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| PUBLIC REPORTING; EFFECTS ON HEALTHCARE CULTURE |
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Medical Informatics 481

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**Part 1: Background**

Project Introduction and study methodology

 CMS and other government agencies have recognized the negative impact medical errors have created to quality of care and overall healthcare costs. Increasing public awareness of these concerns has forced the hand of government agencies to implement public reporting of specific quality measures, which subsequently affect revenue streams and reimbursement. Additionally, powerful quality organizations such as Thomson Reuters aggregate data on specific parameters, subsequently recognizing top performing hospitals for their exceptional quality standards.

 With the evolution and continuous changes to address safety and quality in health care and now with focus on Health Care reform, we would like to evaluate the impact of public reporting and 100 Top Hospital awards/ recognitions on the culture of an organization. Do hospital leaders care or not care, how does public information affect culture and change and what are they doing to become a recognized leader in quality and safety from a cultural perspective.

 Our project focuses on one hospital belonging to a multi-hospital system. Our method of information gathering was interviewing key individuals to gain insight regarding the cultural impact of public reporting specifically involving reports that rate and award hospitals and systems. In addition, an interview with Thomson Reuters was conducted to gain understanding of data outcomes and what the information means in relation to current organizational culture, leadership, and change.

Organizations Background

The hospital we evaluated belongs to one of the largest teaching health systems in the state of Indiana. It belongs to a catholic health system founded in 1914 currently consisting of three Main hospitals and a network of 12 growing hospital campuses expanding beyond Indiana into Illinois. This project was conducted with the main hospital in the system, which houses 231 licensed beds accommodating over 10,000 admissions and 40,000 emergency visits per year. The hospital was founded in 1914 based on the philosophy of meeting humans’ needs through a holistic approach. This remains the guiding principle of the organization as they continue to grow. Being a recognized leader in clinical quality, they have won HealthGrades Distinguished Hospital Award for Clinical Excellence™ three years running and ranked among the top five percent of hospitals nationally for overall clinical performance by Thomson Reuters in 2008 and 2009. As we begin to understand the cultural transitions this organization has experienced while achieving their current state of success, it is important to gain a sense of the current mission and vision. Below is the current mission and vision guiding operations:

**“Our Mission**: To continue Christ's ministry in our Franciscan tradition.”

“Our Vision Statement: St. Francis Medical Group strives to be Indiana's premier

 Multispecialty group, recognized for patient-centered service, high quality, cost-

effective care and excellence in teamwork.”

It is also critical to note that the physicians are also expected to practice under the guiding principles of Respect for Life, Fidelity to the Mission, Compassionate Concern, Joyful Service, and Christian Stewardship.

Background on the change

 Healthcare took center stage in the public eye due to the growing expense of care and insurance, and the concern for quality and safety. Through extensive growth of the internet and public reporting of healthcare data, the public has the ability to shop for healthcare.

 An important aspect to the culture within healthcare organizations today is the effect of outside influence from companies such as Thomson Reuters. An interview with Jean Chenoweth provided insight on the history behind programs and awards related to 100 Top Hospitals. The first 100 Top studies were originally published in the Wall Street Journal but shortly after publication, Modern Healthcare took a strong interest at obtaining the information. After the publication, what is now known as Thomson Reuters (previously HCIA) held an award luncheon to acknowledge hospitals selected as leaders in healthcare quality. The luncheon represented reward from an external source while winning organizations offered internal reward including private jet trips to the awards lunch and financial reward in the form of bonuses. Reward represented success to the organization but also confirmed the importance of nonbiased organizations in determining top health care hospitals, healthcare systems and those providing top care in cardiovascular care.

 Jean Chenoweth, Senior Vice President of Clinical Improvement and 100 Top Hospitals of Thomson Reuters shared the evolution of the 100 Top Hospital program and recognition sought by hospitals. Ms. Chenoweth provided initial insight on cultural expectations that we could anticipate at the hospital we choose based on publically reported data for this facility.

Ms. Chenoweth explained there are two types of hospitals: first time winners and frequent winners. Characteristics of first time winners have demonstrated the desire to build and solidify a culture of quality. Ms. Chenoweth was quick to point out, however, “first time winners are at high risk” because they can take on the “we did it” attitude, which can lead to a break in momentum causing them to slip backwards. Frequent winners are found to have executives that understand change and how to drive change through their organizations. Ms. Chenoweth was quick to point out that these characteristics are those you would find in an organization with effective communication, well developed culture, and is innovative in finding ways of continuous improvement.

