

COMING TO GRIPS WITH CHANGING CANADIAN HEALTH CARE ORGANIZATIONS: CHALLENGES FOR EVALUATION

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Abstract: Canadian health care organizations are in the midst of rapid change. Reduced federal transfer payments have necessitated radical cost containment measures, including mergers, restructuring, downsizing, and outsourcing. At the same time, health care organizations are undergoing a transition in approach to management and accreditation, from quality assurance (QA) to continuous quality improvement (CQI). This article describes that transition, examines the status quo of evaluation activities in both QA-based and CQI-based organizations, and discusses some of the opportunities and challenges facing evaluators in the health care sector.

Résumé: Les organismes canadiens de soins de santé subissent actuellement une mutation rapide. La réduction des paiements de transfert du gouvernement fédéral a entraîné des mesures radicales de restriction des coûts qui ont donné lieu à des fusions, des restructurations, des diminutions de services et à l'obligation de chercher des fonds privés. Ces organismes envisagent désormais leur gestion et leur accréditation sous l'angle de l'amélioration continue de la qualité (ACQ) et non plus de l'assurance de la qualité (AQ). Cet article décrit la transition qui est en train de se produire, examine l'activité d'évaluation telle qu'elle a lieu dans les organismes qui se basent sur l'AQ ou l'ACQ et discute quelques-unes des possibilités et des difficultés auxquelles font face les évaluateurs dans le domaine des soins de santé.

Although the Canadian and American health care systems are notably different, they have two things in common. First, cost containment measures are being applied to health care expenditures in both nations as each attempts to reduce its federal deficit. Second, both countries are undergoing a transition in the basis of their approach to managing and accrediting health care organizations, from quality assurance (QA) to continuous quality

improvement (CQI). In fact, the implementation of CQI practices in health care settings in the 1990s has followed a very similar timetable in both countries. Granted, the recognized “father” of CQI—Edward Deming—is an American. However, Deming and his fellow consultants did not initiate their CQI practices at home, but in Japanese manufacturing organizations, beginning in the 1950s. Deming and his associates claimed productivity would increase by at least 20% through improvements to the quality of the production process and a focus on the “customer” (Deming, 1986).

Today, CQI or TQM (total quality management) practices have been, or are currently being, adopted by North American manufacturing organizations and service industries ranging from the hospitality sector to the health care sector. It should be noted that TQM may be a distinct concept in the minds of consultants who market their services, but both the published literature and the purchasers of CQI/TQM for the most part use these terms interchangeably. Whether one calls the practice CQI or TQM, the challenges remain the same. One such challenge is transferring business practices to the health care sector; another is implementing CQI practices in the midst of cost reductions and organizational change.

The impetus for the present article comes, in part, from personal observations and feedback from health care professionals as I worked with them on evaluation projects and conducted workshops and in-service training on program evaluation. Although the general sentiment on the part of health administrators, managers, and clinicians is that they need to know more about program evaluation, clearly there is a great deal of confusion concerning how it differs from clinical research, from QA, and from CQI. Popular misconceptions abound. The published literature directed at health care professionals has not been of much help, other than a few articles written by evaluators back in the old QA days. In the recent health care literature on CQI, quality care, and quality indicators (e.g., Bernstein & Hilborne, 1993; Price, 1994), the terms “assessment,” “measurement,” and “evaluation” are bandied about interchangeably. A few articles have now emerged in the evaluation literature concerning the role of evaluation and evaluators in CQI organizations in general (Mark & Pines, 1995) and in CQI-based health care organizations specifically (Love, 1994). This article follows up their lead by describing the transition from QA to CQI in health care organizations, and discussing the challenges facing both evaluators entering these organizations and managers and staff working in them.

THE TRANSITION FROM QA TO CQI

Quality assurance, similar to CQI, has its roots in business and industry. QA practices were a part of health care organizations for decades, from their beginnings in departments of medicine and nursing. However, not until 1988 did facility-wide QA become a requirement for receiving the Canadian Council of Hospital Accreditation's full three-year stamp of approval (Rennebohm & O'Brien, 1989). QA can be defined as a periodic process of collecting data on program performance to determine compliance with predetermined standards. Typical QA-based accreditation activities involved reviewing policy and procedure manuals, client files, and treatment plans; examining minutes of staff meetings and staff performance reviews; interviewing key administrators; and, where available, looking at summaries from client satisfaction surveys. Getting ready to put one's best departmental foot forward for the accreditation site visits (the big "spit-and-polish" day, to use a military analogy) was often perceived by department managers and staff alike as an unwelcome obligation. Criticisms of QA included the lack of common standards and defined criteria, the fragmented nature of the reviews, the subjectivity of the process, and the "quick fix" corrective actions that resulted from the process (e.g., rewriting a staff procedure manual). The following quote from a nursing journal editorial typifies the dissatisfaction with QA in the health care system: "Our quality assurance efforts to date have had a low payoff and other than creating mountains of paper have had a minimal effect on the quality of health care" (Wylie, 1991, p. 5).

