SUCCESS COMES FROM HAVING THE PROPER AIM AS WELL AS THE RIGHT AMMUNITION

From Common Sense To Health Cents

VOLUME 2, ISSUE 4

SEPTEMBER/OCTOBER 2003

Getting from Quality Assurance to Performance Improvement

Performance improvement is the latest buzz word on the quality scene. While the initial reaction for many is one of frustration, performance improvement may actually be the means for health care to bring value to its quality efforts. The real question is whether the industry embraces the opportunity this represents or whether it is treated as another burden.

Performance improvement is about implementing those quality improvement decisions that help to ensure the implementation of the hospital's strategic goals and that help in strengthening the healthcare organization's future. In today's healthcare environment, quality is a significant consideration in most strategic plans. It is an important consideration in a hospital's ability to attract and retain patients.

Quality is the common goal in most initiatives that can help rural hospitals to attract the 30% of perspective patients that are bypassing them when seeking out care. For many of our rural healthcare providers, and particularly those on the higher side of the average, this statistic is the difference between surviving and closing. For others, it's the difference between financially hanging versus realizing an operational gain that allows for reinvestment in their organizations.

Finding ways to retain some or all of that 30% is important to the survival of most rural providers. As organizations develop their strategies to strengthen their futures, more serious attention must be given to the role performance improvement activities play in making those strategic plans a reality.

Rural healthcare providers are facing some tough competition for their patients. Today, better roads and means of transportation make it easier for patients to travel greater distances to receive care. People are increasingly willing to travel to get what they want. Added to this, is the fact that we are a society raised to believe that bigger is better. Frequently this creates the assumption that people are automatically going to get better care if they go to a larger hospital. Specialization of medicine, managed care, and the growth of consumerism encourages patients to look at their healthcare relationships as short-term encounters designed to meet their immediate needs. The industry is also dealing with a much more educated consumer who has much higher expectations of their healthcare encounters.

If rural healthcare providers are to stop the out-migration of patients, recover some of those lost in the past and build stronger futures, they need to give people a reason to keep their health care local. Performance improvement initiatives give our quality improvement activities a greater role in achieving these goals and reversing the current negative trends many rural healthcare organizations are experiencing. Patient retention, new patient acquisition, improved profitability, retention of qualified professional staff, stronger reputations, and operational efficiency can all be achieved with a greater focus on performance improvement.

Quality improvement programs of the future can no longer be restricted to only internal activities of assuring quality. They must look at generating the information necessary for rebuilding community confidence and relationships. They must have clearly defined and meaningful outcomes. They can not be activities that exist purely for the purpose of being able to document such activities. They can not be viewed as solely an activity for regulatory compliance. They must be designed for and treated as activities that can create meaningful changes that strengthen an organization's relationships with their communities, patients and employees.

With all the changes and stresses that have impacted rural hospitals in the past two decades, people in our rural communities are uncertain as to what our rural hospitals are

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Strategic Performance Improvement

Does our healthcare organization focus on quality initiatives that promote patient satisfaction, new patient acquisition, patient retention, market share retention and patient profitability.

Quality Assurance *(Are our activities in compliance with current policies, procedures, regulations, standards of care and accreditation requirements.)*

Quality Improvement (*Are we making the right quality improvements decisions to drive efficiency and effectiveness into our operations, quality initiatives, employee satisfaction efforts, and patient satisfaction activities while creating balance with customer service)*

Performance Improvement *(Are we make the right quality improvement decisions to achieve our strategic goals)*

INSIDE THIS ISSUE:

"COMMON SENSE IS SEEING THINGS AS THEY ARE, AND DOING THINGS AS THEY OUGHT TO BE DONE"

Bringing QA, QI and PI Together for Exponential Results

Understanding Why

The first step in having a successful quality program is understanding why we currently have the situation we have where organizations are investing significant resources in their quality initiatives and yet, as an industry, health care continues to lose ground with our public. Too many discussions today focus on "what is happening to us" . We can only create the necessary change if we truly understand "why this is happening to us". When we understand why, we can then create change and control the variables necessary to position our healthcare organizations for success.

Patients are looking for two things when they judge a healthcare service or product: 1) they want their problem fixed or their needs to be met, and 2) they want the provider to make them happy while that need is being met.