 These insights led to the question: What additional findings has Thomson Reuters been able to identify over the years that have a direct affect or influence to culture within organizations? Ms. Chenoweth stated, “Catholic organizations have become frequent winners of the 100 top awards, which we believe is because quality is built into the mission.” Crain’s Detroit Business published an interview with Ms. Chenoweth shortly after our interview in which she stated, “Our data suggests that the leadership of health systems owned by churches may be the most active in aligning quality goals and monitoring achievement of mission across the system.” The data also demonstrates not for profit organizations typically rate higher than for profit hospitals with government hospitals lagging behind. When asked her perspective she felt that government organizations had management challenges to overcome due to the political climate. It is not clear why the differences between profit and non-profit. The article indicates additional studies are necessary to determine differences and affect on the future of these systems. Finally, Ms Chenoweth provided some insight into what to expect in the future. It was pointed out that although COO’s want to make a difference, there has been resistance over the years and it can take a full generation before we see a complete cycle in healthcare. This is believed to be evolving as curriculum at college and universities offer specialized courses.

 The final question posed to Ms Chenoweth was to determine if she could share new developments that will further affect culture within healthcare. This question led to a presentation demonstrating the quadrants utilized in presenting specific data to hospital leadership. All the data is placed on detailed graphs divided into four quadrants. Each quadrant offers insight to the organizational strengths and weaknesses. It guides them in realigning their mission, vision, and organizational goals with the objective of having all measures in the upper right quadrant. The data points in the right upper quadrant (see Appendix D) demonstrates leaderships cohesive front and success driving change resulting in improved quality and safety to patients.

**Part 2: The Study**

 As we embarked on our endeavor to discover the impact publicly reported quality data and awards have on organizational culture, we conducted interviews of key leaders within the selected organization. Given the objective of seeking to obtain the impact public accessibility of quality data had on organizational cultural, we focused our attention to interviews with leaders in roles that truly have the ability to provide such direction. In this regard, our interviews encompassed the following leadership roles: 1.) President & Chief Executive Officer; 2.) Senior Vice President and Chief Operating Officer; 3.) Vice President of Medical Affairs; and, 4.) Director of Standards Compliance & Patient Safety Officer.

 Beginning this endeavor, we began the interviews with the preconceived notion that such public reporting of quality data would be of grave concern due to its potential influence to the public’s selection of an institution for their healthcare needs. However, as we began the interviews, we were quite shocked to discover universally amongst the leadership structure, this simply was not the case. Engaging a consultant to elicit public opinion via surveys, the CEO sought to determine the public’s response and utilization of public reported quality data and its subsequent impact in determining whether they would or would not use his organization in seeking healthcare. Through these surveys, the president was able to determine a lack of knowledge or interest in such data in selecting their institution of choice for healthcare services. Consequently, he made little if any effort toward cultural adjustments simply based on the public accessibility of defined quality data. However, a greater concern surrounded the impending reimbursement structures, which will soon encompass the ability of the institution to maintain or maximize their financial stability. In noting the financial impact poor quality will bring to the institution, the leadership team has devoted time and attention to insuring the highest quality standards, driven by their unwavering devotion to the financial performance of the organization.

 During the interviews, it equally became apparent from all those interviewed that a primary driving force behind their focus and subsequently, the organizations direction and cultural identity surrounded the faith-based mission and values to which they adhere. This became apparent as the interviews progressed and the focus moved toward quality. From the CEO and COO down the ladder of our defined leaders, they equally stressed the role that the faith-based mission and values had toward defining organizational identity and quality. As the Director of Standards Compliance & Patient Safety stated: “Based on our guiding principles of faith, the respect for life, the mission to continue Christ’s ministry in our Franciscan tradition, and the nested organization vision, the expectation of high quality patient care is inevitable”. This feeling was prevalent throughout the leadership structure, each indicting a core perception that the faith-based mission and vision was fundamental to the high quality standards and recognition the organization had received. With the Sisters driving attention to the value of faith-based mission through monthly educational emails and their continued presence on the corporate board, they remain an influential driving force defining organizational direction and purpose, indirectly driving quality through their devotion to mission. This was a point mentioned by all those interviewed surrounding the quality recognition, which the institution has obtained from organizations such as Thompson-Reuters and Healthgrades to name a few.

