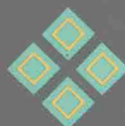
Integrated Quality Management

The Key to Improving Nursing Care Quality



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The Key to Improving Nursing Care Quality

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To

My husband Rob
who, as a professional peer,
shared the glory and frustrations
of creating a new paradigm.

My parents,
William Doyle and Lottie,
for teaching me to value improvement;
brothers Les and Bill for encouragement.

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Margaret Page, and Kathryn Skinner
for enduring friendship throughout this process.

My cat, Grace-Anne, my constant companion for 16 years.

And to God, for all the above.

Marylane Wade Koch

God for all gifts and opportunities.

In memory of my father, Gerald E. Maclin

My mother, Margie Bray Maclin,
for teaching me to persevere.

My son, Alexander McKay Fairly, IV, "Mac,"
for giving me many reasons to persevere.

Alexander McKay Fairly, III, "Alex,"
for support and encouragement.

Paul D'Encarnacao, my mentor

Terrye Maclin Fairly

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Foreword

AMONG the items I treasure is an old, yellowing copy of an article written by psychiatrist Karl Menninger and published in the Summer 1954 issue of the *Menninger Quarterly*. In this article, Dr. Menninger writes: "Time was when a hospital was a place in which to die. It was not a place of mercy and of healing, but one of endurance, charity, and pity. But the meaning of the modern hospital is quite different. It is no longer an asylum, no longer a pest house, no longer a hotel on the way to God. It is a beacon, a lighthouse—and for all its scenes of suffering—a place of joy. It is a place to which people come, not to die, but to cease dying—a place in which to get well. Temporary refuge it may be and, in another sense from the original, truly a 'hotel of God,' a way station—but not one on the way to death, rather a 'resting place' on the way to life."

If this is the mission—the goal—then it also is the measuring stick of the success of the hospital.

❖ A TIME OF TRANSITION

Few could argue with the proposition that the health care "industry" is in transition: (1) *financially*—from a method that gave individual provider, fee-for-service based reimbursement, to one that favors collective, prepaid managed care; (2) *organizationally*—from a loose, eclectic network of free-standing institutions, agencies, and professionals, to large, multipurpose corporations competing for ever-increasing shares of the market; and (3) *methodologically*—from a system of acute, inpatient, institution-based care, to a system of subacute, outpatient, community-based care.

Hospitals, the traditional backbone of American health care, are in transition, and they are operating in a society that itself is in transition—culturally, morally, and technologically. A pervasive sense of transition breeds skepticism. As institutions, methods, and mores are challenged and

changed, stability is undermined, and people lose faith in the constancy of the values, norms, and authorities that shaped the past. The result is a general tendency to distrust, question, and even debunk the authority, purpose, and intentions of organizations and institutions—especially those vital to the public well-being. Moreover, the development of large, collective systems of care delivery inhibits familiarity with persons and even traditions that are basic to the fiduciary relationship, all of which adds to personal withdrawal and alienation. Fear of large-scale institutions adumbrates on those who represent them (administrators, physicians, nurses, and so on). Thus individuals in these positions are required to "prove" themselves constantly because the institutions they represent no longer are deemed trustworthy.

The one constant guaranteeing status and representing success is money. The monetization of status, the equation of worth or value with income, further inhibits recognition of those aspects of professional life/status (commitment, ethical standards, presence, judgment, concern for the social good) that, though not amenable to such quantitative analysis, generally tend to inspire trust and confidence. To illustrate, the word "professional" today is generally used as an antonym for "amateur." A professional is paid; an amateur is not. The more a professional is paid, the "better" professional he or she is perceived to be. In this manner, merit is equated with income, and the punk rock musician who earns $20 million a year is esteemed more highly than the college professor who earns $35,000 a year. Thus social utility becomes secondary to financial gain, which, in turn, sparks fears that professionals will exploit the public to augment their own incomes.

❖ QUALITY, COST, AND OUTCOMES

The problems of society-in-transition are manifest in the health care sector and "concern about quality" is emerging as *the* issue of the decade: the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) included some outcome criteria the last few years; Congress has empowered Peer Review Organizations (PROs) to deny payment to institutions that deliver substandard care; and the media highlight instances of "mismanaged" care. The implications and impact of concern about—and the development of measurements of—quality care are astounding, particularly in light of the ambiguity of the term itself. To begin, does "quality" deal with safety or with amenities? Or with

both? Does it consist of *satisfying* the customer or of providing what the patient *needs*—by no means equable measures.

In 1991 the Chairman and Chief Executive Officer of the Prudential Insurance Company of America, Robert C. Winters, keynoted what the JCAHO has called a "landmark" conference, "Cornerstones of Healthcare in the 1990s: Forging a Framework of Excellence." He began his speech with a story: "Recently," Winters said, "a Florida man had the misfortune to step on a splinter. He went to a local hospital to have it removed. He almost had to be rehospitalized when he got the bill: $3,700. That's some set of tweezers!"

❖ THIRTY PERCENT OF CARE IS UNNECESSARY?

