International Hospital Federation

World Hospitals and Health Services

The Official Journal of the International Hospital Federation

Leadership and Innovation in Asia

❙ Implementing successful strategic plans: A simple formula

❙ The seven common pitfalls of customer service in hospitals

❙ Prosocial motivation and physicians' work attitudes. Effects of a triple synergy on prosocial orientation in a healthcare organization

❙ Development, empowerment and accountability of front line employees

❙ Saving lives together

❙ Quality improvement initiatives by Aga Khan Health Service in the mountains of northern Pakistan

Opinion matters

❙ Built environment and wellbeing in italian psychiatric wards

❙ Fast track surgery, a strategy to improve operational efficiency in a high-complexity hospital in Latin America

Abstracts: Français, Español, 中文

2015 International Awards
International Hospital Federation

Supporting recognition of excellence, innovations and outstanding achievements in global healthcare leadership and management.

IHF / DR KWANG TAE KIM GRAND AWARD

Eligibility

- IHF Full and Associate Members ONLY
- Demonstrated fields of excellence and achievements with proven results at health system or facility level in several areas such as:
- *quality and patient safety*
- *corporate social responsibility*
- *innovations in service delivery at affordable costs*
- *healthcare leadership and management practices*

Award trophy and prizes

Winner:

- US$5,000 t*o cover travel and accommodation for attending the Congress*
- International exposure through IHF publications and healthcare media network

Runners-up:

- 2 complimentary Congress registrations
- International exposure through IHF publications

ENTRY SUBMISSION

Submissions are online-only.
To submit, go to:

https://congress.ihf-fih.org/awards_login

Submission deadline:
12 June 2015

Winners announced:
7 August 2015

ENQUIRIES

Contact: Sheila Anazonwu
IHF Partnership and Project Manager
Email:2015awards@ihf-fih.org
Tel: +41 (0)22 850 9422

IHF EXCELLENCE AWARDS

Categories

- Leadership and Management in Healthcare
- Quality and Safety and Patient-Centered Care
- Corporate Social Responsibility

Eligibility

- IHF Members and Non-Members
- Demonstrated excellence and achievement at facility or unit level through *an activity with proven results*

Award trophy and prizes

Winners:

- US$2,500 t*o cover travel and accommodation for attending the Congress*
- 2 complimentary Congress registrations
- International exposure through IHF publications and healthcare media network

Runners-up:

- 1 complimentary Congress registration/category
- International exposure through IHF publications

Note for Asian countries: If you are considering entering the IHF International Awards, you may also want to enter the **HMA Asian Hospital Management Awards.** Please visit http://hospitalmanagementasia.com/

http://www.worldhospitalcongress.org/en/abstracts-awards

International Hospital Federation

Contents volume 51 number 1

IHF Governing Council members' profiles can be accessed through the following link:
http://www.ihf-fih.org/About-IHF/IHF-Executive-Committee-and-Governing-Council

IHF Newsletter is available in **http://www.ihf-fih.org/IHF-Newsletters**

Subscription

World Hospitals and Health Services is published quarterly. The annual subscription to non-members for 2015 costs £175 or US$280. All subscribers automatically receive a hard copy of the journal, please provide the following information to james.moreno@ihf-fih.org:
-First and Last name of the end user
-e-mail address of the end user

World Hospitals and Health Services is listed in Hospital Literature Index, the single most comprehensive index to English language articles on healthcare policy, planning and administration. The index is produced by the American Hospital Association in co-operation with the National Library of Medicine. Articles published in World Hospitals and Health Services are selectively indexed in Health Care Literature Information Network.

The International Hospital Federation (IHF) is an independent non- political body whose aims are to improve patient safety and promote health in underserved communities. The opinions expressed in this journal are not necessarily those of the International Hospital Federation or Global Health Dynamics.

