Using Quality Measures in Health Care Management: Myths, Realities, and Possibilities

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The Thirtieth Annual George Bugbee Symposium on Hospital Affairs conducted by the Graduate Program in Health Administration and Center for Health Administration Studies of the Graduate School of Business, Division of Biological Sciences, University of Chicago, was held at the McCormick Center Hotel, Chicago, on May 13, 1988. These symposia are a reflection of strong concern of the Graduate Program in Health Administration with complex current issues in health care management.

The topic for this, the Thirtieth Symposium, was chosen by a committee of the Alumni Association because of its relevance in this period of changing environment for health care institutions. These proceedings are published and distributed in the hope that they will prove useful to both practitioners and students of health care management.

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INTRODUCTION

RONALD ANDERSEN. Welcome to the 30th Annual George Bugbee Symposium. This symposium is sponsored by the Graduate Program in Health Administration at the University of Chicago and the Alumni Association of the Program. Our symposium each year is devoted to a topic selected by faculty and alumni for its relevance to current as well as longer-run health policy and management practice. We hope that our symposium will suggest approaches to improve viability and growth of health services organizations.

The symposium is directed toward alumni of the Program, colleagues and friends of the Program and the Center for Health Administration Studies, and students studying health services organization and finance. It is named in honor of George Bugbee, former director of the Program and Center. Among his many accomplishments, George ushered in the modern era of graduate education in health administration based on a blend of sound scholarship, health services research, and practical application in health management and policy. We hope to follow that formula in our symposium as well. The coordinator for the symposium is Odin Anderson, professor and former director of the Center, and our facilitator is Margarita O'Connell. Contributing members of our alumni council to this symposium include Richard Gifford, president of the Alumni Association; Paul Maddrell, and Charles Goulet, as well as participating faculty David Dranove and Lynd Bacon.

Our symposium topic this year is "Using Quality Measures in Health Care Management: Myths, Realities and Possibilities." All of us are aware in recent time of the increased emphasis on quality in health care and the trade-offs between quality and cost. We want to explore today how quality measures are being used and possibly misused for management and policy purposes and look at directions quality management is likely to take in the future. A talented group of speakers will explore these quality issues from different perspectives, including those of providers, consumers, regulators, and third-party payers.

We'll begin with an overview on the state-of-the-art of quality measures presented by Dr. Donn Duncan. Dr. Duncan is Chairman of the Board for Health Systems International in New Haven, Connecticut. He's also a practicing surgeon in Tucson, Arizona. His specialty training was done at Johns Hopkins University. He has been interested in health policy and its implications for many years. He served on the Board of Directors for the Health Planning Council of Southwestern Arizona and also for professional review organizations. He has been a hospital trustee and chief of staff for El Dorado Hospital, an HCA affiliate. Donn has been involved in the development of area-wide physician credentialing and has published in clinical research as well as in the areas of quality assurance and physician credentialing. We're pleased to have Donn as our lead-off speaker today.

DONN DUNCAN. This is, for me, a return to the city of my birth and the state of my youth. It's a privilege and a pleasure to be here and I want to thank Odin Anderson and Ron Andersen for an unusually well thought out and very timely topic that we're going to address today. For those of you who missed Dr. Robert's kick-off yesterday, it was a very stimulating experience to hear what is being addressed in the new areas of measurements in health care. I feel that it is significant that as academicians and regulators, consumers and payers, and administrators and physicians, we've accepted this invitation to come explore the concepts, the measurements and the imperatives of quality. What a different economy our auto manufacturers would have today had they accepted the invitation to quality from the Japanese in the 1950's and 1960's. But each of us in our various institutions has started on the track for quality. But, as Will Rogers said, "Even though we're on the right track, we'll get hit, if we just sit here." So let's look at what is quality and what are quality measurements, realizing that the purpose of these measurements is not only to evaluate, but to modify behavior.

Remember that during the last ten years more information has been collected about the world than during the preceding 10,000 years of mankind and medicine is included in this information explosion, but do not become pessimistic about the numbers of measurements and the task before us. When my family looked out in the backyard of our home in southern Illinois at the fruit trees with the copious fruit on them, trying to figure out what we were going to do with all the fruit, my father said, "Don't worry about it. Eat what you can, and what you can't eat, can." And that's what we need to do with all this information we're going to hear about today. So, let's see what we can digest.

When we talk about quality, we first need to have a definition and I carefully couched this with enough caveats to let me out of any stringent statistical observations. Being a physician gives me license for less rigid statistical constraints, and the second caveat, a practical approach, lets me define the terms. But if we are going to talk about quality, let's look at how some others have defined it. First with the industrial approach is "the insuring of conformance to requirements," which essentially states that we must have our standards. Williamson said that "quality is achievable, benefits not achieved," which is perhaps the lack of quality, but it does point out that we cannot have unachievable or too academic standards. It should be reasonable. And the AMA states that quality is "that which consistently contributes to improvement or maintenance of the quality and/or duration of life." Therefore, any definition of quality has to be linked to outcomes. Now, the Joint Commission defines quality as "the degree of adherence to generally recognized standards of good practice and achievement of anticipated outcomes." So we have our comparative profiles. And Deming states that "reliance on inspection for quality is both ineffective and inefficient," because when you find the defect, it's obviously too late, so the ultimate focus must be on prevention. Let us define quality as a conformance to agreed upon standards for the prevention of avoidable, adverse risks or outcomes. We will do this by the identification of failure to meet standards that have been set.

