



A Message from the Editor

When we started publishing *Transition Watch* five years ago, major changes were occurring in health care management and delivery systems across the country. VHA had just recently reorganized into 22 Veterans Integrated Service Networks in an effort to change from a hospital-based system to a health care system with an emphasis on primary care. These changes led to important organizational “transitions” and research to study them. Our goal for *Transition Watch* was to provide managers and decision makers with timely information about research findings to aid them in their planning and decision making. We particularly focused on three organizational studies being conducted through the MDRC: the Service Line Implementation Study, the Facility Integration Study, and the National Quality Improvement Study.

With these studies nearing an end we considered putting *Transition Watch* to bed permanently. After

much discussion, however, we decided that there was still a need for timely, accessible, health care organizational change information and resources for managers. The health care environment continues to change at a fast pace and VHA managers continue to make strides toward improving the quality and efficiency of care that we provide to veterans. So beginning with this issue of *Transition Watch* we will expand the focus beyond the original three studies to include other management research studies being conducted at the MDRC and elsewhere, as well as provide summaries of new articles, books and other change resources.

We hope that you will continue to find *Transition Watch* to be a useful resource and are, as always, interested in hearing from you with questions or suggestions for future issues. Contact us at any time via email at MDRC.Boston@med.va.gov or phone: 617 278-4433.

Gerry McGlynn, Editor

National VA Quality Improvement Survey: Preliminary Three Year Trends

Mark Meterko, PhD, Martin Charns, DBA, Gary Young, JD PhD, Danielle Valley, MPH

Since 1995, the Veterans Health Administration (VHA) has undertaken an extensive reorganization in an effort to improve the quality and efficiency of the delivery of health care. During this period 54 facilities have been integrated into multi-site healthcare systems, and some variant of service line structure has been implemented in primary care, mental health, or other clinical areas at more than 110 facilities. Staff and financial resources have been shifted from inpatient to outpatient care, exemplified by the opening of about 400 new Community-Based Outpatient Clinics. Perhaps most fundamentally, what had been a highly centralized organization was restructured into 22 geographic networks of facilities with considerable flexibility in determining how to reach national quality and performance goals.

These changes in reporting relationships and budget authority were not ends unto themselves, but

were seen as providing an environment more conducive to the values, attitudes, and behaviors necessary to achieve the vision of “the new VA.” The expectation was that this transformed organization would have a less bureaucratic, more entrepreneurial and team-oriented culture that practiced continuous quality improvement. The importance of service quality would be consistently communicated by leaders at all levels of the organization and exemplified in their behavior. Service quality goals would also be explicitly incorporated into individual employee performance goals. Staff at all levels would receive

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National Quality Survey

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timely and helpful feedback about their progress toward those goals, and efforts to improve service quality would be recognized and rewarded.

The National Quality Improvement Survey (NQIS) was designed to measure and monitor these less tangible but nonetheless crucial aspects of the organizational change process within VHA. Initiated in 1996 with funding from a National Science Foundation grant to Gary Young, JD PhD, of the HSR&D Management Decision and Research Center (MDRC), the NQIS was administered nationally in 1997, 1998 and again in 2000. The purpose of this article is to report preliminary findings regarding three-year trends on the NQIS measures.

NQIS Methods and Measures

The NQIS was administered as a confidential paper-and-pencil questionnaire distributed to staff at each VHA facility through inter-office mail. A postage-paid business reply envelope was provided so that completed questionnaires could be sent directly to the data entry vendor. A second questionnaire was sent to all staff that did not respond to the first mailing.

Three samples were drawn at each VHA facility:

middle managers (service chiefs), front-line supervisors, and general staff. All managers were included, but supervisors and general staff were randomly sampled. A maximum sample of 150 employees was drawn at each facility, depending on the size of the workforce. The sample was also stratified by service (e.g., fiscal, medical administration) to ensure representation from all service groups.

Some questions in the NQIS were adopted from validated measures described in the organization research literature; other questions were developed by researchers at the MDRC. Altogether, measures representing seven dimensions were computed from the survey data; see Table 1.

National Findings

Response Rate. Nationally, completed questionnaires were received from about 70 percent of staff contacted in 1997, 62 percent in 1998, and approximately 46 percent in 2000. The decline in response rate may reflect “survey fatigue” on the part of VHA staff. Also, the survey procedure followed in 2000 involved a longer delay between first and second questionnaire mailings than in previous years. This procedural variation may also account for some of the decline in participation. The bottom line is that the 2000 results should be interpreted with caution due to the relatively low response rate.