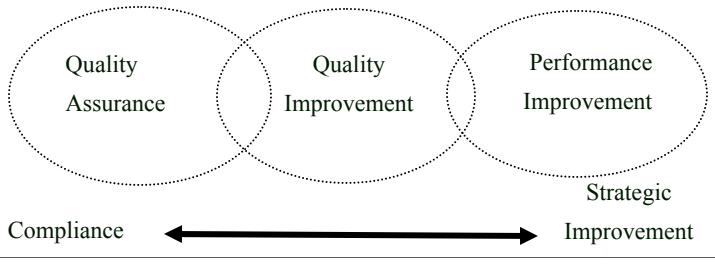
Kevin Miller

In the early 1980's our business world was experiencing serious change. Deregulation created a drastic economic shift and gave birth to the competitive environment that we know today. Companies figured out very quickly that to survive they had to attract and retain customers. The most likely way to do this was to make sure their customers were happy and to find better ways to make them happy. This gave rise to the competitive world of quality we know today. Everyone is constantly looking for the better product that can draw customers in their direction. A by-product of this was greater customer choice. As a result, the loyal customer became an endangered species.

During this largely competitive period of time, health care continued to enjoy many of the same protections it had enjoyed in the past. Some of that protection was because deregulation was not as complete for health care as it was for other industries while other reasons rested in the fact that health care remained a mystical, more difficult industry for the general public to understand. The *art of medicine* caused people to believe that healthcare was a dangerous area for the general public to attempt to flex the power of consumerism.

The push for quality programs primarily came into the healthcare industry through the creation of Medicare regulations and Conditions of Participation. These expectations then translated out into State regulations and accreditation standards such as those of the JCAHO. As a result, the healthcare industry viewed quality as a requirement for regulatory compliance and the damage that that perception created has continued to haunt the industry ever since. As a result, the healthcare industry forfeited a significant aspect of its control as the government became the driving force behind the assurance of quality. Unfortunately, this big brother approach fostered attitudes of negativity instead of achieving the necessary buy-in to create positive, sustainable change.

The Integration of QA, QI and PI Creates a Synergistic Potential for Quality



Over the past two decades, healthcare organizations have frequently deferred control to the government when it came to creating change in their organizations. It has been commonplace for the administration of many organizations to go to their staff and say that they have to change the way of doing business "to make to State happy" or "to keep Medicare certification" or "because it is a JCAHO requirement". Deferred responsibility became easier than convincing our healthcare providers that this was the right things to do for our patients. This was particular true when it came to dealing with physicians. Rather than have the *art of medicine* debate, it was easier to say we had to make changes to keep some greater power happy.

While this deferral of ownership for change was easier in the short run, it has created a nightmare in the long haul. Despite millions of dollars, governmental crackdowns, a raging malpractice crisis and declining public opinion, the healthcare industry continues to struggle to get its hands around the enigma of quality.

Critical to working our way to successful quality improvement programs is getting back to the basics. The needs of our patients must be the driving force behind everything we do and we must get comfortable with "walking the talk".

So, How Do We Get There

The next step in having a successful quality program is understanding the program components and how they all come together. Quality assurance, quality improvement and performance improvement have many commonalities but are not synonymous with each other. These commonalities are what create confusion and frustration for our staff. Out of that confusion and frustration comes a lack of staff support for new initiatives and an inappropriate demand on resources just to maintain initiatives.

Quality assurance, quality improvement and performance improvement all share a common thread and that is to assure that our patients and communities always have access to quality patient care while we maintain viable healthcare organizations. They all work together to assure that our patients feel that their needs are being met to their satisfaction. Patients are looking for two things when they judge a healthcare service or product: 1) they want their problem fixed or their needs to be met, and 2) they want the provider to make them happy while that need is being met. The problem with the quality programs in many healthcare organizations today is that they are too heavily weighted toward quality assurance and they frequently look only at those things that are safe to look at, and not necessarily those things they should look at. It is like the hospital that doesn't want to have a employee satisfaction system because they are afraid of what the employees

We can buy our employees physical presence, but we must win their enthusiasm, loyalty, and commitment to quality. Key to this is leadership that challenges the process, inspires shared vision, enables others to act, models the way, and encourages the heart.

Kouzes & Pozner

might say. The reality is that the employees are saying those things anyway but behind closed doors where the outcomes can be far more damaging to staff moral, staff retention and new staff acquisition.