**Direct Impact:**

As noted above, the public accessibility of neither quality data nor recognition for high quality standards was the primary concern of the leadership team based on the public’s lack of attention to this information; however, they are granularly focused on these very same quality parameters based on their impending implications to reimbursement and financial stability. During our interview of the Senior Vice President & Chief Operating Officer, as we began exploring the implications of public accessible quality data, we were shocked to discover his overall lack of concern surrounding publically reported data. We believed there would inherently be concerns associated with the driving force this would have determining whether patients would or would not use their institution for healthcare needs. Stating, “I don’t believe that reporting of information to the public has changed the culture of the organization in a significant way. However, I believe the recently passed healthcare reform bill that will change our financing system of paying for volume to paying for value will have a significant impact on our culture”, he clearly discounted the public’s perception as a factor for concern. Inversely, the concerns were squarely focused on financial implications associated with reimbursement. In this regard, the President & Chief Executive Officer validated this sentiment when he stated “We are spending much more time focused on achieving quality and satisfaction metrics today, in large part because the federal government is going to tie future payments to the achievement of these metrics which, not coincidentally, are consistent with the publicly reported data”. Further expounding on this topic, the Senior Vice President & Chief Operating Officer continued by stating “In a survey St. Francis recently conducted, a significant majority of consumers do not rely on public websites or hospital awards to choose their healthcare resource so these accolades are not key business drivers today”. As we progressed through the various interviews, it quickly became apparent that our preconceived notions were incorrect, thus the public accessibility of quality data was of little significance when it came to driving organizational culture.

 Focusing our attention to the other end of the spectrum, the institution has received numerous awards from quality driven institutions such as Thompson-Reuters and Healthgrades for their achievement of exceptional quality standards but again, leadership sees little value or driving force behind this acknowledgement. During my interview with the President & Chief Executive Officer, he supported this concept through his statement “I do not believe that awards are value adds to the organization. Having said that, it is always nice to be recognized for a job well done and we are very appreciative of recognition that comes our way.” Again, this came as a great surprise to us, believing that such accolades would surely provide a positive influence to the leadership team and clinicians as they sought to highlight their value-driven care surrounding quality. Based on our discussion with the core leadership team, they universally failed to acknowledge any value added from such recognition. However, although verbally making these statements, we could not help but notice a large banner hanging outside the organization proclaiming to the public their recently awarded 100 Top Hospitals recognition by Thomson Reuters. Thus, although leadership fails to acknowledge the influence to culture this award brings, it clearly had an impact on their actions in regards to highlighting their accomplishments. Furthermore, leadership captured the value of this recognition with their staff through congratulatory banners and signs praising their staff for “their” accomplishment. Here again, the leadership used this national recognition as leverage in enhancing the staff’s feelings of ownership and pride in their work. In eliciting these feelings within the staff, they captured their sense of pride, made them feel good about their work and work efforts, and perpetuated the desire to continue to perform at a high level, structural motivation at its finest!

**Indirect Impact:**

 Coming to the realization that public access and perception of quality data lacked leverage against organizational culture, we quickly came to recognize the indirect impact to leadership and their cultural transformation that quality data had as it related to reimbursement and financial impact. As we noted above, the reporting of defined quality parameters on public accessible websites for their review and scrutiny was of little concern to the leadership given the little value the public itself pays to this information in selecting an institution for their healthcare. We found their driving force behind cultural development did not reside with public accessibility of data, but with the impending reimbursement structures associated with governmental payments. Encompassing approximately 50% of institutions revenue stream, pending governmental payment structures associated with quality measures is of great concern, especially given third party payers willingness to follow the guidelines outlined by the governmental regulations. Consequently, we find the financial impacts surrounding these quality markers on reimbursement the driving force behind leadership’s attention and subsequent modification to organizational culture. In this regard, the leadership team focuses a great deal of time and attention in defining and driving culture to meet the defined quality parameters. Highlighting this focus, the Senior Vice President & Chief Operating Officer stated, “When we do not receive a 5-star rating from Healthgrades, our Quality department takes a deep dive into the data to determine where we fell short of 5-star performance and puts appropriate corrective actions in place to facilitate improvement.” Clearly, they are vested in meeting or exceeding the quality matrix for success.