Several evaluators, also recognizing the limitations of QA, advocated addressing program effectiveness more broadly in terms of patient outcomes that are jointly influenced by a number of departments, and complementing the more process-oriented QA focus on department-specific clinical practices (e.g., Clemenhagen, 1987; Ferris et al., 1992; Rennebohm & O'Brien, 1989; Stuart, Rutman, & Staisey, 1985). All these articles sought to educate health care professionals on program evaluation. As Clemenhagen (1987, p. 3) stated, in the health care field "program evaluation is poorly understood and infrequently applied." In attempting to clarify the distinctions, authors portrayed QA as input and process oriented. In contrast, program evaluation was portrayed as the mechanism to document patient care outcomes, to learn which patients benefit most, and to explore whether there are better alternatives to achieving patient outcome objectives. None of these articles advocated doing away with QA, but rather suggested incorporating complementary evaluation

strategies—most notably summative approaches, but also needs assessment and implementation approaches. In addition, some of these articles (e.g., Rennebohm & O'Brien, 1989) stressed the need to integrate both process and outcome data into the organization's management information systems.

In the 1980s, workload measurement and management information systems (MISs) were becoming more commonplace and more advanced thanks to computer technology. Cockerill and O'Brien-Pallas (1990) describe the tremendous increase in workload measurement systems between 1978 and 1989 in North American hospitals, fueled by the encouragement, if not the mandates, of accreditation bodies. Surveying a representative sample of Canadian hospitals, these researchers found a variety of workload systems being used. It is noteworthy that most of the systems were vendor installed, versus internally developed (Cockerill & O'Brien-Pallas, 1990). Advances in computer technology heralded the means for hospital management to improve quality of service by tracking service delivery and the movement of patients (e.g., Koon & de Laat, 1993).

Two other important trends in health care have been the evolution of a multidisciplinary, team-based approach—challenging the reductionistic model within which each discipline addresses one aspect of patient care—and the increased involvement of patients in health care decisions—challenging the historic and paternalistic assumption that the health care provider knows what is best (e.g., Gage, 1994; Rada, 1986). Rada describes the evolving trend from “patient” to “client” to “customer” and the move from viewing hospitals as catering to physicians to seeing them as directly marketing health services to the public.

Thus, several trends conspired to give rise to the adoption of CQI management principles by health care organizations: dissatisfaction with outmoded, reactive QA practices for accountability; technological advances in workload measurement and information systems; and the evolution of a patient-centered, team-based approach to care. But the single most important factor that has led to the adoption of CQI may be the rising cost of health care.

THE ADOPTION OF CQI

The early manifestations of the CQI movement first became visible in North America in the 1980s with the formation of problem-solving

teams, “quality circles,” and other employee-involvement programs. Beginning in the late 1980s and early 1990s, CQI management principles were being touted as beneficial for the health care sector. For instance, the Ontario Premier’s Council on Health Strategy stated in 1991 that “the health care sector can learn a great deal from modern management science and particularly from the Japanese and American experiences in the total quality management of individuals and organizations” (p. 5). The multidisciplinary, team-based approach to care, the consumer focus, and the desire to improve quality of health care appeared to be consistent with a CQI philosophy. Lobbying by key decision makers led to the Canadian Council of Health Facilities Accreditation’s (CCHFA) developing a new, “revitalized” CQI-based set of accreditation guidelines, drafted in 1992, piloted in 1994, and implemented beginning in 1995 with the hospital sector. Other sectors of health care—chronic care, long-term care, home care, rehabilitation, mental health—are moving quickly to put CQI management practices into place.