Historically, we look first at the structure in an institution. We ask, "Did we have in place the equipment, the personnel, the committees necessary that imply quality performances could occur?" We next looked at the process of care, the treatment protocols, the evaluation of aseptic techniques in the operating room, the timely reporting of x-ray findings, the innumerable audits. I'm not minimizing the process of quality, as it may represent a large portion of opportunity, but we now look at outcomes and question the accuracy of diagnosis, both clinical accuracy for real-time treatment intervention and coding accuracy for retrospective analysis and profiling.

We're all familiar with the publishing of statistics, especially on mortality, complications, and readmission. But we can now answer to those statistics with *case mix* and severity adjustment with more accurate reflection of those statistics. Resource measures such as cost and length of stay can be refined with acuity or severity measures which anticipate which patients will most likely become your cost or length of stay outliers, which means these measures allow us to manage rather than to react. We also have necessity measures, "Is that admission or surgery necessary?"

Patient satisfaction is normally analyzed in post-discharge surveys. This is appropriate, but when an adverse event occurs during hospitalization, immediate intervention is required. A large hospital group was able to change significant numbers of patient's attitudes following an adverse event. They did this with what is known as an ombudsman, an intervention team which went immediately to the patient. It tried to determine and ascertain what the adverse outcome was, and then immediately and appropriately, if possible, react to it. Before the immediate intervention program, only 50 percent of the patients queried would return to the same facility. But after the intervention program, approximately 95 percent stated they would return. Impressive statistic. We now see risk management programs expanded to evaluate both clinical and administrative incidents, from falls to malpractice. And the credentialing of physicians and all allied health care professionals now includes not only what did they do, right or wrong, such as complications, poor citizenship, or malpractice, but what specific diagnoses can they treat, what procedures can they do. This is our current direction of privileging. But perhaps the most rapidly expanding area of interest is now in clinical indicators, health status, and severity adjustment. We can now demonstrate which doctors' patients improve or deteriorate, and answer the question of premature discharge: Are patients being discharged quicker and sicker? I testified before Congress, trying to answer that specific question about quicker and sicker, and used as one of the examples the fact that 20 years ago, when we did a herniorrhaphy, the patient would remain in the hospital from two to three weeks. The patient would be sent home with his sutures removed, not requiring antibiotics or pain medication, and immediately returned to work. Now, that same patient if he were admitted, and most of them are done as outpatients, would obviously go home with his sutures, occasionally go home with antibiotics, and most patients go home with some pain medication. It certainly is quicker and most would contend sicker. I tried to point out that those patients rarely get nosocomial infections, pulmonary emboli, have atelectasis or pneumonia. So I think we have to very carefully define our terms and ascertain if this is really a change in practice patterns. The severity of illness concept is having a good reception by physicians, as this allows a physician to look at his or her patient mix with greater specificity, and we can objectively demonstrate whether patients are discharged sicker.

If we are to look at quality, we need a process, and if good quality is a conformance to agreed upon standards, we must first evaluate the standards to make sure they are clearly defined and relevant. Perhaps the key to this process is that the standards are agreed upon by your key medical staff, because they are the people who will have to communicate and gain the commitment of the entire medical staff. Those people in the institution who have the respect and the positions of responsibility must be the ones who will carry this commitment forward. When the deviations from the established standards are measured, they're evaluated to determine if they are disease-process deviations or truly adverse outcomes. Then, we take action and modify behavior. Monitoring, especially with the development of indicators, is the core of the prevention process. We periodically review standards, because the standards are changing dynamically in health care. Regulatory aspects are changing and technology is changing, so we have to periodically review these standards. Now, the Joint Commission is becoming more aggressive with a performance-oriented accreditation system with specific indicators, which are clearly defined, measurable, clinically relevant, and adjusted for severity. Since the clinical indicator is the core of the system, I'd like to take this opportunity to look in-depth at one of the systems.

A clinical indicator is defined as an occurrence with a significant probability of being associated with an adverse patient outcome. These are things that, when they occur in a hospital, have significance. The genesis of the clinical indicator is very interesting. It actually began in 1976 in California when the medical association, in response to a malpractice crisis, tried to create a system where they could compensate what they defined or described as potentially compensable events, or PCE's. They ranked them as deaths, a major permanent injury, major temporary injury, minor permanent, and so forth. Then, they tried to develop a compensation system. Something very interesting was derived from that system and that was the fact that prior to the adverse outcome incident, or a PCE, potentially compensable event, certain indicators were noted, such as an unplanned return to surgery, and then something happened to the patient, or an unscheduled transfer to a special unit, such as your intensive care unit, or something that happened or was happening or about to happen to the patient such as an acute MI during surgery. That was the first utilization of indicators, called generic outcome screens. This was the genesis of the clinical indicators we are now beginning to see and that the Joint Commission has brought forth and recommended.