The Role of Quality Assurance

Quality assurance is about protecting the present. It is assuring compliance with all the requirements the healthcare organization must live under today. It is about making sure our patients' needs are being met today with the resources available to us to assure their safety and well-being.

Quality assurance is about quality control, policy and procedure compliance, credentialing, privileging, and all those activities that protect the organization and patient today. Risk management is an important aspect of quality assurance. Strong quality assurance programs assure that an organization will not have any surprises that result in poor patient care or poor outcomes.

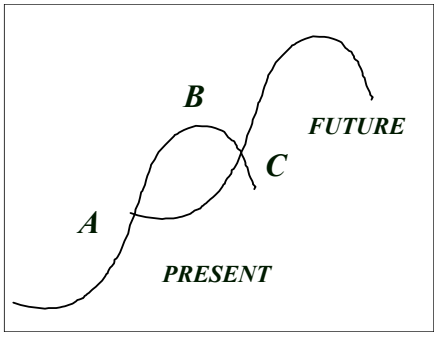
The weakness in quality assurance programs is that they are about today. Because they are about compliance, they are about promoting continuation of today's behaviors. They are about promoting status quo and in today's healthcare environment, status quo is dangerous to long term survival. It is also dangerous to patient care because of the exponential technological growth that healthcare is experiencing. What was good patient care last month could easily be outdated treatment today.

Healthcare organizations will always need to have strong quality assurance programs as they are critical to protecting our patients and organizations on a day-to-day basis. What becomes critically important in today's healthcare environment is to have our quality assurance activities tightly linked to strong quality improvement programs.

The Role of Quality Improvement

While the quality assurance aspect of a healthcare organization's program protects our patients and organizations on a day-to-day basis, the quality improvement program identifies and orchestras the creation of the quality healthcare services of tomorrow. Quality improvement is the futuristic sister of quality assurance. It is constantly looking for opportunities to improve the way we deliver care and conduct business. It is about challenging status quo. It is about securing and protecting the organization's future.

Quality improvement is about finding ways to improve customer satisfaction, assure patient retention, acquire new patients, improve profitability and strive for better market share. It is about creating a successful future and not just waiting for it to happen.



Quality assurance and quality improvement must co-exist and both must be strong. While quality improvement helps to create the organization's future business curve, quality assurance is working to make sure the current business curve remains strong. If either business curve is weak, the organization and patient can suffer. Once quality improvement has identified and implemented new and improved healthcare services or operational processes, quality assurance takes over and makes sure that the activity happens the way it needs to happen.

This hands-off is critical as this is where the glue is created that makes the new behavior part of every day life. Whenever an organization implements a change as part of its quality improvement initiatives, the quality assurance side of the program must monitor, coach and reinforce the new behavior. It is recommended that this reinforcement occur for a minimum of six months as that is approximately how long it takes for new behavior to become habit for the average person. Until that new desired behavior becomes habit, there is always the chance people will fall back into the old comfortable way of doing things.

Too often, an organization creates a change and then quickly moves on to a new initiative with the assumption that everyone will embrace the change. When staff are stressed or uncomfortable in the new behavior, there is a natural tendency to migrate back to the old ways of performing. This is how great intentions deteriorate into status quo. This lack of follow-through is one of the primary reasons many quality improvement programs gain the reputation of being ineffective.

The Role of Performance Improvement

Performance improvement is the aspect of the program that makes our quality improvement initiatives strategic. This is the part of the program that makes sure that our quality initiatives help to build a stronger future. It assures that all the initiatives throughout the organization have common goals and objectives. It takes those thousand points of light and focuses them for well-orchestrated change that assures that the organization's future business curve will happen as planned. It is the process that ties the strategic plan to the operations of the organization.

Performance improvement and quality improvement must work hand-in-hand to focus the organization's efforts. Performance improvement gives meaning to the quality-related activities. In today's environment, where staff view quality initiatives as busy work imposed on them to complicate their lives, it is critically important that organizations find ways to communicate value. Employees and professional staff must understand the contribution that the quality initiatives bring to patient care and the organization's future. They must feel ownership for the contribution they make to creating that future.

Success has a price tag on it, and the tag reads COURAGE, DETERMINATION, DISCIPLINE, RISK TAKING, PERSEVERANCE, and CONSISTENCY—doing the RIGHT THING for the RIGHT REASONS.