As noted previously, the U.S. health care system is moving in a similar direction on a similar timeline (e.g., Veatch, 1994). In its premier issue, the U.S. *Joint Commission Journal on Quality Improvement* (1993, p. 221) defined organizational performance as “the way in which a health care organization carries out or accomplishes its organizational functions” from patient admission, assessment, and treatment through to discharge. Nine dimensions of organizational performance were emphasized: efficacy, effectiveness, efficiency, appropriateness, availability, timeliness, continuity, safety, and respect/caring. These dimensions are highly similar to those contained in the Canadian accreditation guidelines for health organizations.

An examination of the CCHFA (recently renamed the CCHSA, substituting the term “Services” for “Facilities”) framework reveals several key concepts: (1) the “commitment to quality” and creation of a “quality culture”; (2) a “mission, values and vision” that are shared by all members of the organization; (3) “leadership and employee empowerment/teamwork”; (4) a focus on the “customer”; and (5) ongoing evaluation, measurement of performance, and regular feedback (see CCHFA, 1993; CCHSA, 1994). In keeping with the new emphasis on generic standards for multidisciplinary patient care “groupings” (as opposed to discipline-specific standards), the CCHSA document identifies nine major groups for acute care organizations (such as “ambulatory care,” “surgical care,” and “maternal/child

care”), noting that such groupings are to be defined by each individual facility through its own reorganization (CCHFA, 1993). In the 1994 document, *evaluation* is defined as the “assessment of the degree of success in meeting the goals of the organization, organizational/unit or client/patient”; *effectiveness* as “achieving or attaining results, goals or objectives, meaning working on the right things”; and *efficiency* “refers to how well resources are brought together to achieve results, with minimal expenditures, meaning doing things right” (p. 47).

The CCHSA document also describes a “sample” site visit in which two notable changes from the old QA days are evident. One difference is that the surveyors may now wish to meet with clients/patients themselves who are at different stages of the care process (e.g., newly admitted versus soon to be discharged). The second major difference involves the surveyors’ now meeting with front-line workers and not just with administrators. Touring the facility, talking to patients and staff more informally, and then meeting with clinical care teams to see how they work together and to discuss specific “QI projects” are typical activities in the new procedures. As in the old QA days, surveyors may still choose to look at patient records and review procedure manuals; however, these activities are no longer the primary focus.

Veatch (1994) describes a very similar process taking place in the accreditation of U.S. hospitals and details some of the challenges facing both the multidisciplinary team of “surveyors” and the organizations undergoing this transition. One observation from the surveyors’ perspective was that “some would prefer we tell them exactly what to do and how to do it, but that’s not possible because every hospital is different and every organization has different resources” (p. 6). The focus for improvement, the mechanism chosen to improve care, and the method of measuring performance improvement are left up to the individual organization and their various QI teams. To illustrate the transition, Veatch described a group of hospital personnel gathered to discuss patient and family education services with a surveyor. “They’ve come armed with notebooks documenting activities [since the last accreditation visit] ... and poised to show off copies of [their] new educational brochure ... But the surveyor doesn’t want to look—he wants to talk. [He asks] if this hospital were to get into serious financial problems and needed to cut funding, how would you defend the importance of patient and family education?” (p. 1). Not surprisingly, Veatch reports that this group was caught off guard.

The organization's CEO and senior staff are undoubtedly better prepared than middle managers and front-line staff for the role they play in this new CQI-based accreditation process. As described by Veatch, the organization's leaders are expected to "drive" the organization's quality improvement initiative. Typically, the surveyors meet with these leaders early in the process, looking for a strategic plan consistent with the organization's mission and vision (CCHSA, 1994; Veatch, 1994).

Clearly, the transition to CQI-based management practices has presented a number of opportunities for consultants. Most organizations contemplating the transition begin by holding "mission/vision" workshops for their organizational leaders. Once these leaders become committed to making the transition, the next task is to disseminate the new work philosophy throughout the organization. Often consulting teams are brought in to conduct these CQI/TQM workshops and training sessions for various levels of the organization. Given the emphasis on "performance measurement," the opportunities for information systems developers and managers abound. Many health care organizations, especially hospitals, are also bringing in marketing specialists to track "market share," or number of patients from a given catchment area being attracted to their facility.

