

## **The Business Case for Quality: Case Studies and an Analysis**

Sheila Leatherman, Donald Berwick, Debra Iles, Lawrence S. Lewin, Frank Davidoff, Thomas Nolan, Maureen Bisognano

The financial implications of implementing quality improvements are often poorly understood. Simply put, does improving quality yield a return on investment? We examine four cases—management of high-cost pharmaceuticals, diabetes management, smoking cessation, and wellness programs in the workplace—to understand the financial and clinical implications of improving care. We explore costs and benefits, in both the short and the long term, to four stakeholders with different and sometimes conflicting interests: providers, purchasers and employers, individual patients and society. Finally, we recommend policy changes to better align financial incentives for superior quality of care.

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## **Employers' Efforts to Measure and Improve Hospital Quality: Determinants of Success**

Ateev Mehrotra, Thomas Dudley

We examined 11 communities in which an employer coalition created a report card to compare the performance of the community's hospitals. After interviewing employer coalition and hospital representatives from each community, we found great variability in report cards' capacity to prompt quality improvement. Although some were successful, others had less impact because of conflicts between employer coalitions and hospitals. Areas of disagreement included selection of appropriate goals, methodology of quality measurement, whether report cards should be publicly released and the use of economic incentives to improve quality. We describe these conflicts and offer recommendations for future hospital report cards.

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## **Hospital Disclosure Practices: Results Of A National Survey**

Rae M. Lamb, David M. Studdert, Richard M.J. Bohmer, Donald M. Berwick, Troyen A. Brennan

New patient safety standards from JCAHO that require hospi-

tals to disclose to patients all unexpected outcomes of care took effect July 1, 2001. In an early 2002 survey of risk managers at a nationally representative sample of hospitals, the vast majority reported that their hospital's practice was to disclose harm at least some of the time, although only one-third of hospitals actually had board-approved policies in place. More than half of respondents reported that they would always disclose a death or serious injury, but when presented with actual clinical scenarios, respondents were much less likely to disclose preventable harms than to disclose nonpreventable harms of comparable severity. Reluctance to disclose preventable harms was twice as likely to occur at hospitals having major concerns about the malpractice implications of disclosure.

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## **The Paradoxical Impact of Health Care Restructuring in Canada on Nursing as a Profession**

Alena Heitlinger

This article draws on the concept of "countervailing powers" to explore some of the contradictory effects of Canadian healthcare restructuring on nursing. The main focus is on key institutional powers in the nursing field, the major individual and collective strategies nurses have adopted in response to restructuring and the ways in which the interaction between global and national market forces and the aggregate responses of nurses has created a severe shortage of nurses. The global shortage has led to a global competition for nurses' labour. This, along with government budget surpluses, has increased nurses' bargaining power, forcing governments and hospital managers to reverse nursing spending cuts; to offer more secure professional jobs, as opposed to casual work; to engage in aggressive, bonuses-laden recruitment of nurses, both within Canada and abroad; and, more generally, to rethink some of their restructuring strategies. However, since the bargaining power of nurses is largely market-dependent and, as such, highly variable, there does not seem to be much potential for a sustained increase in the institutionalized power of the nursing profession.

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[www.baywood.metapress.com/app/home/contribution.asp?wap=4h8ac83gwq7rnhrhj3y&referrer=parent&backto=issue,3,13;journal,1,129;linkingpublicationresults,1,1](http://www.baywood.metapress.com/app/home/contribution.asp?wap=4h8ac83gwq7rnhrhj3y&referrer=parent&backto=issue,3,13;journal,1,129;linkingpublicationresults,1,1)

### Survey Highlights Extent of NHS Doctor-Manager Divide

Doctors and managers differ widely in their views about the state of doctor-manager relationships in the NHS, with chief executives being the most optimistic and clinical directors the least, found a study recently reported in the *British Medical Journal*.

A total of 1,092 NHS doctors and managers responded to a survey about their views on the doctor-manager relationship. Three-quarters of chief executives rated the quality of current doctor-manager relationships as 4 or more on a scale of 1 (poor) to 5 (excellent), compared with just 37% of clinical directors. Furthermore, 78% of chief executives thought that doctor-manager relationships would improve over the next year, compared with just 28% of clinical directors.

Clinical directors often seemed to have views markedly divergent from – and much less positive than – the views held across the other three groups. For instance, they were less likely than each of the other groups to agree that

“management staff in this hospital are consistently of high quality,” that “managers are well versed in clinical activity,” and that “doctors have sufficient influence on hospital management.”

The only statement that received near-unanimous approval from clinical directors (90%) was “medical staff in this hospital are consistently of high quality.”

Clinical directors were easily the most disaffected, with many holding negative opinions about managers’ capabilities, the respective balance of power and influence between managers and clinicians, and the prospects for improved relations, say the authors.

Unless such divergence is addressed, further difficulties in delivery of the government’s ambitious agenda for modernization are likely, they conclude.

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[www.bmj.com/cgi/content/full/326/7390/626](http://www.bmj.com/cgi/content/full/326/7390/626)

## Are you a physician leader?

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### Benefits of joining

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- *physician management education* — developed in collaboration with the Canadian Medical Association’s Physician Manager Institute (PMI) to provide you with the latest management skills and information
- *online Q&A program* — colleagues from around the country can provide answers to your most challenging management questions.

### For more information contact

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