Let us look at some of the Joint Commission indicators that have been recommended. First, there are hospital-wide indicators which may occur in any or many particular areas: developing or worsening of decubitus ulcers, the development of pneumonia in patients treated in special care units. They also have location-specific indicators, such as anesthesia indicators; e.g., cardiac arrests related to anesthesia care. There is an interesting story about this particular indicator. At a particular institution a patient had a cardiac arrest, and at the time of arrest, blood is frequently drawn for examination. The blood in this patient was drawn and it was noted that she had extremely low potassium, hypokalemia. It's known that with certain general anesthetics a very low potassium predisposes the heart to irritability, to arrhythmias and cardiac arrest. It is also known that many diuretics lower the potassium, and indeed this patient had received diuretics. The indicator now is: Patients receiving diuretics must have their potassium evaluated prior to a general anesthetic. This is a very exciting development. Discovery of the opportunity for preventing adverse events

is by any definition, better quality. Now, the Joint Commission will also recommend some specialty-specific indicators, such as in obstetrics and anesthesia.

If we have these indicators, we need a process to collect and evaluate them. When a clinical indicator occurs, record first what was the indicator, such as unplanned return to surgery, and we want to know when it occurred. There is the recent story of the ICU nurse who was injecting patients with a lethal substance. She was found by knowing when it occurred. It was on her shift that these patients were being mortally injured.

You want to know where it occurred—the location—and who is responsible for assessing whether the clinical indicator was the result of poor quality. Someone has to make that decision, and that person should be a person who is a peer of the person under consideration. The reason for that is, in addition to assessing the clinical indicator, there will have to be a judgment made whether that clinical indicator was indeed the result of poor quality.

If the clinical indicator is determined to be a quality problem, then you record what actually happened. Before we were discussing the CMIFS Study, *The California Medical Insurance Feasibility Study*, which gave us the generic screens. We derived from that study that the description of the actual impact on the patient would be death, major permanent, major temporary, and so on. An example of this: Major permanent injury could be blindness; major temporary, a paralysis that clears; minor permanent, scarring from a burn; minor temporary, a drug reaction. And then we should record the potential impact on the patient. When a potentially compensable event occurs, it does not always lead to an adverse outcome, such as a wrong medication given to a patient.

Then, we want to know the cause of the quality problem. Is it a performance problem? Delay? Did the patient rupture his appendix because the doctor always takes two hours coming to the operating room? And, we want to know who. Who is responsible for the quality problem? And lastly, the action taken to correct this problem. This information is then retained for profiling as it's an opportunity for credentialing your health care professionals.

Dr. John Smith is a surgeon. It is his time of reappointment. During this period of time, we have been collecting these quality indicators. This is just a condensed list of a long list of surgical indicators. We collect in the third column the volume or the number of those indicators. And, the next column, how many are a problem, and which of those were the physician's responsibility? Then, the average adverse effect. This is ranked—six would be death; five, major permanent effect. This is just one of the myriad of measurements one can use with this information.

What are the pitfalls and the problems that we're seeing with all these measurements? First, we discovered that a lot of the information that was being collected was not very accurate, but fortunately we now have systems which enhance our accuracy. First, make sure that we're getting good information. Without your commitment as leaders and that of your key medical staff, you will not have acceptance by your medical staff. You can't have a system and not have teeth in it, because their failure to act will lead to a loss of credibility with your medical and hospital staff. The standards must be attainable, must be

achievable. Failure to comply will expose the hospital to legal risk. If we fail to maintain the standards as the dynamics of medicine change, they will be inappropriate. I added another potential problem that may be the most important of all: the dehumanization of patients. We must not forget that all of these measurements are attached to somebody. See what happens to patients? They begin to become numbers.

Fortunately, these problems are not fundamental, and they can be solved. In fact, we're seeing a significant number of benefits, and this is the really exciting part. You increase hospital staff morale. People are eager to be talking about and involved in quality. By the nature of our expectations, higher quality institutions attract a higher quality medical staff. You can have greater specificity of evaluation and improve your credentialing process. You're prepared for a closed staff. You have good communication, and you have a "do it right first time" syndrome in which productivity improves with your commitment to quality.

I've responded somewhat to Ron Andersen's request. This is, if not puncturing a myth, at least swinging a needle at a balloon—and that is higher quality can lower cost. Be courageous. Higher quality *does* lower cost. We've just completed a study that shows that, on average, a nosocomial infection will double the cost of a hospital stay in patients with similar diagnosis, similar characteristics, matched DRGs. We're talking about the same patients, that on average, a nosocomial infection will double the cost of their hospital stay. We are now in what, I feel, is the most exciting part—what are the patient characteristics or the indicators that precede that adverse event, that infection? We're basically following and examining those patients regularly to determine what characteristics, which hopefully we will be able to ascertain on admission, they have that will identify them as at risk for this adverse outcome. Then prevention can occur.