Leadership and Innovation in Asia

ERIC DE ROODENBEKE
CHIEF EXECUTIVE OFFICER
INTERNATIONAL HOSPITAL FEDERATION

ALEXANDER S PREKER
CHAIR, EXTERNAL ADVISORY BOARD,
INTERNATIONAL HOSPITAL FEDERATION

In this edition of the World Hospitals and Health Services (WHHS) Journal, we feature some of the innovative approaches to hospital management and care that were showcased at the 2014 Hospital Management Asia (HMA) Conference in Cebu City, Philippines.

The HMA helps hospitals and healthcare managers an opportunity to learn specific tools and techniques to do their jobs better, in an environment of quality learning and networking with peers. Key to this process is the staging of how-to, skills-related workshops, run only by experienced professionals and industry experts.

New and innovative approaches that were discussed at the 2014 HMA conference include: pro-social ways to motivate health care workers in China, new approaches to quality improvement in rural areas by Aga Khan Health Services in Pakistan, new life saving approaches to dialysis in Malaysia, common pitfalls to achieving high standards of consumer services in the Philippines, development, empowerment and accountability of front-line employees in India and the benefits of implementing visionary strategic plans for hospital management in Mongolia. The issue also includes two "Opinion Matters" articles: ways to improve psychiatric wards in Italy and improving operational efficiency through fast-track surgery in Latin America.

For over fourteen years now, the AHA has recognized innovation in hospital care in Asia through its Asian Hospital Management Awards (AHMA). The awards reward outstanding programs and best practices that served patients, hospital employees, and the community. In 2014, the Apollo Hospital Group in India won the Outstanding Achievement Award and Dr. Chalerm Harnphanich, M.D won the Lifetime Achievement Award.

In looking at future trends in Asia, health policy and service delivery has become a hotspot. As the middle-class grows, expectations for better healthcare and education is increasing throughout the region. Overall health expenditure has more than doubled in the past 10 years. The tax-paying middle-classes demand both improved quality and better value for money spent using their hard earned income. They are no longer satisfied by the old ways of providing health care.

Social media and other mass communication methods are putting the spotlight on hospitals and healthcare managers in ways that were unheard of even 10 years ago. This is driving change in health care as policy makers and leaders have to adapt much more quickly than they did in the past.

The International Hospital Federation is committed to helping its membership stay ahead of the curve by providing up-to-date information through the WHHS Journal and other communication on recent trends and innovations that are occurring across the world.

Implementing successful strategic plans: A simple formula

WHITNEY BLONDEAU
DIRECTOR OF HEALTH EDUCATION AND
COMMUNICATION AT UNITED FAMILY
HEALTHCARE, MONGOLIA AND CHINA

BENOIT BLONDEAU
CHIEF MEDICAL OFFICER AND CHAIR,
DEPARTMENT OF SURGERY AT UNITED FAMILY
INTERMED HOSPITAL IN ULAANBAATAR, MONGOLIA

ABSTRACT: Strategic planning is a process. One way to think of strategic planning is to envision its development and design as a framework that will help your hospital navigate through internal and external changing environments over time. Although the process of strategic planning can feel daunting, following a simple formula involving five steps using the mnemonic B.E.G.I.N. (Begin, Evaluate, Goals & Objectives, Integration, and Next steps) will help the planning process feel more manageable, and lead you to greater success.

INTRODUCTION. Many definitions of Strategic planning exist. For this publication, we will use "the process of determining where an organization intends to be in the future and how it will get there. It is a way of designing the best future course for the institution and outlining the optimal path of moving toward that designation" (1). One way to think of strategic planning is to envision its development and design as a framework that will help your hospital navigate through internal and external changing environments over time (2). Although the process of strategic planning can feel daunting, following a structured process involving five steps using the mnemonic B.E.G.I.N. (Figure 1) will guide the planning process, feel more manageable, and lead to greater success.

FIGURE 1: B.E.G.I.N.: A 5 STEP STRATEGIC PLANNING FORMULA

Source: Whitney Blondeau, PhD, MBA. Medical Vortex, LLC 2014.

