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# Continuous Quality Improvement

## A Means to Enhance and Coordinate Cancer Care

by E. Strode Weaver, M.H.S.A., M.B.A., and Barbara Young, M.A.

The Board of Directors at MultiCare Health System in Tacoma, Wash., dedicated funds in 1991 to underwrite a demonstration project designed to promote the learning and application of continuous quality improvement (CQI) methodology and tools. The primary goal of the initiative, called the Quality Demonstration Project, was to achieve measurable improvements in clinical outcomes and customer service. Secondary goals included increased systems efficiency and reduced costs as by-products of the development and implementation of the process.

MultiCare distributed the funds to component hospitals after conducting an extensive review of applications submitted by interested departments at Tacoma General and Mary Bridge Children's Hospitals. Emphasis was placed on multidisciplinary, interdepartmental proposals that addressed key clinical and service priorities. Once selected, allocated dollars to underwrite the implementation of proposal-specific CQI project teams became available in the third quarter of 1992 for use throughout 1993.

MultiCare Regional Cancer Center began conducting focus groups in 1991 with cancer patients, community members, physicians, and other care givers to identify opportunities to enhance care delivery. What emerged from the focus groups was anecdotal evidence underscoring a need to improve coordination of care for cancer patients across a spectrum of services ranging from the physician office setting and the hospital inpatient unit to home health services. Specifically, focus group participants identified the following as key issues of concern:

- the absence of any standardized medical/therapy data accompanying patients from service to service
- excellent service at the individual unit level overshadowed by patients' perception of an "awkward" and "confusing" overall transfer process from one service to another
- incomplete patient information including clinical status and therapy orders necessitating multiple phone calls among staff members.

With these findings in mind, staff at the cancer center and its home health component, Associated Health Services, organized a work group that created a proposal for funding of the Quality Demonstration Project entitled "The Cancer Care Quality Improvement Project." The main premise of the proposal was that dissatisfaction with the transfer process could only be eliminated by improving the process itself. Given this, the primary customer groups were identified as cancer patients, physicians, and MultiCare Cancer Center care providers.

### OBJECTIVES AND STANDARDS

The Cancer Care Quality Improvement Project was comprised of two separate multidisciplinary teams. The project team included primarily front-line service providers representing the MultiCare Regional Cancer Center, the affiliated medical oncology physician practice, two Tacoma General Hospital nursing units, and Associated Health Services. The team was responsible for identifying problem areas and then developing solutions

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to those problems. Their work was overseen by a guidance team, whose membership included department managers and cancer center administrative staff.

The team's task was to meticulously document and improve the administrative steps required to register and transfer patients from targeted Tacoma General inpatient nursing units to home health services provided by Associated Health. The anticipated benefit for patients was a more "seamless" transition when moving from service to service. Similarly, the benefit to staff was expected to be decreased variation in the type and amount of vital patient information transferred between services, resulting in increased operating efficiency and, hence, more time for direct patient care.

To achieve these goals, the team developed the following specific objectives and achievement standards:

- to establish a mechanism for obtaining baseline patient satisfaction data regarding the transfer process that would be used to identify additional opportunities for process improvement
- to increase selected internal and external satisfaction with the transfer process as measured by achievement of a score 4.0 (on a scale of 1 to 5)
- to contribute to increased customer satisfaction through the use of an improved transfer form and process (as measured by a 95 percent transfer form completion rate and average transfer form completion time of 15 minutes or less).