THE POTENTIAL FIT FOR EVALUATION

Are the new CQI organizations more receptive to evaluation and evaluators? Are such organizations willing and able to provide evaluation training for their personnel and to hire external evaluation consultants? This section will review the few published articles that have begun to address this topic. For instance, a recent article by Boisclair, Moynagh, and Werhar-Seebach (1994) mentions the complementary roles of auditors and evaluators in the increased accountability demands on health care institutions. Evaluation professionals are seen "as an excellent resource, providing management with crucial information... and valuable advice on criteria" (p. 285). Audit, or third-party examination, meanwhile, provides assurance to the board and others that the information reported by management is "fair and complete" (p. 285).

Arnold Love (1994) argues that during this time of transition and restructuring in health care, "internal evaluation is an ideal tool for managing change" (p. 163) and "fits well with the recent emphasis

on micromanagement and decentralized decision making” (p. 162). However, internal evaluation capability develops over time and in stages. Love describes a five-stage model moving from ad hoc evaluation (stage 1) to systematic internal evaluation (stage 2) to goal evaluation (stage 3) to effectiveness, efficiency, and strategic benefit evaluations (stages 4, 5, and 6). It is noteworthy that “consumer satisfaction” measurement is located in stage 2. Love notes that “consumer satisfaction studies also can be an important part of effectiveness evaluation (stage 4), when joined with indicators of service outcome” (p. 167). This point will be referred to below when I discuss the status quo of evaluation in health care organizations. For now, it is important to note that Love describes the ideal culture for internal evaluation as part of a “learning organization—one that uses information to guide decision and action rather than to control subordinates” (p. 170). In a receptive organizational climate, the roles of managers and internal evaluators are complementary. In fact, many organizations place evaluation functions directly under the control of senior management, according to Love.

Love does acknowledge that in a climate of diminishing resources, evaluation units may need to be created “by acquiring evaluation staff on a part-time basis from the ranks of their senior managers” (p. 171). Structural changes from centralized to decentralized management and lack of adequate funding to hire skilled evaluation staff present challenges to the enhancement of internal evaluation. Skepticism about the “real intentions” of evaluation is likely to increase in a climate of organizational restructuring that “may have resulted in terminations and lost positions” (p. 171). Internal evaluators may be negatively perceived as “number crunchers,” “hatchet men,” or “dragon ladies.”

Several of the same points are raised in an article by Mark and Pines (1995), although they do not focus specifically on health care organizations. Mark and Pines speculate that, in some ways, evaluation activities may actually be “easier” or more readily accepted in a CQI organization. For instance, the organization’s objectives, together with program activities and resources, will often be documented. Personnel will be trained in group problem-solving techniques and systems approaches such as flow charting. Staff will be given time to work on “QI” projects in addition to their normal assignments, including the development of actual or potential measures of program performance. Most importantly, quality-improvement teams will be empowered to make decisions and changes in a proactive manner. Certainly, CQI projects may provide much of the informa-

tion needed for an “evaluability assessment” and facilitate both the development of a program logic model and the planning and utilization of summative evaluation. Stakeholder analysis should also be enhanced in a CQI organization given the focus on “vendor-customer” transactions. However, this scenario assumes that the organization in question has had a “successful” or positive experience with CQI and that staff have actually experienced ownership of organizational change.

Mark and Pines also present the alternative scenario in which an evaluator is about to enter an organization that has had a negative experience with CQI or a “history of failed CQI.” CQI may “fail” because the balance of power never actually shifted away from upper-level management who were unwilling to share decision-making authority with CQI teams, or because quality-control initiatives proceeded without accompanying and rigorous field-testing. In such a climate, staff are “likely to be cynical about any kind of information-based organizational change technique, including evaluation” (p. 134).

Finally, Mark and Pines addressed the key issue of whether CQI organizations believe evaluators are necessary. In some ways, “internal, formative evaluation that is continuous may be hard to distinguish from CQI” (p. 136). “Some adherents of CQI believe that it removes the need for any other form of evaluation” (p. 137). As noted previously, the concepts “ongoing evaluation,” “measurement of performance,” and “regular feedback” are built into the new CQI-based accreditation framework for health care organizations. But that does not necessarily mean that members of health organizations understand or practice “program evaluation.”

