problem.

"Quality health care is that which consistently and predictably delivers the desired outcome and recognizes that desired outcomes may be different for different patients," said Patricia Stoltz, PA-C, director of quality improvement for Henry Ford Health System in Detroit, MI and a session moderator.

Stoltz said that US health care leaders have received a wake-up call to improve the value of care, which includes both the quality and cost of care. "We must improve quality while maintaining or reducing cost," she said.

Noting that CQI was first applied in the US auto industry, Stoltz explained that Ford, Xerox, and other major corporations used CQI to become globally competitive after suffering dramatic setbacks in the 1960s and '70s. In 1986, health care organizations began to adopt CQI strategies. "Results are coming in from organizations all across the US." Stoltz said. "What we see is that CQI works."

As a result of CQI initiatives, hospitals have reduced post-surgical wound infections, mortality rates and adverse drug reactions. Stoltz said that her own institution has used CQI tools to redesign the management of obstetrical care. Women with uncomplicated births are now discharged after 24 hours; they undergo a prenatal course and receive two visits from a home health care nurse following the birth. Not only are patients more satisfied with the new system, but the hospital saves $100 per case, she said.

Kotys challenged leaders to work with employees at every level to define the mission, vision, values, and goals of the organization. She encouraged managers to adopt the following basic principles of quality management:

- Focus on the process, issue, or behavior, not on the person.
- Maintain the self-confidence and self-esteem of others.
- Maintain strong partnerships with both internal customers (staff) and external customers (patients).

- Take initiative to improve processes and to improve those partnerships.

- Lead by example.

Following her presentation, Kotys led a discussion of panelists from AIHA partnership institutions and the World Health Organization (WHO). Sergei Novikov, MD, chief physician at Municipal Hospital No. 2 in Vladivostok, Russia, spoke of the lessons learned in overcoming barriers to quality improvement.

Sandra McCormick, vice president of Lutheran Hospital in LaCrosse, WI, said that "the CQI environment requires a thought revolution and changes in style of leadership." She stressed that leaders must serve as facilitators to coordinate all parts of the system into an effective operation.

Bakyt Tumenova, MD, chief of the Department of Social Services in Semipalatinsk, Kazakstan, said that lack of money is no reason to postpone quality improvement. "When you are talking about improving quality, there is one thing that doesn't require money: the work of people," she said. "It is impossible to solve everything. We pick areas that require less financial investment."

Trevor MacPherson, MD, vice president of quality management at Magee-Women's Hospital in Pittsburgh, PA, encouraged managers to select areas for improvement that yield a high rate of return. He stressed the importance of careful team composition and of developing an appropriate time line for improvement projects. "If you can't begin to solve the problem within three to six months," he said, "you've either got the wrong team or the wrong problem."

Kirsten Johansen and Franklin Apfel, with WHO's Regional Office for Europe in Copenhagen, Denmark, briefly described WHO's common European health strategy, which includes 38 outcome targets and 200 health indicators. They emphasized that an important part of that strategy is the development of data systems to allow countries to compare results.

Johansen noted that when comparative data for European countries became available in the 1980s, many countries were surprised by the results. For example, Belgium had high perinatal mortality and Denmark had poor oral health compared with neighboring countries. Knowledge of regional variations helped these countries recognize and address weaknesses in their health care systems.

With comparative data, a plan for management and other tools in hand, health care practitioners are ready to attack specific problems.

Stoltz asked conference participants to work with colleagues from their partnership institutions to identify an area for improvement. Representatives from the Murmansk-Jacksonville partnership, for example, focused on improving the survival of post-myocardial infarction (MI) patients. Their goal is to shorten length of hospital stay while improving mortality and morbidity outcomes. After looking at the whole process of pre-hospital, inpatient, and post-hospital care, they began to develop a schedule for long-term follow-up care, which requires linking polyclinic and hospital-based activities.

Linda Headrick, MD, associate professor of medicine at Case Western Reserve University in Cleveland, OH, outlined ways to map the process of care using an example of a quality improvement team seeking to better the treatment of acute MI patients. The team developed a flowchart of the process of care from the patient's point of view. Because the physicians, nurses, pharmacists, technicians, and other health care personnel are generally involved only in a specific segment of the care process, they are not used to looking at the whole process as the patient sees it. When they finally mapped out the care process from the patient's perspective, they found many ways to improve it.

Participants learned to design and conduct tests of change to evaluate how their efforts improved quality. One tool to assess this change is the Demings cycle for continuous improvement, which stresses four points: plan, do, check and act. Using flowcharts they had created, partners planned a pilot test of change they could implement.

The flurry of flowcharts and the challenges of confronting quality issues sparked the resourcefulness of AIHA partners both in the NIS and US.

"What's important is to get all of us to see creatively beyond money as the only way to solve problems," said Cheri Galbraith, RN, partnership coordinator, at Hennepin County Medical Center in Minneapolis, MN. "We're already seeing improvements in EMS and cardiovascular care. I think our partners are doing the process already, they just haven't put it into CQI terms."