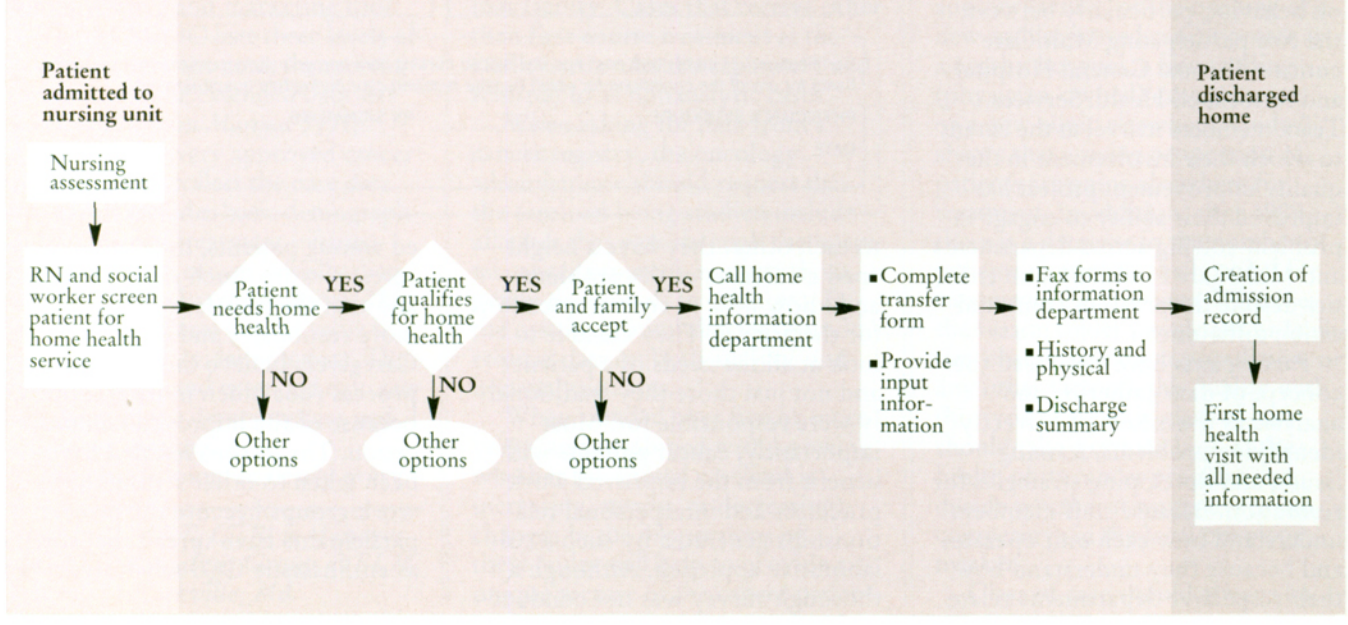
## VALUES AND BENEFITS

Over a 12-month period, the project team developed a detailed process flow chart (Figure 1) and a satisfaction survey instrument, along with baseline and end-point data related to form completion rates, average completion time, and satisfaction with the process. Much to the team's surprise, the flow-charting exercise validated the original transfer process of moving patients and patient data from one source to another. What they discovered were areas in need of improvement, including 1) the amount and type of patient data to be transferred, 2) the actual means of conveying data from inpatient units to the home health agency, and 3) the transfer form itself. This revelation led to the development of a standardized data set and a revised universal data transfer form (see Exhibit 1), along with a system of faxing information from nursing unit discharge to the intake department at Associated Health Services. The revised data transfer form can be used by all units at every stage of the transfer process, thus eliminating the redundancy in medical, personal, and demographic questions that were common in the old forms. The team also revised procedural guidelines that were piloted in the participating proposal units and eventually implemented system-wide.

Participants learned the value of setting objectives and engaging in scientific data collection. Gathering baseline and end-point data enabled the project team members to validate their efforts, to measure their progress, and to take pride in their collective achievement of enhanced service outcomes. They knew they were making a difference because the data showed a more than 120 percent increase in form completion rates and a nearly 25 percent decrease in average form completion time, from 16.5 minutes in October 1992 to 12.4 minutes in November 1993. Both of these findings were indicative of new operating efficiencies that could translate into increased direct patient care time. Satisfaction with the process also improved dramatically, from a 2.6 rating out of 5 in October 1992 to 4.0 in November 1993.