Mark and Pines argue that the implementation of CQI itself should be subjected to evaluation to examine factors facilitating and hindering success in various organizations, rates of participation at different levels, cost (including time spent on CQI teams), effects of team decisions on organizational changes, and effects on staff attitudes and behavior. In addition, Mark and Pines argue that CQI organizations require summative evaluation, particularly those that are tax supported. Unlike the private sector, Mark and Pines note, social programs have no direct market test such as increased sales and market share to indicate effectiveness. However, as noted previously, some health care organizations are in fact currently tracking their “market share.” In any case, these evaluators acknowledge that summative evaluation is particularly challenging when

programs are continuously undergoing change, which occurs by definition in a CQI organization. Recognizing the threats to internal and external validity and helping programs “avoid premature summative evaluation” are ways in which evaluators can contribute to CQI organizations. Similar to Love (1994), Mark and Pines (1995) advocate evaluation training and support to assist staff in undertaking or participating in evaluation activities. According to both, in CQI organizations such training will necessitate explanation of how evaluation techniques and terminology are different from, but complementary to, those used in CQI.

THE MIDST OF THE REVOLUTION

Reports written by CEOs of Canadian hospitals (e.g., Hassen, 1993; Nordal, 1994) present a positive picture—at least publicly—of this early transition to CQI-based management practices, although acknowledging that some hard choices and cutbacks will need to be made. For instance, Hassen claims that TQM is even more applicable to health care delivery than to business and industry “because the practices of the majority of health care professionals are value-based on concepts of service, care and compassion for the sick and injured” (p. 63). Similarly, the CCHFA’s (1993) “revitalized” framework—“commitment to quality,” “shared vision,” “teamwork/employee empowerment,” “customer focus”—is highly positive in tone. It is possible that both the developers of these new accreditation guidelines and CEOs of health care organizations truly believe that CQI-based management can work as well in the health care sector as in the profit sector. On the other hand, with reduced transfer payments and the need for radical cost containment measures, they may feel they have no choice but to adopt a more hardline business-oriented stance if their organizations are to survive. Some critics have gone so far as to state: “make no mistake, there seems to be little doubt in anyone’s mind that cost containment, not the quality of care, is at the core of this health care revolution” (Rada, 1986, p. 276). Even the Joint Commission—a champion of improving the quality of health care—acknowledged that “improvements in performance efficiency is a popular route to containing the costs of health care” (*Joint Commission Journal on Quality Improvement*, 1993, p. 217). Nevertheless, everyone would probably agree that trying to preserve quality patient care in the face of necessary cost reductions is the ultimate mission of health care organizations today. The issue is whether CQI is the best means to achieving the desired end.

At this juncture, it may be helpful to go back to the underpinnings of CQI and look at the six major ideas put forth by Deming (1986): (1) focus on how work is done rather than outcomes, and on customer needs or satisfaction versus management or worker preferences; (2) the (CQI) process will be improved by employees working in teams, which will be autonomous or at least self-managed in ways that eliminate the need for management hierarchies of supervision; (3) improvements will come from employees' commitment to the work and to the new philosophy; (4) training, education, and self-improvement—worker-led innovation—will replace inspection, monitoring, slogans, and exhortation; (5) workers will become multiskilled through working in teams, and central goals will be elimination of waste (duplication) and zero defects; and (6) fear will be driven out of the work relationship, providing a firm basis for CQI and innovation. Deming noted that, at least initially, innovation requires expenditures. He further noted that, ideally, CQI should not be introduced in a climate of fear and uncertainty.

According to Rifkin (1995), strategies for reducing waste and cutting costs are part and parcel of the “lean production practices” embodied in the CQI/TQM approach. These strategies include flattening hierarchies (primarily removing middle-management positions), downsizing, and automation (replacing human workers with machines wherever possible), reducing the collective bargaining rights of unions, and replacing full-time positions with less costly part-time positions (eliminating costly benefit packages). The Japanese refer to CQI as *kaizen* (pronounced “ky’zen”), meaning the relentless quest for a better way, higher-quality artisanry, continuously reaching and stretching to outdo yourself and to better yesterday’s performance. As described by Rifkin, the price of sustaining the practice of *kaizen* over the long haul is a dramatic increase in worker stress and injury. The situation has become so serious in Japan manufacturing and industry that the government coined the term *karoshi* to explain the human pathology resulting from the new “lean production” philosophy (Kenney & Florida, 1993).

Despite the tenets of CQI put forward by Deming (1986), Rifkin argues that, in the private sector, corporate profits are increasing at the expense of worker morale and health. Rifkin claims that CQI is “management by coercion” (p. 182), workers are under constant scrutiny, multiskilling entails doing several jobs as co-workers are displaced, and fear of losing one’s own job has actually increased in the workplace. Can the same be said of Canadian health care organizations that have made the transition to CQI-based management practices?