When price is leveled, you can differentiate on quality and have an opportunity for increased market share. Improved quality decreases liability. You'll be better prepared for future reimbursement issues. You'll have greater negotiating strength with payers and HMOs and PPOs. You'll be prepared to respond to the regulators. What an enviable position to be in—to be your community leader based on quality.

It's appropriate to talk about the future. What are some reasonable predictions relative to these measurements? Before doing this, I always like to look at the track record of other prophet's predictions. "The world won't need more than six mainframe computers," Thomas Watson, a knowledgeable individual, 1944. "Japan will never be a threat to the U.S. auto industry," *Business Week*, 1956. And "I don't need a bodyguard," Jimmy Hoffa, 1974.

In spite of these, I feel safe with the following predictions. New quality measures will continue to be developed with increasing specificity, and with clinical indicators for each of our I-9 codes. QA activities will continue to improve the quality of care. Quality not only will become, but must become, a prime focus of hospital management. Quality measurement will not only identify the lack of quality, but will begin to define optimal quality. Not what went wrong, but reasonable expectations. And the emphasis of quality activities will change from review and evaluation to prevention. If you're an administrator, the most important aspect to your economic future, I do believe, is that the price paid for hospital care will in part be determined based on the hospital's performance on quality

measures. The hospitals that most effectively communicated the quality of their care will be the ones that succeed in the 1990's.

Statistics are necessary but insufficient to have quality. It takes commitment. What an opportunity we have. I would just like to recommend a book totally unrelated to health care, a non-medical book, that's a story of quality. It's my current airplane book, by the way. It's the story of Ray Kroc, founder of McDonalds, and his commitment to quality. Ray Kroc drove that industry by his commitment to what he called "QSC": "Quality, Service and Cleanliness." I believe that health care will be driven by QSC also, by quality, service, and communication—our ability to communicate our quality to our payers and to our consumers. To be successful, quality must be managed and quality must have top management commitment, not just involvement. Remember that leaders are just ordinary persons with extraordinary commitment. Management must be dedicated to the on-going improvement of quality. We must continue down the right track for quality, knowing that this is something we can impact—something as leaders and administrators that we can change. Not everything we can change. Sir Winston Churchill was at a reception—and those of you who read *Churchill* know that he liked his brandy, frequently to excess. And, he'd been drinking at this reception when a young woman came up and said, "Sir Winston, you're drunk." He said nothing, and she left. He continued to enjoy his brandy. She returned. She said, "Sir Winston, you're very drunk." Again, he said nothing. Again, she left. And again, he enjoyed more brandy. She returned. She said, "Sir Winston, you're really very drunk." He looked up and said, "Countess, you're ugly, Countess, you're very ugly, Countess, you're really very ugly. And tomorrow, I'll be sober." Tomorrow the emphasis on the importance of quality will still be with us.

QUESTIONS AND ANSWERS FOLLOWING TALK BY DR. DUNCAN

DONN DUNCAN. I neglected to mention the name of the Ray Kroc book. It's called *McDonalds: Behind The Arches*. It's written by John Love. It's a hard copy book, if you're interested in finding it at your bookstore.

QUESTION. The statement about higher quality resulting in lower costs seems almost too good to be true. You are all aware of the distinction between Cadillac and Volkswagen medicine and the general belief that Cadillac medicine's higher quality, but also includes higher costs. And I recall Edward Kennedy talking about his hope that all people would receive the same quality of care that his father received. It was extremely extensive and some of us wondered if that wasn't a bit unrealistic. And, I wonder how we reconcile this kind of optimistic relationship that you're observing with some of these past observations.

DONN DUNCAN. I knew you were going to ask that question, because I saw your eyebrows go up yesterday when one of your students said, "I think I know that higher quality lowers cost." And he said, "We want to think that, but where's the evidence?" I think part of the answer lies in that we have historically confused quantity of health care, because we never really talked much about quality. Because there's always been an attempt at good quality of health care. But now that we begin to feel we can measure or have measurements that we can use as surrogates for quality, we're beginning to talk about quality in its real sense and your example and the examples of unit costs are really more related to quantity. How many units of care are available? And more units of care cost more dollars. But we're talking about perhaps lessening the quantity through the methodology of improving the quality. For example, the nosocomial infection I gave as an example. The minute that infection is documented, then we start increasing the unit cost, because of the expensive antibiotics and probably the increased length of stay and the other things that are occurring. Because we didn't have quality measurements, we were confusing how much is available to the person. You know the old story that when the doctor's in, London went on strike, health care improved. That's reaching a little bit, but they have less quantity and perhaps better quality.

QUESTION. I get the impression that the quality concept is now after the patient is in the system. You also better include quality as to the growth of ease of access to the system for acute care particularly and also the convenience of access to the system. I mean, from here, you've heard, "See your doctor early." Now, they're seeing the doctor too early, at least by some allegations. Are you incorporating quality in access to the system?