Perhaps the most significant long-term benefits of the project were the interpersonal lessons that were learned. Health care workers are often so focused on tasks they do not understand the linkages between each others' responsibilities and, thus, are unable to see the entire picture of an individual patient's treatment, which can include such diverse areas as nutrition, I.V. therapy, or psychosocial needs. However, at MultiCare, interdepartmental communication has been enhanced because project

**Figure 1. Patient transfer from hospital to home health service**



team members act as liaisons between units. Prior to this change, caregivers were reluctant to cross lines into each others' territories because they did not understand one another's responsibilities. Now, if a problem or question arises team members are available to help facilitate a resolution.

Because they are now familiar with each others' duties, caregivers are able to predict what needs will arise at each stage of the transfer process and help prepare for those needs. For instance, caregivers at the inpatient level now understand what happens during a patient's first visit with a home health care specialist and thus, are able to better prepare the patient for that visit and provide the home health caregiver with the appropriate information. Once the decision has been made to transfer the patient to home health care, the inpatient unit initiates paperwork and immediately faxes it to the home health agency. Authorizations for such treatment are then obtained from both the physician and the insurance carrier. If the patient declines home health service, caregivers must then communicate with the attending physician and decide the proper course of outpatient treatment. The improvement project has helped caregivers judge the probability of a transfer, which in turn can help eliminate unnecessary work and prevent the awkwardness that may accompany an unwanted transfer.

## CHANGING BEHAVIORS

The knowledge gained from the project has had a significant impact on behavior, particularly between the two participating MultiCare entities: Tacoma General Hospital and Associated Health Services. Team members marvel at the extent to which their involvement in the quality improvement project has improved their ability to engage in problem-solving across departments and MultiCare Health System entities despite the previous communication difficulties.

Participants have embraced the concept of data gathering and analysis as the means of correctly identifying problems, framing issues, and developing strategies for resolution. Because staff members understand how each unit operates and because they understand how their respective departments relate to each other, they have a heightened awareness of the problems and know how to answer questions for themselves. They are able to look at all the needs of a patient and not just those they traditionally were responsible for. Most importantly, cancer patients will benefit from the improved work processes and interpersonal relationships generated by such a collaborative approach. Although a thorough survey was not conducted among patients, most have said caregivers are much more informed and that the transfer process is more responsive and orderly. Caregivers believe the transfer process runs much more smoothly because of the improved communication. The lessons learned have been taken to other settings and work groups because the project participants have spread the word as enthusiastic CQI advocates. ■

## Exhibit 1

PILOT STUDY FORM (Revised 10/13/93)

**MULTICARE** FOR HOME HEALTH AGENCY TRANSFERS

**PATIENT TRANSFER FORM**

Patient's Name (Last, First, MI)

Address

City State Zip Telephone

Date of Birth Age Sex

Marital Status: S M W D Sep

Relative/Guardian (specify relationship)

Last First Relationship

Address Telephone

ATTENDING PHYSICIAN:

OTHER PHYSICIANS:

DIAGNOSIS:

ALLERGIES:

HT WT

NURSING DISCHARGE ASSESSMENT

MENTAL STATUS:

CARDIAC/CIRCULATORY:

RESPIRATORY:

GU (including caths):

GI/NUTRITION:

SKIN:

VENOUS ACCESS DEVICE:

SUPPLIES SENT:

FACILITY TRANSFER:

From To

Adm. Date Discharge Date

PHYSICIAN ORDER

Diet:

Activity:

Lab Tests:

Medications:

SERVICES ORDERED
(please check)

__ R.N.

P.T.

__ O.T.

SPEECH THERAPY

__ M.S.W.

HOME HEALTH AIDE

__ OTHER

Certification: ❑ I certify that post hospital skilled nursing care is medically necessary on a continuing basis for any of the conditions for which he/she received care during this hospitalization.

PHYSICIAN'S SIGNATURE RN SIGNATURE

DATE