The recent study by Armstrong, Armstrong, Choiniere, Myhalovshiy, and White (1996) consisting of 25 focus groups from 10 different Ontario hospitals is one of the first attempts to examine the implementation of CQI-based practices in the health care sector. Armstrong et al. report that many workers were initially enthusiastic about TQM/CQI's potential to give them a greater say in decision-making concerning how to reduce waste and enhance patient care. But, although the actual "process" of introducing TQM/CQI differed widely from hospital to hospital, many employees found the training exercises patronizing, irrelevant (to health care), and a waste of time and money. Most importantly, workers felt their years of experience were ignored, they had no choice in the matter (of taking a CQI approach or attending training sessions), the selection process for training was under management control, and there was little follow-up to the initial training process. In other words, few employees felt "empowered" or adequately trained to undergo the transition, much less committed to the process.

As CQI-based practices were implemented in their hospitals, "limited resources restricted innovation" and even the most enthusiastic supporters of CQI were "quickly disillusioned." Armstrong et al. (1996) concluded that such business practices are not readily transferable to health care, in which patients are not the same as "customers." Similar to Rifkin (1995), Armstrong et al. claim that multiskilling is simply a mechanism for reducing "downtime" and forcing workers to take on other jobs, often without adequate training. Both also describe workers as feeling "constantly on guard," pitted against each other and against management, and falsely promised that their efforts would mean the survival of their organizations and their own jobs.

Coutts (1996) used findings from the Armstrong et al. report to publish an article in the *Globe and Mail* entitled "Business theory seen as failure in hospitals." The media is known for its sensationalism, but public confidence in our health care system is probably declining as individuals read or hear reports of "soaring rates of readmission for babies after early neonatal discharge" or "growing problems of infection control in hospitals due to the lowering of cleaning standards" (see Coutts, 1996).

One only has to pick up a newspaper to be aware of the tremendous changes currently taking place in health care. Hospital closures and mergers, as well as accompanying massive staff layoffs, are happening at breakneck speed throughout Canada. Unions are fighting

for their very survival. One of the notable features of current collective bargaining rights is what is referred to as “chain bumping.” As staff with greater seniority displace those with less seniority through the system, managers have their hands full dealing with staff changes and retraining while at the same time maintaining patient care. This feature of downsizing and restructuring in health care warrants evaluation—what is the impact on patient care? On the quality of worklife of front-line staff and managers, and on the relationship between these groups? Regarding chain bumping, Armstrong et al. (1996, p. 28) argue that “soon this backlog of trained people will be exhausted, and the job will increasingly be done by those who have never been formally taught the necessary skills.” Whether or not this is true remains to be seen. However, Armstrong et al. are correct in their assertion that we frequently miss opportunities for evaluation.

When interpreting the findings of Armstrong et al. (1996), one must keep in mind that this particular study was partially funded and supported by the unions. In any case, the study represents only one perspective and a snapshot taken at one point in time. It would be very informative to conduct a similar study of managers working in these hospitals, to compare their perceptions to those of front-line workers at this early stage of the transition. Studies like those conducted by Armstrong et al. (1996) and Armstrong, Choiniere, Feldberg, and White (1994) should be also be conducted periodically to examine and become accustomed to changes in health care delivery.

Despite assertions by both Rifkin (1995) and Armstrong et al. (1996) that CQI principles and downsizing are inseparable, we lack the evaluative data to draw this conclusion. A comparative case study in which downsizing takes place in an environment in which CQI has not been seriously attempted versus one in which CQI has been successfully implemented is necessary to address this issue. Most health care professionals would probably agree that the new accreditation guidelines are better than the old QA “paper exercise.” The bottom line is the extent to which quality patient care can be maintained despite cost-cutting measures, and whether CQI can provide this information.

COMING TO GRIPS WITH THE REVOLUTION IN HEALTH CARE

CQI was developed for the manufacturing sector, and it is hardly surprising that improved and increased productivity that leads to a

greater market share is the ultimate goal of most for-profit organizations. In contrast, even though the “revitalized” guidelines for health care embody many CQI principles, they do recognize the importance of measuring “results” in terms of client outcomes and not simply service outputs. The final section of this article will discuss current measurement efforts in the health care sector, namely, client satisfaction and workload assessments, and how evaluators can assist in moving toward measurement of “performance” in terms of client outcomes.