DONN DUNCAN. Yes, and an excellent point. This happened to be one of the concerns when we were discussing quality of care issues with Congress. If Congress gives the wrong incentive to those people who control the institutions, where at least acute care is delivered in a hospital, and the incentive states that we're not going to pay you enough for your burn patients or your people with the leukemias—that is, the patients that appear to be insufficiently reimbursed for the resources that they consume, then we're giving a wrong message. And, I think it's very important that the people who are determining what these reimbursements will be are sensitive to that issue. There are other things we didn't touch

on. For example the severity system. If used appropriately, we will be able to objectively measure those which should have access to the system. Very critical. But I think your point's well taken, and I think it's in an area that we need to explore more.

QUESTION. I might add this also. I began to feel that the doctor and management will be entered into an almost unconscious collusion against the patient and all the determinations are professional and bureaucratic. And the patient, himself or herself, will have less and less control over what takes that person to the system.

DONN DUNCAN. That's a good point.

QUESTION. You spoke of quality. You spoke of management's role. I wondered if you'd speak a little bit towards government's role, particularly as they are looking at what indicators they can use to evaluate quality of health care, which they have responsibility to share.

DONN DUNCAN. Let me restate what I think was the question. You're talking about the example of the Joint Commission obtaining indicator information and how that will be used to assist or to determine regulations for management, is that the question?

QUESTION. What I'm looking at is the Board of Trustee level. What do you see as the future requirement for hospital board composition for quality care?

DONN DUNCAN. Thank you. Yes. I think we're going to see a necessity for a change in the composition of boards and this is always a sticky question in any institution. We've gone from the only person who was an administrator and a physician, to trained and skilled professional managers today. I feel that the number one role will have to include a significant number of physicians who can help that board have better understanding of these complicated issues. However, I've been impressed with the value of business people, lay people, sitting on boards who can make excellent decisions, because they understand the principles of good management, understand the principles in general of quality. You don't have to be a physician to understand valid measurements of systems. I would say that, if your board in general does not include physicians or those people who have some peer relationship for understanding these new measurements coming out, it will be a change that will be critical in the future. However, I've also been part of an institution that had virtually an all physician board, and I thought that was as inappropriate.

A PROVIDER'S VIEW—THE OTHER QUALITY INDICATOR: CORPORATE VALUES AND ETHICS IN A CHANGING HEALTH CARE ENVIRONMENT

RONALD ANDERSEN. Our second speaker is Richard Wade. He has been vice president of communications of the Maryland Hospital Association since 1979. Prior to this, he served as press secretary to various officials in the State of Maryland. In his career he's done extensive work in journalism and in television writing as well. He's a trustee of the Annapolis Opera and Colonial Theater. We're pleased to have Richard here to present the views of a provider organization, which is very much interested in other aspects of quality as well.

RICHARD WADE. Good morning. I'm from Maryland, a most unusual state, particularly in terms of the things that happen with regard to health care. Let me introduce Maryland to you. It's where the Chesapeake Bay is, as some of you know. It's the home of the "Star Spangled Banner." You can go out to Fort McHenry and see where an important event in our history actually happened. Babe Ruth was born there, and Edgar Allen Poe died there. Maryland is also the birthplace of a woman for whom a king of England once gave up his throne—Wallis Simpson. It has a city, Baltimore, which is rising from urban decay. If you have visited us, you have seen the enormous progress of the Inner Harbor. It's very impressive. And we have a baseball team that I won't even begin to discuss with you.

It is the land of fallen political heroes. Spiro Agnew was once our governor. Back in the 1970's, we seemed to have a continuing stream of political leaders who left public office and reported to a federal penitentiary in Pennsylvania. We're also a state with state level hospital rate regulation and believe it or not, hospitals support it. We also probably have more data available publicly about the financial and clinical performance of hospitals than anywhere in America. And while that may sound like an enormous pain in the neck for institutions, it's turned out to be a blessing in its way and it's an important part of the context of what I'm going to talk with you about today.

Perhaps no facet of the environment in which hospitals function has changed as dramatically as the effort to define quality and to measure it. Everybody's getting into the act. The Joint Commission is making some remarkable progress. Insurers are preparing to plunge in, as are other constituencies. I learned recently that the Health Advocacy Program of the AARP is eager to begin to study quality data and to do their own analysis of it. The Washington power of what is known as the "Grey Lobby"—Claude Pepper and AARP—means they will be extremely influential in helping people in their constituency determine their definition of quality.

All of this began as a spark. It flared a few years ago in highly regulated states such as Maryland, where data became public and an enterprising press pursued it into print. Just a few years ago on an August afternoon, I received a call from the *Washington Post*. The dialogue went something like this. *Post* Reporter: "I'd like your comments on the Nader report." MHA: "What Nader report?" *Washington Post*: "Oh, I just came back from a press conference. The Ralph Nader Public Health Research Group has released its report."