Hospital Strategic Planning

According to Kaissi and Begun, hospitals conduct strategic planning as typically explained in textbooks, with 87 percent using a formal plan, comprehensive, largely implemented, and developed in concert with physicians and the governing boards (3). Ideally, strategic planning needs to be approached with a variety of stakeholders involved in the construction and development of the overall plan. The question is how to begin this daunting task?

Step 1: Begin

One may wonder how to start the strategic planning process, and how not to feel overwhelmed. Often, the most difficult part of strategic planning is envisioning where to begin, but a few helpful suggestions may help you and your hospital get started with the strategic planning process.

One of the first questions to ask is if the hospital – that is: employees and leaders- is ready for change?

This seems to be such an easy question to answer, since the normative answer is 'yes.' It is assumed that we all need to be ready for change, as healthcare is an ever-changing environment. There are very few who would take the risk to answer 'no' when the only acceptable answer is yes. But the reality of life and the multitude of academic and lay press publications show that indeed, humans and institutions are ready to change, as long as changes involve others only (1).

The essential question of entering uncertainty with change isn't with the change being all about uncertainty. Embarking on change and the beginning of strategic planning requires a transparent discussion with a collaborative management style, suggesting input from the bottom-up. The suggested length for a manageable strategic plan is 1-3 years. Creating a strategic plan much longer than 3 years leaves room for many uncertain variables such as change in leadership or the need for realignment of goals and objectives for unforeseen circumstances.

Regardless of the style of management, obtaining buy-in and support for implementation of a strategic plan needs clarity and focused communication dissemination. If hospital management engages in the risk of discordance between expression and action, they will exhibit cognitive dissonance.
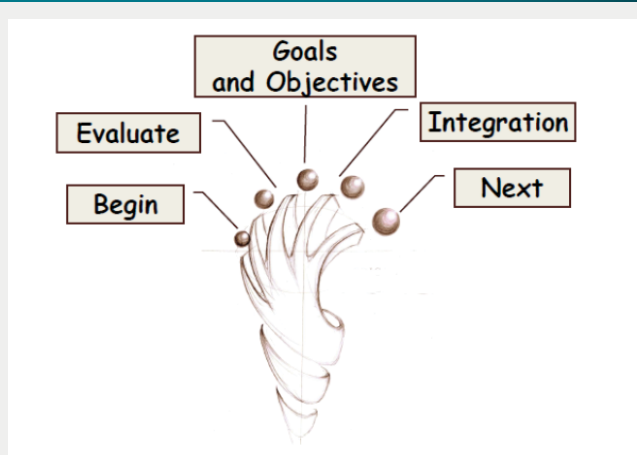
This places the start of the strategic planning process in a risky position, with limited support from individuals and teams needing to support the strategic planning process.

In an ideal hypothetical model, hospitals work with transparency and collaboration. This is the structure that will be used for the rest of this article.

Step 2: Evaluate

Planting the set, or setting the stage, is the next step in strategic planning.

As the hospital is engaging in a new part of its life by establishing its future for the next 1-3 years, it will design and adopt a common language, through environmental assessment.

If present and used, mission and vision statements will be revisited and necessarily modified. If absent, mission and vision statements represent essential steps in the necessary buy-in for alignment to the strategic plan. At this point, it is also essential to remember that a strategic plan responds to a question or a set of questions. In what direction is the hospital going, why is it going that direction, and how will it get there? What is the environment?

It is important to take the time to clearly answer this set of questions, as the answers will greatly influence the direction of the strategic planning for the hospital. One of the ways to evaluate the status of your hospital, and to look at different dimensions needing to be included in the strategic plan is the SWOT matrix: Strengths, Weaknesses, Opportunities and Threats.

The theory of the SWOT analysis is easy to understand. The difficulty resides in the data and information collection to fill the matrix four spaces. Depending on the quality of the data, verified or assumed, the analysis of the SWOT matrix may guide firmly or loosely the decision-making.