Consumer satisfaction surveys represent the status quo when it comes to internal “evaluation” or “ongoing monitoring and feedback.” This is not surprising for several reasons: (1) it is undoubtedly the easiest way to pay lip service to the new “customer-focused,” CQI-based accreditation requirements; (2) it allows one to address at least some of the dimensions of organization performance: availability, accessibility, timeliness, continuity, and respect/caring; and (3) it is readily adaptable to each organization and service (everyone can develop their own client satisfaction questionnaire). Evaluators themselves give credibility to the use of client satisfaction surveys as a “barometer of quality” (e.g., Gorey, Chandler, & Osmun, 1996; Molnar & Stup, 1994). Fortunately, some evaluators caution that client satisfaction measures must be supplemented by evaluation of care processes and outcomes (e.g., Anderson & Brazil, 1995; Mark & Pines, 1995).

Although evaluators recognize the limitations and biases inherent in client satisfaction questionnaire surveys (see, for example, Mason, 1996), often practitioners with little psychometric and evaluation training do not. As previously mentioned, consumer satisfaction linkages with service outcomes represent a higher stage of internal evaluation capability; stand-alone consumer satisfaction studies are further back in the evolutionary process—Love (1994) locates such studies in stage 2, “systematic internal evaluation.” I would argue that stand-alone consumer satisfaction surveys might be more appropriately considered back in stage 1, “ad hoc evaluation.” Nonetheless, the important point is that the development of internal evaluation capabilities requires commitment from the leaders of the organization, evaluation training of managers and staff, and time to evolve and move through the stages as outlined by Love.

Workload measurement is also commonplace in health care organizations, and has been for some time. Under the old QA system of

accountability, staff perceptions of workload measurement were not highly favorable (see, for example, Cockerill & O'Brien-Pallas, 1990; Wylie, 1991). A big problem with workload measurement in health care is that workload can be very unpredictable (such as instances in which a patient “crashes” on a given shift), and may not be evenly distributed in a given time period. Workload measurement also fails to capture the more indirect aspects of care, such as patient education and support, and according to McNiven, O'Brien-Pallas, and Hodnett (1993) should be replaced with work-sampling techniques. Work sampling, or time-and-motion measurement, is very similar to a procedure in CQI-driven manufacturing organizations described and criticized by Rifkin (1995). These techniques may also not be perceived favorably. For example, Armstrong et al. (1996) note that standardization of work tasks and measurement formulas—central to TQM—add to staff workload, fail to consider individual patient needs, and are perceived as a means of assessing employee performance.

As noted previously, many workload systems are vendor installed with little input from front-line personnel or middle managers, hardly a recipe for commitment or empowerment. In any case, whether work sampling or more traditional forms of workload measurement are used, workload indicators are still about levels of input or activity and not performance in terms of patient outcomes. The Office of the Comptroller General (1991) put it most succinctly: “Workload measures may indicate how hard people are working but not whether they are accomplishing anything” (p. 18).

There is currently little agreement concerning the measurement of clinical indicators or patient outcomes, much less standardization of outcome measures, routine tracking of health outcomes, and incorporation of such outcomes into information management systems (see, for example, Bernstein & Hilborne, 1993; *Medical Outcomes Trust Bulletin*, 1996). Despite being data rich, we are currently information poor. The U.S. Joint Commission cautioned that “the linkage between organizational performance and patient health outcomes may be self-evident to many individuals, but there has been indifference and even open hostility to the concept in the past” (*Joint Commission Journal on Quality Improvement*, 1993, p. 215). Based on my observations and discussions with health care professionals in a variety of health care organizations as well as a reading of the health care literature, the “linkages” between workload measurement, client satisfaction results, and health outcomes are not self-evident to many people. Nor is the distinction between “outcomes”

and “outputs.” Outputs—in terms of number of patients discharged or length of stay—need to be linked to health outcomes. Are patients who are discharged earlier in better or worse health? What is the rate of readmission or infection? And client outcomes need to be linked to client characteristics (demographics, health status at admission, motivational factors, etc.). What are the relative benefits of a given health care service? Which patients benefit the most?