 Setting the expectations for quality, leadership extends their efforts through utilization of consultants and institutional benchmarks in establishing guidelines and markers defining levels of performance. Responsibility and accountability is established with the management structure to obtain or exceed these markers. Detailed action plans and defined time parameters are required for any performance below these set levels subsequently leading to defined periods whereby compliance must be obtained or repercussions will ensue. The principle of structural motivation comes into play-staff recognition for success while establishing well-defined accountability and responsibility structures in outlining expected performance.

 During the course of the interview, the influence of governmental standards on leadership direction was apparent. This directly correlates to the information noted above, the driving forces behind newly defined reimbursement structures associated with quality data, a key force behind organizational financial performance. In attempting to meet these demands, leadership has expanded its quality associated leadership team and staff, setting expectations for them to define processes and patient care standards, which will meet or exceed expected quality standards. Utilizing Healthgrades five star rating as their barometer, quality staff is required to develop detailed action plans outlining steps, which will be taken to obtain five star ratings for any quality standards of which this rating is not achieved. Furthering these efforts, the institutional management team and staff are fully engaged in activating these plans, tying accomplishment to their performance reviews. Based on these principles, the institution engages in establishing yearly goals and objectives that incorporate the quality standards. With this as the foundation, staff sequentially (based on the hierarchical structure) must establish individual goals and objectives which are nested into the organization goals, thus setting a common focus of quality as a primary yearly objective. In utilizing these goals and objectives as a component of the employee’s yearly performance review and subsequent merit raise, the individual has a stake in obtaining success. This is a clear example of structural motivation. In establishing individual rewards for quality standards, the staff is highly motivated to meet or exceed their goals resulting in obtaining institutional excellence in quality.

 Having noted the key factors associated with quality data from a leadership perspective, it should be noted their peripheral concerns associated with equality of data and the ability of the public to be able to interpret the information which they have access. Although they did not dwell on this topic, they felt compelled to express concerns related to the ability of the public to understand the information they were viewing. In this regard, the Director of Standards Compliance & Patient Safety Officer expressed:

“I am concerned about the public understanding the information that is provided and being able to understand how this information impacts the quality of care they are receiving. The other concern that I have is in many arenas we are told that we must provide information at the fifth grade reading level. Some experts are saying it should be at the understanding of the third grade reading level. We have a challenge in healthcare as to how we are going to present this outcome data in an understandable way for those at the third or fifth grade reading level. There are issues of literacy and cultural diversity to also be addressed. I do not believe that in the healthcare system we are doing a good job in making healthcare information available to individuals that are non-English speaking or illiterate. I am also concerned that the healthcare public reporting process now, like Hospital Compare, is still written for those who work in the healthcare field. I do not believe that the information is easily understood by the general public who does not have a healthcare background. I do not believe that the information currently available is of much value to the healthcare consumer trying to make decisions regarding healthcare for their families.”

In this regard, the ability of the public to understand the available data streams presents challenges to the institutions who must report it. Furthermore, the Vice President of Medical Affairs voiced concern in regards to the equality of data stating, “public reporting should happen in a very responsible way to ensure that each organization’s data is comparably displayed and that it is easy enough for the consumer to understand without being so simplistic as not to accurately compare and contrast the very real differences that exist between hospital types or patient acuity.” Consequently, although the organizational leadership seems to discard the cultural impact of these concerns, they appear to be socially motivated to be favorably compared to the competitors.

**Other Impacts:**

 Finally, a clear influence on organizational culture surrounds the faith-based mission and vision in which the institution was founded. In speaking with the leadership team, it is clear that the guiding principles associated with their faith-based foundation was, without question, the driving force behind everything they do. From executive board direction through departmental decisions, the mission and vision supersedes all other components of the decision matrix when mapping out and defining business process and patient care. This became evident as each member of the leadership team interviewed mentioned, in some form or fashion, the influence the faith-based mission and vision had on corporate direction and institutional decision-making. From the CEO’s comments related to “fidelity to mission” to the Vice President of Medical Affairs comment related to “pillars of faith-based decision parameters,” they all noted the value and affect these guiding principles provided. Such guiding influence is based on sound principles, setting a strong foundation for evaluating institutional direction. Here we truly find the principle of reciprocity: Faith-based principles are grounded in essence on the principles of reciprocity – do onto others as you would want them to do unto you. Another perspective is self-sacrifice for the greater good of humankind. In using faith as a guiding principle, it establishes the concept of dignity for life and respect for humankind, putting the focus on the individual and efforts toward enhancement of his well-being on all levels. This keeps them grounded on the needs of the patient and limits leadership’s ability to define decisions strictly based on business principles.