James. M. Meston

Creating Strategic Performance Improvement in the Emergency Room

Pleasantville Hospital is a 29 bed hospital with all the traditional hospital-based services including an eight bed emergency room. Analysis of the hospital's market demonstrates that the hospital's emergency room enjoys 58% of the potential market in its primary service area and 38% of the potential market in its secondary service area. It competes with three other hospitals for patients in these areas. All of the competing hospitals are of equal or larger size to Pleasantville Hospital.

As part of the Hospital's strategic plan, the board and senior management team have decided that they want to enjoy the reputation of being the preferred provider for emergency room services in both the primary and secondary service areas of the hospital. This strategic goal is defined as achieving 85% of the market in the hospital's primary service area and 70% in the secondary area. Efforts for achieving this growth will concentrate on the "walking-wounded" population. The reason for this focus is three-fold:

1) Due to the regulatory requirements of EMTALA, a hospital already sees the seriously and critically ill patients in its service area because ambulances are obligated to bring those patients to the closest hospital. This is not a population where marketing efforts would be appropriate.

2) The "walking-wounded" constitutes the population where strong customer service and marketing activities have the potential to influence decision-making. These are the patients who actively choose where they will go for emergency room care based on who meets their needs best. The three competing hospitals have mediocre to poor reputations for wait times and turn around times. Pleasantville Hospital has a good reputation but has never focused on making it great or marketing it. If Pleasantville Hospital concentrates on establishing a reputation for consistently excellent care delivered in timeframes recognized to be customer sensitive, there is a good chance that patients will migrate in their direction. We live in a time where people are impatient and conscious of the value of their time. They appreciate service providers who are also sensitive to this.

3) The "walking-wounded" tend to help balance the financial picture for emergency rooms in smaller, rural hospitals. Contrary to common assumptions, higher acuities do not routinely equate to significantly higher reimbursement. In the majority of today's reimbursement systems, the higher the complexity of the patient care delivered in the emergency room, the lower the percentage of charges covered by the insurance carrier. For small and rural hospitals, this can be particularly troublesome as they frequently transfer these more complex cases out to a tertiary care facility and do not benefit from the inpatient reimbursement that these patients generate. As a result, the smaller hospital benefits from a higher percentage of "walking wounded" patients to help improve the revenue and expense ratios.

As part of the strategic management process, the hospital identified all those quality-related initiatives that must occur if the strategic goal of doubling emergency room volume is to occur. The team assigned to this project looked at needs in the areas of staff, operations, customer service, and financial management. Those strategic quality initiatives are outlined in Figure 1.

The ED strategic management team then development a series of indicators for each of the key areas. These indicators will then be monitored regularly by the team to determine progress in achieving the strategic goals. Figure Two outlines the indicators chosen by the team. From these indicators, a smaller set of indicators was chosen to include in the strategic management report for the Board of Trustees. The following important points were used as guidelines for the development of the indicators:

1. No more than 25 indicators plus or minus three are to be monitored on a monthly basis at any point in time. It is important to the process that efforts remain focused on those activities that have the greatest potential to yield positive outcomes. One of the common mistakes made by healthcare organizations is to overwhelm their management team and staff with too many monitors and variables. Having too many monitors can dilute the process and often distracts attention away from those activities that are truly important. Prioritization of activities will remain critical throughout the strategic progress to assure that the

Figure One

Financial Goals

All patient bills will be accurate on first billing 99% of the time.	Repeat billing compliance concerns for correctable occurrences will occur in less than 2% of bills.	All patient bills will be sent out within 30 days of ED visit.	Revenue/expense ratio will improve by a minimum of 10%.

Customer Value Goals

Patient satisfaction surveys will reflect at least a 97% satisfaction score in all areas.	Repeat complaints for correctable concerns will occur in less than 2% of the ED cases.	Cases with a potential for or actual harm will occur 0% of the time.	New patients will report hospital reputation as their reason for their visit in > 70% of the cases.

Operational Goals

All walking-wounded patients will have nursing contact within 15 minutes and physician contact within 20 minutes	All patients will be discharged from the emergency room within 2 hours of registration with all care needs met.	All ancillary testing will be initiated within 15 minutes of the order and be completed within 30 minutes of initiation.	All compliance requirements with policy, procedure, and standards of patient care will be met 98% of the time with no fall-outs having the potential for or actual harm occurrences.