When told they should be developing “outcome indicators,” often health care practitioners do not have the time or psychometric background to do so. They need assistance with the development of outcome measures that are clinically meaningful and user-friendly, in addition to being scientifically credible. They need assistance with patient tracking to establish clinical benchmarks for their patient groups (as opposed to selecting “success criteria” out of thin air). They need reassurance that evaluation data are not simply used to document program “success versus failure,” that numbers alone are value neutral, and that such data can help them argue for what can realistically be expected from their service given cutbacks. For instance, if recommended length of stay post-surgery has been reduced from five to three days, what functional outcomes can reasonably be achieved over the shorter time period? Similarly, what patient outcomes can realistically be expected with reduced home-care visits or physiotherapy sessions? As stated in a recent *Medical Outcomes Trust Bulletin* (1996, p. 2), we need to “stop and begin to educate the people who have to use these measures as to what they mean, what their strengths are, what their limitations are, and how they fit the whole trust of total quality management.” We also need to involve clinicians and patients themselves in the collaborative development of these outcome tools. As researchers we sometimes tend to ignore “process validity” in the scale-development process.

Health professions in teaching hospitals also need to be aware that clinical research (often using randomized controlled trials, careful screening of subjects, and measures that are researcher administered and scored) is different from the “good enough” methodologies and realities of program evaluation. Programs need to look at whether any change is occurring (tracking patient groups) and when (incremental change) before worrying about comparison or control groups. Old pre/post designs may no longer be appropriate in an organizational climate that is undergoing continuous change in service delivery. Evaluators need to develop and disseminate new methodologies, such as those building on time series designs, to health care practitioners.

The current restructuring of health care in Canada will undoubtedly result in new forms of health care delivery. Although we still do not know exactly which shape this will take, there certainly seems to be a movement away from institutional to community-based care, an increased emphasis on prevention and health promotion, and a trend toward outsourcing or contracting out and privatizing aspects of health care and related support services. When the dust settles, perhaps the restructured Canadian health care organizations will enter a “stable” phase in which summative evaluation can more readily take place. On the other hand, a stable phase in health care may never be seen again in our lifetimes. In any case, as Mark & Pines (1995) note, evaluators will undoubtedly see a variety of differences between traditional (non-CQI) and newer, CQI-based organizations. They go on to say that their contentions are presently only “best guesses” because “the intersection of evaluation is too young for confident, definitive statements on the impact of CQI on evaluation” (p. 133).

To continue on in this mode of speculation, one wonders who will be left in our downsized health organizations to undertake evaluation activities. Traditionally, managers have assumed internal evaluation responsibilities (Love, 1994). However, many middle-management positions are being eliminated in organizational downsizing. And remaining managers have their hands full dealing with staff changes and retraining. Some hospitals are moving toward a structure of “core staffing,” drawing from pools of laid-off “casual” workers as necessary. Currently, most health care organizations have CQI coordinator/specialist positions (also called QI or QM—quality management). Many of these positions are filled by managers who were formerly “QA” coordinators. Often the switch in status is simply a matter of changing job titles on office doors, business cards, and personnel files. Although these individuals have received CQI training, they often have not received formal training in program evaluation (although many of them are flocking to continuing education workshops—such as the Canadian Evaluation Society’s Essential Skills Series—on program evaluation). More so all the time, these individuals themselves, and not their organizations, are footing the bill for this training. But though they may retain their jobs (some have not) during the restructuring process, one wonders whether they too will receive the dreaded pink slips once restructuring has been completed in their particular organization. On the positive side, many downsized organizations—in a variety of sectors—appear to be hiring on a contractual basis, which may create more opportunities for individuals with evaluation skills.

CONCLUSION

Evaluators have a vital role to play in changing health care organizations. Clearly, health care service deliverers, junior and senior managers, CEOs, boards of directors, government representatives, and the media all need to be better informed about program evaluation. As an evaluation community, we need to share new workable methodologies, as well as practical and ethical dilemmas we have encountered, and not simply publish glowing pictures of our endeavors. Above all, we need to be sensitive to the concerns of those working in today's environment of organizational change and uncertainty.

To end on a lighter note, one hospital has made the following cartoon into team t-shirts: Three people are sitting around a board table. In the first caption, the leader says: "Let's go around and give updates on our QI projects." The second person replies: "My project is a pathetic series of poorly conceived and impossible-to-implement strategies lacking a mission and vision ..." The leader interrupts: "It's customary to say something positive—make something up." To which the third person says: "I think I need a hug." Anyone working in or with health care organizations today would, I believe, agree with this sentiment.

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