Citing Winslow et al. in their 1988 study published in the *New England Journal of Medicine,* Winters quoted the following statistics: 65% of carotid endarterectomies were questionable; 56% of the indications for Medicare-reimbursed pacemaker implantations were either ambiguous or nonexistent . . . and as much as 30% of the medical services delivered in the United States "may be unnecessary, ineffective, or inappropriate."

According to Winters, "physicians control the market and their decisions account for 75 percent of the costs . . . Some people get angry when you suggest that individuals other than physicians should have a voice in deciding what treatments are prescribed . . . Yet, how many of us are getting our money's worth? At the Prudential, we have invested $300 million in developing a national managed care network that will influence prices and treatments. CIGNA, AETNA, Travelers, Metropolitan, Humana, and Kaiser are all doing much the same. Insurance companies are in a whole new business. We don't just write the checks anymore. We manage care. We approve providers, negotiate reimbursement, and screen hospitals. Our goal is to assess the quality and appropriateness of care."

❖ THE PUBLIC: WE'VE GOT TO START SOMEWHERE

Professionals' battles over the validity of measurement data won't be allowed to stop the march toward paying for patient outcomes rather than health care's process. Winters drove home the message from a recent Pennsylvania Health Care Cost Containment Council study: "A quarter of all stroke patients in one hospital died, while in a nearby hospital no stroke patients died. Now some people look at these numbers and call them mean-

ingless . . . That data right now may not take all factors into account. But we've got to start somewhere. The Pennsylvania study found extraordinary differences among hospitals on price and success rates."

And "start," they (and we?) are: in July 1990 nine major payors met with the Managed Health Care Association and InterStudy to design a strategy for outcomes research. Moreover, the Feds aren't lagging far behind. The top priority for the newly founded (and underfunded) Federal Agency for Health Care Policy and Research is the development of medical practice guidelines. Many medical specialty groups have published practice parameters . . . and a hospital quality index—or *Consumers' Guide*—was published in 1992.

❖ JCAHO: PERFORMANCE DATA COMES FIRST

Dr. Dennis O'Leary, president of JCAHO, summed up the conferees' growing consensus on comprehensively tracking providers' care effectiveness in these ways: ". . . Much of our discussion . . . has addressed different aspects of what I will call the 'new evaluation tools' because that's what they really are: standards or guidelines, performance measures, and large, new databases . . . The fact of the matter is that we must look at patient outcomes at different steps along the way. If the ultimate functional outcome is death, that's a little bit late. There are a variety of other intermediate measurement points about which we need information and for which we should have the ability to hold somebody accountable, if only to ask that previous performance be improved in the future.

"Not surprisingly, there seems to be a continuing comfort level with structural standards and structural measures. These include board certification or training that serves as a proxy for likely good performances. As performance data become increasingly available, we may eventually wake up to find out, for instance, that professional training and board certification don't make a large amount of difference. Quite clearly the discomforts of the future are likely to revolve around being willing to acknowledge good performance without requiring that the performer have various tickets as proof of competence. No one disagreed that physicians and other practitioner groups must be intimately involved in development of performance measures and clinical standards . . . Interestingly, and I think reassuringly, there was almost universal agreement that unnecessary and/or ineffective care should not be paid for . . . ."

❖ EVERYBODY'S BUSINESS: TOTAL QUALITY MANAGEMENT

Moreover, Dr. O'Leary continued: "Organizations will be using performance measures, they will be applying clinical standards and practice guidelines, and they will be engaging in continuous quality improvement efforts . . . the rational system of tomorrow will be a standards-based system, but one that progressively emphasizes performance over structural requirements . . . This system will inherently say that one of the important jobs that must get done is to measure and monitor performance. Thus there will clearly be a place for data—data that derives from good performance measures, data that professionals can believe . . . these databases will be crucial because isolated and fragmentary data, particularly in the case of small providers, of which there are many, will be of little use to provider or purchaser . . . ."

Dr. O'Leary concluded: "The Washington bureaucracy is taking a hard-nosed posture. 'Yes,' they tell us, 'we understand that the methods we are using today are not very good, but we intend to use them until something better comes along.' That mentality is pervasive, and it has further raised the stakes. So the name of the game, in a very real sense, is to prudently but expeditiously build a better mousetrap. . . ."

Integrated Quality Management: The Key to Improving Nursing Care Quality offers nursing leaders a practical tool—one of Dr. O'Leary's "better mousetraps"—for integrating quality assessment and improvement into everyday practice. Marylane Wade Koch and Terrye Maclin Fairly are to be commended for clearly and concisely addressing a complex subject.

Leah Curtin, ScD, RN, FAAN
Editor
Nursing Management
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Preface

IN the 1940s and 1950s health care technology and the discovery of antibiotics led to the proliferation of hospitals and health care delivery. In the 1960s health care access was improved by creation of Medicare and Medicaid, but costs also increased, with the federal government paying the greatest portion of the costs. By the 1970s the government applied regulatory approaches to attempt cost control, and in the 1980s these efforts accelerated. In the 1990s quality, as well as cost and access, became health care's major focus.