Employee Contribution Goals

ER employees will report optimum efficiency and effectiveness of employee support systems	Repeat inefficiency and ineffectiveness for employee support systems will occur in less than 2% of identified opportunities.	Employees will maintain all necessary credentials and educational updates necessary to maintain optimum skills	Employees will maintain performance error rates of less than 2% with no events resulting in potential for or actual harm occurrences.

two most important resources are maximized: time and energy.

2. Indicators will be more heavily weighted on clinical and operational activities as these have the greatest potential for impacting the desired change. Using Kaplan and Norton's guidelines from the balanced scorecard, the team will develop indicators as follows: 3-5 financial indicators with a one indicator swing; 3-5 customer value indicators with a one indicator swing, 8-10 clinical/operational indicators with a 2 indicator swing; and 3-5 employee contribution goals with a one indicator swing. As indicators are deleted and added over time, the ratio of financial, clinical/operational, customer value and employee indicators will remain consistent.

3. All indicators will be customer focused. Important to the process is the creation of stronger patient and employee value propositions. An important aspect of the cultural shift to be created by this process is an understanding by everyone that patient perception is our reality. The question is not whether the hospital thinks it gives good care. The true question is whether the patients and community perceive that the hospital gives good care.

3. The strategic management team for the Emergency Room will follow the following membership rules:

   a. 80% of the membership will consist of frontline employees.

   b. The team will have representation from every major clinical and support department that can impact the strategic goals.

   c. The team will meet monthly to assess progress against the strategic goals.

   d. The team will have a chairperson.

   e. Meetings will be limited to one hour.

   f. Each team member will select a teammate to facilitate information sharing and assignment follow-up. Each teammate will update the other if one is absent and will bring assignments for each other.

Indicator	*Source*	*Target/Frequency*
1. Financial		
Emergency Room Visits	Hospital Statistics	Monthly
Category 1		
Category 2		
Category 3		
Category 4		
Category 5		
Billing Compliance	Billing Department Report	Quarterly
Payer Mix	Hospital Statistics	Monthly
Medicare		
Medicaid		
Commercial		
Self-Pay		
Amount Billed	Billing Department Report	Monthly
Amount Recovered	Billing Department Report	Monthly
Net Gain	Billing Department Report	Monthly
2. **Customer Value**		
New Patients	Hospital Statistics	Monthly
Primary Service Area		
Secondary Service Area		
Tertiary Service Area		
Revisits Within 72 Hours	Emergency Room Tracking	Monthly
Customer Satisfaction	Customer Satisfaction Surveys	Quarterly
Complaints	Emergency Room Tracking	Monthly
Patient/Family		
Provider		
Other Healthcare Facilities		
Other		
Reasons for New Patient Visits	Emergency Room Tracking	Quarterly
3. Operational		
Not Seen in 20 minutes by Physician	Emergency Room Tracking	Monthly
Not Seen by Nurse in 15 Minutes	Emergency Room Tracking	Monthly
Patient Not Discharged in 2 Hours	Emergency Room Tracking	Monthly
Elopements	Emergency Room Tracking	Monthly
Incidents	Emergency Room Tracking	Monthly
Medication Errors		
Patient Injuries		
Other Injuries		
Policy/Procedure/Protocol Deviations	Emergency Room Tracking	Monthly
Ancillary Testing Not Started Within	Emergency Room Tracking	Monthly
20 Minutes of Order		
Ancillary Testing Not Completed Within	Emergency Room Tracking	Monthly
30 Minutes of Initiation		
Admission > 1 Hour From Decision to Admit	Emergency Room Tracking	Monthly
Transferred Patients with Stay of >4 Hours	Emergency Room Tracking	Monthly
Days in AR	Bill Department Report	Monthly
4. **Employees**		
Repeat Policy/Procedural Deviations	Emergency Room Tracking	Monthly
Employee Skill Preparation	Education Tracking	Quarterly
Procedural Inefficiencies	Emergency Room Tracking	Monthly
New Ideas/Suggestion Implementation	Emergency Room Tracking	Monthly

Creating Strategic Performance Improvement in Swing Bed Services

Over a decade ago, the federal government created a new program that allowed rural hospitals to provide short-term skilled care for patients that would benefit from this level of care. This program allowed communities who lacked easy access to other skilled providers to now have the service in their community. It also became an opportunity for hospitals experiencing declining acute care inpatient volumes to have another level of service to help stabilize their operations. While some hospitals found this program to be a strategic opportunity, others have struggled with its implementation.