(I'll never forget it as long as I live.) *Post* again: "*Surgery in Maryland Hospitals 1979 and 1980—Charges and Deaths.*" What happened? The Ralph Nader Public Health Research Group had gone to the Maryland Health Services Cost Review Commission, our regulatory agency, and tapped into the extensive public data base there. It was a Maryland study because Maryland was the only state with so much data so public. It wasn't very subtle, but it was effective. And, it was more than a spark. It began to happen in other places around the country. The PROs evolved, but hospitals deflected, generally, charges of "quicker and sicker" discharges. The PROs were, after all, a cost-cutting, cost-saving mechanism. The sparks really turned to flame a couple of years ago when the HCFA began the public release of Medicare mortality data. That unprecedented action, and the behavior of hospitals and others it spawned, left much to be desired. That first wave of the release of the rawest kind of quality data—mortality data—drew resentment and defensiveness from hospitals and doctors. Some insulted the public and their patients and other constituencies by implying that such data and what it meant were none of their business. And the most pivotal action of all, perhaps, was when the old Joint Commission on the Accreditation of Hospitals secured a new name, a new leader and a new set of objectives—the Agenda for Change. If I wanted to graphically demonstrate the impact this is going to have on hospitals, I'd show you an old *New Yorker* cartoon of several years ago. There's a mountain and standing at the foot of the mountain is a grizzled, gnome-like man with a beard. He's dressed in skins and furs, and he has a yoke on his shoulders. And, on each side of the yoke is a huge bucket with steam pouring out of it. The caption: "Before the invention of the volcano, the hot molten lava had to be carried down the mountain by hand to pour on the sleeping villagers."

Now, think about that. Hospitals are the sleeping villagers and the HCFA, the Joint Commission and everybody else getting into the act are the volcanoes. An overstatement? Not by much. Health care professionals and others eventually will sort through the quagmire, arrive at better measures of quality. But how, then, will these perceptions of what constitutes quality affect reimbursement, competition, consumer choices and clinical decisions?

The debate over quality soon will leave the comfortable cocoon of research and theory, and enter a very dangerous, practical and political world. Now, as the one offering you today the provider's point of view, here is a brief, narrow perspective of how I think providers may handle the transition to this new era of quality measurement. The short answer is torturously. Hospitals, by their nature, their organization and their constituencies are designed, and created to be centers of conflict and contradiction. The educational and political tasks before us as institutions are enormous in getting through this transition. We haven't even begun to address that aspect of the transition. We still are finding a language. But let's begin with hospital boards of trustees. Not only boards today, but trustees of the future. As we prepare leaders from the community to be part of the hospital governance system, we have to begin to identify ways to get them to think about these kinds of quality issues. The old ways will not do and failure to meet the new challenge could seriously harm efforts to preserve the voluntary, historical roots of America's hospital system.

Remember when we used to have hospital administrators? They've vanished. Today, we have CEOs. We're very corporate. Can that hold in this era of transition? Hospital executives at every level may well be forced to rethink the shape of their role inside the

institution in this age of quality accountability. There'll be more than mere accrediting and regulatory standards. We're really looking at a change in the institutional way of life.

Hospitals must begin to invent a new language for talking with our very many publics. We've lately become enamored with the corporate way of talking to our publics. We have product-line management in our hospitals. We have business plans. We're diversifying. Can we afford to lose the public's trust? Is our candor important to the transition to the quality era? Do we have to begin to talk to our publics in a different way?

I'd like now to try to put quality into a larger context—with some other challenges facing hospitals. The next few minutes may be very depressing. But hospitals in America face an eroding public and political image overlayed on the already incredible economic pressures they face from every side. We have gone down the road of marketing advertising, joint venturing and the whole entrepreneurial package with little or no knowledge of or preparation for its effect. They are roads strewn with broken glass and potholes. Hospitals, as community institutions, are trying to cope with a breakdown of a series of historical relationships that—until probably this decade—helped us be strong, caring and right-minded places. Hospitals and doctors are at odds. Doctors in competition with hospitals, stealing their business and even their employees. Whole medical staffs in revolt. House staffs talk about unionization. Doctors, frustrated with a perceived loss of power in their ability to treat their patients as they would want to treat them, blame hospitals, not always the reimbursement system or other controls on them. They take it out on the only sure thing that's in sight: hospitals. Nurses and hospitals. Nurses and hospitals are staring at each other across a chasm today, and while we would like to think it's economic, there's more to it than that. Nurses are looking at the traditional center of their profession: hospitals and seeing institutions either unable or unwilling to shake off ancient stereotypes and become agents for change in their professions. Their work environment, their image, and the way they're treated by others are at issue and hospitals seem loathe to help. In Maryland, we created a Center for Nursing at our hospital association. As we went around the state, doing focus groups with nurses, one thing we heard time after time was the nurses' frustration that when they have ideas to improve quality or efficiency in their institutions, they more often than not fall on deaf ears. We don't listen.

And, for all the guest relations and marketing, I wonder: Is the distance between hospitals and their patients actually widening? Statistics on malpractice suits and the zeal with which new forms of regulation are dumped down upon us would seem to suggest strongly that no one trusts us anymore. Remember, I said this was going to be depressing. Are we getting high tech and low touch? Is that a quality issue?