Table 1. Principal NQIS Measures

Measure	Interpretation
Risk-Taking Culture	Innovation, risk-taking, and an entrepreneurial spirit characterize relationships among staff and the way in which things get done at the facility.
Group Culture	Relationships among staff and the way in which things get done at the facility are characterized by teamwork and cooperation.
Quality System Survey (QSS) Scale	Problem solving practices, data availability, and management practices reflect a genuine commitment to continuous quality improvement.
Leadership	Top management at the facility promote and exemplify commitment to service quality goals.
Performance Goals	Individual performance goals emphasize service quality improvement.
Evaluation & Feedback	Staff receive constructive feedback about their performance, and have data available to assess their own progress as well.
Reward & Recognition	Staff efforts to improve service quality are recognized and rewarded.

Organization Culture. Staff rated facility culture as increasingly bureaucratic and less risk-taking and innovative over the three years of the study. Ratings of group culture also declined significantly over the same period.

Quality System Survey (QSS) Scale. Staff perceptions of support for and commitment to continuous quality improvement (CQI) have been stable at about 3.4 on a 5-point scale ranging from strongly disagree (1) to strongly agree (5). A QSS scale score below 4 (agree) suggests that staff perceive only modest commitment toward CQI within VA.

Leadership. This measure was based on responses from mid-level managers (service chiefs) only and reflects their perceptions of the commitment of top management at their facilities to continuous quality improvement. Scores for all three years were about midway between 3 (neutral) and 4 (agree), indicating that middle managers perceive only a modest degree of involvement in and advocacy for CQI among facility leadership. After being stable from 1997 (3.5) to 1998 (3.6), the Leadership scale declined significantly in 2000 (3.3).

Performance Goals. Scores on this scale were stable at about 3.7 on the 5-point scale over all three years of the study, suggesting that staff do not see service excellence being explicitly and consistently emphasized in their performance goals.

Evaluation and Feedback. This measure has been stable at about 3.4 out of 5, suggesting that staff do not see themselves as consistently receiving constructive performance feedback from their supervisors or having sufficient information available to assess their own progress.

Reward and Recognition. With scores between 2 (disagree) and 3 (neutral) on the 5-point disagree/agree scale, Reward and Recognition has been the least favorably rated of the five non-culture dimensions measured by the NQIS. Respondents do not feel that their efforts to improve service quality have been noticed and reinforced.

Facility-Level Results. At the facility level, considerable variation was evident on most NQIS measures. For example, the most risk-tolerant, entrepreneurial facility in 2000 had a score on that culture dimension that was

over twice that of the most risk-averse, bureaucratic facility. There was almost a fourfold difference between the scores at the lowest and highest facility on the group culture dimension in 2000.

Next Steps

The MDRC has proposed a continuation of the survey and has received funding from HSR&D for an additional year of revision and refinement. During this period we will determine whether and how to modify the NQIS to maximize its value to both managers and researchers, and to ensure that it complements other VA employee surveys.

To guide these efforts, the MDRC is forming a steering committee that will include representation from HSR&D, Network leadership, the Office of Quality and Performance, and the Office of the Assistant Deputy Under Secretary for Health, among others. Over the coming year the committee will review the NQIS results and those of other prior employee surveys, determine what domains should be included in a revised survey, provide guidance regarding administration of the revised survey, review the 2002 results, and make recommendations regarding how to distribute and support use of the data.

Transition Watch is a quarterly publication of the Office of Research and Development's Health Services Research and Development Service. Its goal is to provide timely, accessible health care change information and resources to aid VHA managers in their planning and decision making. Summaries and analysis of ongoing survey and management studies within VHA will be included, as well as organizational change resources from within and outside VA. For more information or to provide us with your questions or suggestions, please contact:

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Resources for Managers

Highlights from the Literature

Irene E. Cramer, PhD, LICSW

The healthcare manager works in an environment of continuing, multiple and critical time demands. It is such a hectic and immediate environment that it is often difficult to take the long view and to reflect on where the manager's organization needs to go. Summaries of two recent articles and a new book are offered here to provoke thought about improving health care organizations and systems, provide a context for understanding managers' challenges, and possibly facilitate identification of some effective strategies for VA managers.

Reviving Staff Spirit: A Key to Impressive Service

Scott G. *Journal of Health Care Management* 2001; 46: 293-295.

In this article, Gail Scott focuses on improving customer service. Staff who take ownership of the organization's current status and buy into the organization's missions and values will be actively engaged, resulting in a better focus on the customer's needs. She identifies eight strategies especially relevant during a time of worker shortage:

- **Raise the bar:** Rather than easing expectations when demands are high the manager should consider that employees may want to work in an environment where there is an expectation that they will do their best. With this comes "pride, professionalism, positive morale, commitment, and unity."
- **Eliminate roadblocks:** Employees will do their work better without extra obstacles. Scott suggests focusing on a few issues (i.e. turnaround time in support areas), using rapid-cycle response techniques, and pressing for results.
- **Empower staff:** Managers should clarify the goals and ground rules and then step out of the way so that staff can become more involved in providing quality service.
- **Create a learning environment:** Staff realize that in addition to a paycheck they will also have the opportunity to "develop their potential and learn new skills."