Learning how to integrate skilled care into the traditional acute care services and helping staff to achieve a comfort level with their role in this new level of care is key to its successful implementation. Understanding the patients that would benefit from this level of care and how to utilize these beds in the configuration of services offered to the community can have a significant impact on hospital operations and financial performance. This is a particularly important service for small rural hospitals that serve a predominantly geriatric population and especially for Critical Access Hospitals.

Friendly Hospital is a 25 bed critical access hospital. The impact of the changing healthcare industry has prompted a serious decline in the traditional acute care inpatient volumes. Their average daily census on the medical surgical floor is roughly 30% during busy times and can fall as low as 5% during lean time. Staff retention is problematic and physician frustration is high. The hospital has had a swing bed designation for approximately six years yet their average daily census for these patients is less than three with an average length of stay of four days.

The Hospital's board and senior management team determined that it would be in the Hospital's best interest to focus on the development of the service. A market analysis determined that the hospital had lost approximately $550,000 in potential swing bed revenues in the past year due to a poor utilization of the service. The Hospital's neighboring long term care facility has been experiencing declining public favor over the past two year. Members of the community are reportedly having family members admitted to long term care facilities in other communities. The Hospital had historically transferred short-term skilled patients to the nursing home but is now receiving criticism and family pressures not to make such moves. As a result, patients are leaving the community for short-term skilled care and this is not making families happy.

Figure Three reflects the major activities that this Hospital identified as critical to its success in establishing successful short-term skilled services in their swing beds. A team was assigned to oversee this process and the quality indicators outlined in Figure Four were developed. The team guidelines outlined on pages 4 & 5 were utilized.

The team process was particularly important in this situation as the front-line employees needed to develop a greater comfort level with this new service. Swing beds reflected a new level of care for the hospital. As the hospital did not have an affiliated long term care facility, skilled care was new to the majority of the staff. As these patients fall under a different set of regulations with different care planning and documentation needs, the hospital's staff did not feel comfortable in caring for them. As a result, those who controlled admissions were turning patients away.

This hospital, like many, added swing beds to their complement of services without considering the impact the new level of care would have on the staff. Important to the addition of such a service are questions such as: What new knowledge will the staff need to have? What new skills will the staff need to have? What new guidelines, policies and procedures will need to be available? Are our current resources adequate? What do we need to do to make this new service a success?

Figure Three

Financial Goals

All patient bills will be accurate on first billing 99% of the time.	All patient bills will be sent out within 30 days of discharge and 10 days of primary and secondary payments.	Revenue expense ratios will improve by 25%.	Repeat billing compliance concerns for correctable occurrences will occur in less than 1% of bills.

Customer Value Goals

Patient satisfaction surveys will reflect a 97% satisfaction score in all areas.	2% or < of patients will not progress to goals with reasons due to patient controlled variables outside of the hospital's realm of influence.	Cases with a potential for or actual harm will occur 0% of the time.	Repeat complaints for correctable concerns will occur in less than 2% of the swing bed cases.

Operational Goals

All ancillary and support services will occur so as not to delay treatment decisions or care.	The patients will experience a strong continuum of care from acute admission through skilled care discharge.	Patients will demonstrate continuous progress towards goals throughout stay with appropriate interventions for those 2% or < who do not.	All compliance requirements with policy, procedure, and standards of patient care will be met 98% of the time with no fall-out with the potential for or actual harm occurrences.

Employee Goals

Employees will maintain necessary credentials and educational updates necessary to maintain optimum skills.	Employees will verbalize and demonstrate a comfort level with skilled patient management activities.	Swing bed employees will report optimum efficiency and effectiveness of employee support systems with repeat inefficiencies and ineffective occurring in less than 2% of opportunities for improvement.	Employees will maintain performance error rates of less than 2% with no events resulting in the potential for or actual harm occurrences.