**Recommendations:**

 As we moved through the interview process and began to analyze the impact of public reporting of quality data and recognition it might bring to organizational culture, a few observations and recommendations were noted. During the interview process, as the discussion migrated toward quality data and its impact to culture, it became apparent that the leadership team did not have a full understanding of the existing culture within the organization. In this regard, lacking the knowledge from which the organizational perspective is driven, it is difficult for them to influence and change direction and focus. In order to move the organization toward a fundamental focus of quality, those responsible for driving the change must understand the current perspective and driving force motivating their employees. Working from this perspective, the leadership team would be empowered to leverage their efforts against this defined culture in moving it to one of defined quality standards. Reflecting back on Ms. Chenoweth’s statements, they should yield caution in taking the “we did it” attitude or risk setbacks. Lack of understanding the culture will result in added difficulty in the ability to determine appropriate action plans to drive change resulting in failure.

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APPENDIX A

Interview Questions:

1. Could you confirm you current job title and your role within the organization?
2. Could you provide a brief background about your history in becoming position title. For example: were you an employee that has worked their way up through promotion or were you brought into the organization in your current role?
3. If you were hired into the organization in your current role were there any specific issues concerns that you were to address? If so, did any of the changes that you were charged with have an impact on culture change within the organization?
4. As healthcare has come to the forefront of concerns along more informed consumers with increased access to the internet, what concerns do you have about public reporting of information regarding you organizations performance?
5. Do you ever or have you ever used the public websites to review your organizations information or a competitors information? If so, what information do you find most useful? What is least useful?
6. As public reporting as evolved so has awards such as those for 100 top hospitals, top systems and cardiac hospitals. Do you view these types of awards and recognitions as having added value to your organization?
7. Have you ever won an award?
8. Have you used the results of the studies to influence decisions at your organization? If so, could you provide an example?
9. How do these decisions impact the culture of the organization or any changes that occur that are specific to the public information?
10. Would you feel comfortable allowing me to use your name when quoting any responses provided during this interview?
11. Would you prefer your organization be blinded or is it acceptable to use the organization name?
12. If we have any follow-up questions would you be available and if so what is the best way to contact you?

Please note, these were the basic questions but were adapted based on the interviewee and direction of the interview.

APPENDIX B

Interviews:

President & Chief Executive Officer: Hired into the organization as the Executive Vice President & Chief Operating Officer in 1990 having previous experience with the then current CEO at another healthcare entity on the east coast, thus having an established work ethic founded on healthcare business principles. Although he was not hired to address specific issues at the time, his astute business acumen related to healthcare was viewed as beneficial based on the perceived challenges healthcare would soon face. He was promoted to his current role in 1999 when the CEO at that time was promoted to the position of corporate president.

Executive Vice President & Chief Operating Officer: Hired into the organization in 1993 as Manager of Finance. In 1997, was promoted to Director of Financial Planning and Business Development and CFO of the Medical Group, a division of the organization related to the management of purchased physician practices. In 1999, took on the role of interim President of the Medical Group. Left the organization in 2000 to work in a consulting role for Price Waterhouse but came back in 2002 as Executive Director (administrator) of one of the facilities campuses and was promoted to current role in April 2006. He too was known for his astute business acumen in the arena of healthcare.

Vice President of Medical Affairs: Hired into the organization as the Director of Residency Program in 1992 having previous experience serving in that role at another healthcare institution. He was promoted to current position three weeks ago due to the retirement of the previous VPMA. He is known for his progressive nature and knowledge of healthcare technology.

Director of Standards Compliance & Patient Safety Officer: Hired into the organization in 1988 as the Diabetes Coordinator. Transitioned to the quality and control department in 1990, assimilating to Manager and eventually current position of Director. Has obtained advanced training in quality. She participates in many national quality organizations and nationally recognized for her work in quality initiatives. Additionally, she currently serves in a corporate leadership role surrounding our quality structure and initiatives.

Senior Vice President of Clinical Improvement and 100 Top Hospitals: Acquired through acquisition of several companies over the past 17 years. She is innovative and has deep knowledge of hospital quality and safety striving assist hospital identifying areas requiring improvement. She travels nationally to hospitals presenting outcomes of their own facilities as well compares to benchmark and peers. Additionally, she shares with them the implications of the data on leadership and culture within the organization.

APPENDIX C

Participating Institutions: Thomson Reuters

 Hospital (Blind Study)

APPENDIX D