- **Focus on teamwork:** Although teamwork is often implicit in the work people do, teams need to know about the work that others do. Create opportunities for frontline staff to be more knowledgeable about the multiple aspects of the organization. "Job shadowing and interdepartmental dialogs" lead staff to identify what they need from other departments to ensure goal achievement. Managers may need assistance to learn how to do this and may benefit from educational and supportive forums.
- **Flexible environment:** Employees have a variety of scheduling needs, thus a one-size-fits-all model may not work in today's intergenerational, multicultural work environment.
- **Encourage balance:** A better balance may lessen the effects of stress on staff morale. Employees may fear the negative impact that work stress will have on their health and personal lives. Managers can help staff prioritize and set balanced goals and limits for each workday, and encourage discussion of non-work-related activities and interests.
- **Celebrate:** Recognize staff for their contributions and achievements.

Improving the Quality of Health Care: Who Will Lead?

Becker E, Chassin M. *Health Affairs* 2001; 20: 164-179.

In this article, Elise Becker and Mark Chassin identify three types of quality problems often seen in healthcare organizations: 1) underuse: patients do not get beneficial health services; 2) overuse: patients undergo treatment or procedures from which they will not benefit; and 3) misuse: patients receive appropriate medical care but it is provided badly. The reasons for each problem vary depending on which one it is. Overuse is often the result of a fee-for-service payment system, physicians' beliefs that their services and procedures are of value to their patients, and American patients' stance as activists who expect their doctors to do something about their com-

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plaints. Underuse occurs as a result of financial barriers (i.e. lack of insurance), patients' distrust of the healthcare system, healthcare providers' difficulties in acquiring and retaining the information needed to order appropriate services, and a poorly organized and uncoordinated health care delivery system. Misuse occurs when "competent professionals make mistakes and the systems in which they practice fail to prevent those mistakes from causing harm," or because there are "poor providers."

The authors identify several obstacles to improving healthcare quality:

- The use of treatment guidelines and associated quality improvement activities are widely promoted for use in the healthcare system; however these are expensive activities, guidelines and measurement tools are not readily available, and "there are no clear role models of exemplary delivery systems to emulate."
- It is often difficult to justify the substantial expenditures for system-wide quality improvement.
- There is a lack of demand for improvement: purchasers of health care insurance are focused primarily on low costs, and consumers want freedom of choice and unhindered access to providers and services.
- The production of health care is a local matter: the strength that could come from a national movement does not exist.

These barriers to quality improvement indicate that leadership is necessary. The authors suggest that healthcare providers, having lost their once unchallenged control over the delivery of healthcare, could reclaim a leadership role as they "already have as their primary mission the obligation to provide health care of the highest quality." We are fortunate in VA to have a strong quality improvement infrastructure and a growing

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patient safety infrastructure across our national system to tackle these obstacles.

Becker and Chassin suggest that it is possible for hospitals, medical practices and integrated delivery systems to "implement a strategy that first targets quality improvement priorities" that would improve the financial status of the institution. With this type of success, the quality improvement programs could then extend to projects neutral in respect to fiscal costs, and finally extend to projects that even though they may increase cost would increase quality. The results of a comprehensive quality improvement program could include: a reduced risk of malpractice, increased leverage when negotiating contracts with other entities (i.e. academic medical centers), and increased numbers of consumers asking for a higher priority on quality. The article concludes with a description of several examples of system improvement.

Oxymorons: The Myth of a U.S. Health Care System

Kleinke JD. San Francisco: Jossey Bass, 2001.

A new book, released in October, focuses on the impact of the managed care model on the quality of health care provided to the insured population. With 40 cents of the health care dollar being used by insurers and providers "in an administrative grudge-match over the other 60 cents" the author notes that "we get nothing except more confusion, more chaos, more micro-process, and less medical care." Although a supporter of market driven reform since the 1990's, Kleinke describes how the U.S. health care system is failing because it does not represent a real marketplace. Rather than just the patient and the provider buying and selling services in the marketplace, there are multiple parties in-between, including the consumer's employer and management organizations focused on helping providers handle the details of managed care. He describes how:

"Each party has its own economic agenda and administrative process, and each is ultimately in conflict with all the others over the same medical dollar. The result is not a fluid, responsive marketplace, but an ever-expanding Tower of Babel of paperwork and rules that even the most tenacious patient often cannot navigate."

Kleinke identifies several "guideposts" that the marketplace can be expected to fix as well as some broad regulatory solutions for aspects that the marketplace cannot fix.

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