Figure Four

Indicator	*Source*	*Target/Frequency*
1. Financial		
Discharges	Hospital Statistics	Monthly
Patient Days	Hospital Statistics	Monthly
Average Length of Stay	Hospital Statistics	Monthly
Case Mix	Hospital Statistics	Monthly
Payer Mix	Hospital Statistics	Monthly
Medicare		
Medicaid		
Commercial		
Self-Pay		
Amount Billed	Billing Department Report	Monthly
Amount Recovered	Billing Department Report	Monthly
2. Customer Value		
Patient Source	Hospital Statistics	Monthly
Primary Service Area		
Secondary Service Area		
Tertiary Service Area		
Patient Origination	Hospital Statistics	Monthly
Friendly Hospital		
Other Acute Care Facility		
Readmission Within 30 Days	Swing Bed Unit Tracking	Monthly
Customer Satisfaction	Customer Satisfaction Surveys	Quarterly
Complaints	Swing Bed Unit Tracking	Monthly
Patient/Family		
Provider		
Other Healthcare Facilities		
Other		
3. Operational		
Transitions Back to Acute Care	Swing Bed Unit Tracking	Monthly
Don't Progress to Goals	Swing Bed Unit Tracking	Monthly
Incidents	Swing Bed Unit Tracking	Monthly
Patient Falls		
Medication Error		
Decubitus		
Skin Tears		
Nosocomial Infections		
Patient Injuries (not falls)		
Discharge Delays	Swing Bed Unit Tracking	Monthly
Policy/Procedure/Protocol Deviation	Swing Bed Unit Tracking	Monthly
Billing Compliance	Billing Department Report	Quarterly
Days in AR	Monthly Financial Report	Monthly
4. Employee Value		
Repeat Policy/Procedural Deviations	Swing Bed Unit Tracking	Monthly
Employee Skill Preparation	Education Tracking	Quarterly
Procedural Inefficiencies	Swing Bed Unit Tracking	Monthly
New Ideas/Suggestion Implementation	Swing Bed Unit Tracking	Monthly

"Most bold change is the result of a hundred thousand tiny changes that culminate in a bold product, procedure or structure."

Thomas Peters

Darlene D. Bainbridge & Associates, Inc. is a consulting firm that specializes in issues affecting rural and smaller healthcare providers and communities. Mrs. Bainbridge holds certifications in both healthcare quality and healthcare risk management. She brings more than 20 years of experience in both areas to her consulting relationships. Coupling this with her experience in rural hospital, long term care, and network leadership, she has a perspective of healthcare that facilitates creating value-added solutions. "At Darlene D. Bainbridge & Associates, Inc., we are committed to helping our nation's healthcare organizations to find ways to meet the challenges of our rapidly changing healthcare environment and to make their success a reality."

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Inside This Issue:

" Getting From Quality Assurance to Performance Improvement"

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Recommended Reading Materials:

1. *The Balanced Score Card* by Robert S. Kaplan & David P. Norton, 1996.
2. *The Strategy Focused Organization* by Robert S. Kaplan & David P. Norton, 2001.
3. *Who Moved My Cheese* by Spencer Johnson, M.D., 1998.
4. *Selling the Invisible; A Field Guide to Modern Marketing* by Harry Beckwith. 1997. Warner Books.
5. D*ifferentiate or Die; Survival in Our Era of Killer Competition* by Jack Trout & Steve Rivkin. 2000. John Wiley & Sons, Inc.

and what they can do. Our rural healthcare providers must give their communities reasons that have meaning in their eyes for keeping their health care local. Performance improvement programs of the future must:

1. understand and act on what patients and communities perceive as having value in the delivery of healthcare,
2. be responsive to opportunities to improve performance and relationships,
3. be integrally linked to the organization's strategic plan,
4. work hand-in-hand with the organization's marketing program,
5. communicate value and produce meaningful, measurable, and tangible outcomes, and
6. focus on patient satisfaction, patient retention, patient profitability, new patient acquisition and market share retention.

Quality is about connecting with our patients and communities.

Quality is about connecting with our patients and communities. It is much more than the delivery of a service. It is about creating ties that make the patient want to choose the healthcare organization as their preferred provider. These ties are important today to preserve those relationships that exist and they are critical for tomorrow as the waves of consumerism grow stronger and penetrate even more deeply into our rural communities.

For many organizations, their current quality activities are the equivalent of rearranging the deck chairs of the Titantic to try and keep it afloat. Quality initiatives of today must focus on performance improvement. Healthcare providers can only regain the respect of their public if they takes charge of their futures.