Health care delivery today is influenced by multiple factors. There is an ever-increasing number of elderly persons whose primary health care coverage is Medicare. Indigent care is assumed by state-supported Medicaid. Cost for that care continues to escalate while demands for quality and scrutiny of care provided are also increasing. Growing numbers of the chronically ill are living longer. There is also a greater volume of individuals who are uninsured by private insurance yet ineligible for Medicare and Medicaid.

Future trends mandate that high quality, cost-efficient care will be key to the survival of any health care provider. Even today some third-party payors reward providers with preferred contracts, based on positive patient care outcomes. The goal for health care providers is cost management with greater emphasis on quality approaches.

Health care was once assumed to be safe and of high quality. The malpractice crisis of the 1970s was the first indication that "assuming quality" was invalid. With the pressure to manage costs and protect and/or increase market share, progressive health care entities began adopting components of the industrial model of quality and developed similar quality programs. In particular, continuous quality improvement (CQI) and total quality management (TQM) are being implemented in health care settings throughout the United States. CQI and TQM share a management philosophy that enlists every associate or employee of an organization to improve processes

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through an interdisciplinary "team" approach. As part of improving quality, resources are better managed, and costs are decreased. Such integrated quality management is an essential component of health care continuous quality improvement (CQI) processes. This book illustrates a model for integrating the quality management processes of infection control, utilization management, risk and safety management, and quality assessment into CQI for improved patient care outcomes.

Chapter 1 describes the evolution of quality management and introduces the processes of integrated quality management into CQI. The goals of quality management are defined. Influences that have brought quality to the forefront, such as the media, consumerism, regulation, and reimbursement are discussed. Nursing practice implications are introduced. Chapter 2 describes the concept of synergy in integrated quality management and the implications for today's nursing professional.

Chapter 3 reviews the history of the industrial quality control model and describes the major leaders and their philosophies. A history of health care quality management is then given, and comparisons are drawn between the two. Chapter 4 describes the historical evolution of regulations that affect the individual processes of integrated quality management.

Chapters 5, 6, 7, and 8 give more details of specific processes in integrated quality management. Chapter 9 defines integration and presents Neuman's Systems Model as a conceptual framework for the integrated quality management model. The use of the cause-and-effect diagram, or "fishbone," is introduced as a quality management tool for proactive patient care planning in professional nursing practice.

Chapter 10 describes the necessity and advantages of collaborative practice in integrated quality management. It gives strategies and examples of collaborative quality management for nurses. The opportunity for improved patient care outcomes through interdisciplinary quality improvement teams is explored.

Chapters 11, 12, 13, and 14 offer applications of integrated quality management in various health care settings such as acute care, home care, long-term care, and ambulatory care. Finally, Chapter 15 looks at the future of integrated quality management with discussion of implications for nursing research, ethics, increased technology, and the Nursing Agenda for Health Care Reform.

The authors believe that integrated quality management has great potential for demonstrating the value of professional nursing to the many

customers of health care. Some of the benefits to nursing include improved communication, interdisciplinary collaboration and sharing, more coordinated care, and increased visibility for the practicing nurse. Proactive problem solving through integrated quality management means improved patient care outcomes. The end result is better health care with better use of resources and empowerment of professional nurses.

We are especially grateful for the opportunity to publish this book with the patience and diligent editorial assistance of Darlene Como and Brigitte Pocta. We thank Dr. Sylvia Price for her encouragement and mentoring in professional development. We must thank our friends and family for their willingness to allow the time needed for this endeavor. Special thanks to Sandra Bassett for her leadership and coaching as a quality professional peer.

Join us as we explore where nursing has been and where it can go through synergistic integrated quality management. Let's get started. . .there is no time like the present to start shaping the future.

Marylane Wade Koch
Terrye Maclin Fairly

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CHAPTER

1

Introduction to Quality Management

THE U.S. health care system moved from the focus of access to health care services in the 1970s to cost containment for care in the 1980s. This has been the prevailing national health care issue in the past decade as demonstrated by the introduction of the federal Prospective Payment System (PPS), which uses a series of diagnostic related groups (DRGs) to determine a hospital's reimbursement for care provided to Medicare patients. Changes in payment methodology created changes in payor attitudes, resulting in alternatives to traditional health care delivery. The system began to restructure. The emergence of alternative delivery systems became the trend. Outpatient services, often considered uncovered for reimbursement in the 1970s, became the preferred alternative in the 1980s. Home care, long-term care, and outpatient services were less expensive ways to deliver some types of health care. The balance of power in health care shifted from the provider to the consumer, mainly third-party payors such as the federal government, businesses, and insurers.

The 1990s marked a new era of focused interest in health care: quality. The question of the consumer is, "Can quality health care be delivered at cost efficient prices?" The challenge to the provider is delivery of quality health care in the most appropriate setting at reasonable cost. As the public becomes more educated, the importance of defining "quality" has come to the forefront. Health care professionals must rise to this challenge by developing and implementing a process that manages the multifaceted issues inherent in quality care.

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