On the political and general public fronts, everyone from members of Congress to county commissioners in Kansas are beginning to look at hospitals in a brand new way: as sources of tax revenue. This is an astounding development. Across America, the not-for-profit, tax-exempt status is under attack. Are we acting so differently today that the public is ready to treat us differently? If we behave like big corporations, society will treat us like big corporations. Are we viewing ourselves the way we want the public to view us?

Of course, we continue to be under attack from the federal government and others over costs—we're spending too much money...outpacing inflation. We're making too much

money from Medicare. We're wasting resources. We're operating on people unnecessarily and putting people in the hospital that don't need to be there. And we're discharging patients sicker and quicker. I'll end my depressing list of problems facing America's hospitals. The challenges are formidable and they go to the root of a broad definition of quality...not just care.

Coming to grips with the broader questions of quality—how we will define it and measure it at every level of our institutions, clinical yes, but governance, management, and much more. Of all the myriad challenges facing hospitals today, we must recognize that hospitals' organizational values and ethics or, in the current business parlance, our corporate values and ethics are on the line equally with our medical values and ethics. And how we manage and communicate this transition to a new era of quality accountability will be, in my view, the key to solving some of the other problems I mentioned earlier: our eroding relationships with doctors and nurses, the public's crumbling perception of us, as well as how we are viewed politically and ultimately how resources are distributed by those who reimburse us.

In Maryland, we have been concerned about corporate values and ethics and their link to quality.

First, let me give you a snapshot of the Maryland Hospital Association. Our governing body is made up of hospital trustees. The chief trustee leaders from our member institutions make up our Board of Trustees. Our policy process and much of our view of the world is tied to the voluntary character of community hospitals. Our current board chairman is a former United States Senator from Maryland. About 18 months ago, he viewed the horrible savings and loan scandal plaguing our state, the headlines about government and business ethics and asked: "Does the subject of corporate values and ethics have any relevance to hospitals and the environment in which they're operating? Does it have anything to do with the quality of care we're delivering to our patients?" He appointed a task force, chaired by a prominent hospital trustee, and including physicians and chief executive officers ...one of whom was a former chairman of the American College of Healthcare Executives. Their charge: to look at the issue of corporate values and ethics and its implications for a whole range of things hospitals were doing. The task force's first action was to come up with a definition of corporate values and ethics. Easy you might think. But actually, it took quite a while. Here it is: "A health care organization's corporate ethics are its values and standards in action as a caregiver, employer, buyer, seller, business partner, and member of the community it serves." With that statement in hand, they began a fascinating discussion and debate of some of the most critical issues facing hospitals. When they issued their report to the members of the Maryland Hospital Association several months later, they connected quality of care issues and corporate values and ethics in a dramatic way. Our corporate ethics and our medical ethics they said are entwined inextricably. They are the cornerstones of our public credibility and they are how we're going to be measured in the future—how we're going to be viewed, reimbursed, and even protected. We will be tested as community service organizations not against a standard of care, but against a standard of overall behavior.

Let me for a second digress to a brief description of what we're doing in Maryland on quality of care. You will see why the link was so direct to us. We have just received a Robert Wood Johnson grant to collect, analyze and research quality indicator data from our

hospitals. What began 18 months ago as a pilot project with a few hospitals has grown to an effort involving 46 Maryland hospitals. We are gathering data on ten clinical indicators. The goal: to give hospitals—boards of trustees, medical staffs, and executives—tools to measure and influence quality of care. I'll quickly list the indicators: mortality rates, perioperative mortality rates, surgical wound infection rates, readmission rates, readmissions to ICUs, unscheduled returns to the O.R., admissions following ambulatory surgery, newborn mortality rates, hospital-acquired infection rates and autopsy rates. Through a long process, hospitals came to a decision not only to submit such data, but to share it with other hospitals for comparison and trending by medical staffs, boards of trustees, and executives. This is research no other set of institutions in America is doing. And what is the goal? Changes in individual and organizational behavior affecting clinical outcomes.

Let's go back to that definition of corporate values and ethics and test the quality connection: values and standards in action—*first* as caregiver. Now let's look further into the report for other quality connections. Our committee zeroed in on 14 areas of hospitals' policymaking and activity that they thought were extremely sensitive to the institutions' values and ethics. They urged every Maryland hospital to review these areas in depth. Here are the fourteen; I think you'll find them interesting.

The first is very basic: the institution's *mission statement*. Does it give the community, the medical staff, employees, payers, vendors, and other providers a clear understanding of the institution's expectation of itself and, indirectly, of them?

Uncompensated care. In an era of financial squeeze and "patient dumping," is one measure of our quality of care to all the quality of care we give to those least able to pay for it?

Access to levels of care. Hospitals are often the gateway for many who seek medical care. In America today, for example, we're faced with a serious problem in obstetrical care for poor women. Some obstetricians, driven by professional liability and other concerns are telling hospitals, "There are some patients we're not going to care for, and you better figure out how they're going to get care." Hospitals are scrambling to come up with solutions. And it may not stop with obstetricians...it could well spread to other kinds of services. How we deal with those kinds of problems is a test of our commitment, not only to quality, but to our institutional values. How are we doing?

Necessity and appropriateness of care. While this issue is at the heart of our medical ethics, it also reflects our corporate value system. Do hospitals make organizational decisions which result in some people getting services they don't need—just because they can pay for it, while others are not getting services just because they can't? What about the decision to shut down a service that may be needed, but isn't profitable? Is there a quality implication there?

Advertising. Hospitals flushed a billion dollars down the media pipeline last year alone. What did we buy? Did we ever know what we wanted to buy? And what have we said to the public about our quality? Is it time to begin to use these kinds of resources for the long process of informing, educating and helping our many publics understand clearly what it is we can and cannot do, and be the advocate for our patients and those who care for them? My favorite advertising story revolves around a New York hospital—a fine Catholic

institution. It ran a touching series of ads in the *New York Times*—quarter-page, beautiful ads. No graphics, but the most warm, dramatic narratives about doctors, nurses, patients and the good things that happen in a hospital. Then, one day, another kind of ad from the hospital appeared. Its headline was, "Not our last ad, we hope." It was an appeal to the public. The hospital's advertising budget had run out and they were asking the public to contribute a quarter of a million dollars to a special fund administered by "Sister Margaret" to keep the campaigns going. It actually was two ads. The first one was titled, "In Search of Angels," seeking the funds. The second ad was "Not Our Last Ad," when the public had not responded. Just think what a quarter of a million dollars can buy for an institution.

The public release of clinical and other hospital data. How we react to the legitimate rights and needs of the public to know more about us will communicate more about us as value driven institutions than most anything else. In many states, even the most basic hospital cost data isn't available to the public. We're making a major transition to an era of quality—when the public will want to know much more than mortality data.

Conflicts of interest. Boards, management, medical staff and others. As we gain the tools to define and measure quality of care, we will be challenged to create new ways to be sure that quality is what our patients are getting. It's the interest of patients which must prevail. Yet, are there situations in hospitals where self-interest leapfrogs over the patients' interest? When a hospital offers physicians free offices, loans and business partnerships, are we always certain it's in the patients' best interest?

Purchasing, contracting, and vendor relations. On the surface another business issue. What about quality? A hospital on the East Coast suffered through a lot of bad publicity regarding the quality of their emergency room care. The hospital seemed unable to explain to the public what the quality problems were or how they were going to solve them. The inside story: the hospital was in the process of renegotiating their contract with their ER physician group when the story broke. The institution had a case of lockjaw. They couldn't talk to the public about quality when they were trying to talk to their doctors on economic issues. What was the public left to think about the quality of care in that ER?

Joint ventures. The hospital-physician joint venture is very common today and often a positive relationship for all: hospital, physician and public. But could a hospital's business relationship with another provider of care cause them to treat that provider differently in terms of quality oversight? For example, a hospital joint ventures with a physician group to open a magnetic resonance imaging center. It's a business relationship. Will that relationship cause the hospital to view those physicians differently as they practice inside the institution?

Medical staff, administration and appointments. Is credentialing in a hospital a business decision or a quality of patient care decision? Some hospital boards are having a tough time answering that question.

Network allegiances. Across America, hospitals are running for cover everywhere. They're merging, joining formal systems. They're clustering in less formal arrangements, such as the Voluntary Hospitals of America. The question: are these arrangements driven by the

institution's mission and its values? Are they affecting the efficiency and the effectiveness of patient care? For the better? If not, why not?

Competitive behavior in general is causing some troubling behavior with quality implications. Not long ago, a California hospital advertised its heart surgery mortality rate. It bought big ads in the Palm Springs newspapers and trumpeted its low mortality rate for open heart surgery, in comparison to the hospitals across town. It said, basically, "Come here. We'll do your open heart surgery and you'll have less chance of dying." The strategy made big headlines, but what were they saying to the public about the quality of care? Was it true?

Levels of profitability. A hospital's financial requirements can have an enormous impact, real and perceived, on quality of care. It is in no one's interest for the hospitals of America to starve financially. But it's probably in no one's interest either for the profit mentality to take hold. And frankly, the bottom-line mentality is gripping a lot of institutions. We'll never convince the public that more is always better. The current attacks on hospitals' tax-exempt status may be one way the public is answering: less is better.

There's more to the list of issues, but my time on the program is about up. Let me close by noting that the tests facing hospitals in the last decade of this century will transcend individual issues of reimbursement, rationing, the nurse shortage and others. I would bet those issues will be resolved if and when we are successful in dealing with the quality question. Clinical measures of quality of patient care, yes, but quality in the broader sense: quality of our caregivers, the quality of our mission, quality of our community-based governance, and quality and honesty of our communication. Are we doing the right things? Are we doing them well? The questions must be asked...in surgery and in strategic plans...in the MRI center and in materials management...at the bedside and in the boardroom.