Small hospitals form a vital part of the health care network, serving communities that would often otherwise lack acute and basic care. It is, therefore, important to understand how strategy unfolds in these organizations. In a recent article, using semi-structured interviews, the authors asked Chief Executive Officers (CEOs) of seven small hospitals how they evaluated their hospital environment and how this contributed to their strategic planning. The authors found two major themes. First, CEOs of small hospitals felt they were in highly dynamic and hostile environments, but did not stress the complexity of being in these environments. Second, it was through continual negotiations with key stakeholders that helped transition the CEOs' insights into organizational strategies (4). This second finding is essential. Most hospital CEOs act by delegation from a Board of Directors or other supervising body. It is the Board's responsibility and fiduciary accountability to obtain clear information from the management team. Combined perspectives, and clear evaluation of the environment, will allow for strategic planning to be successful.

Step 3: Goals and Objectives

The next step of strategic planning occurs when all the necessary individuals and teams have been included in the strategic planning process, when the mission and vision statements have been designed or refurbished, and when the analysis of the SWOT matrix is strong. This is when the hospital is ready to define goals and objectives, and as importantly, in conjunction with their goals and objectives, develop performance indicators.

Goals, objectives, and performance indicators help shape two critical components of a strategic plan: relevance and measurability. In addition to development of these components, it is important to remember to assess causality and dependence as they relate to what is considered relevant and what is being measured. Having a long list of performance indicators does not necessarily result in more accurate goals and objectives for the hospital's strategic plan. It is important to take time to think about which performance indicators, and which goals and objectives are relevant and reflective of actual processes in place throughout the hospital. Without this introspection, the risk is misaligned strategic goals and objectives.

During this step of developing goals and objectives, many institutions use management systems such as the balanced scorecard designed by Kaplan and Norton (5). Management systems have several advantages. Mainly they allow the analysis of results in a contextual fashion, as they aggregate data pertinent to a common topic.

Step 4: Integration

Based on the first three steps outlined for strategic planning, everyone involved should have clarity of her or his role, responsibilities and accountabilities. At this point, to integrate all of the necessary components, utilization of a timeline is critical. Following consensus of the plan, a timeline with precise points for deliverables will support the overall team effort for hospital implementation.

This is a crucial step, in that it is also where the drafting and refining of the strategic plan for the hospital occurs. It integrates all the previous steps to produce the first draft of the strategic plan. It also involves agreeing on the format of the plan, final revisions and adoption of the strategic plan.

How your strategic plan is disseminated and implemented is in part, dependent upon the commitment of your hospital's leadership. One recent study assessed Chief Executive Officers (CEO) and their personality profiles (6). The authors compared CEO personality profiles to those maximizing performance with support of change efforts. The conclusion of the authors was a suggestion to select CEOs who would be most supportive of strategic change and plan implementation.

Having support from hospital leadership is indeed critical to the success of a strategic plan's development, implementation, and ultimate acceptance. Yet, it is as important to have all staff who work within the hospital understand his or her role, how each department supports the global vision of the strategic plan, and establish ongoing meetings for discussion of how the strategic plan is being

integrated at all levels of the hospital.

Step 5: Next

So what to do next, after the strategic plan has been designed, goals and objectives have been developed a SWOT analysis has been performed, and the plan is being integrated into the culture of the hospital? In this step, you will implement your hospital strategic plan. Annual targets, performance indicators, and processes will be identified, as they will be critical to successfully accomplishing your plan.

The comprehensive implementation of your strategic plan needs iterative verifications of understanding, engagement and support from employees, managers, and staff. In addition to disseminating the newly created strategic plan, a feedback system needs to be implemented at the same time the strategic plan is disseminated. Despite all the best intentions, a well-designed strategic plan adopted by an enthusiastic workforce may have unforeseen flaws, which can create ambiguities. As a result, unexpected and unidentified obstacles may appear.

Creating a feedback system for all employees, so they may provide comments, suggestions, and ideas for how to improve aspects of what to this point has been theoretical. The true test of a successful strategic plan is in the implementation and eventual evaluation of its measurable outcomes.

Conclusion

Many hospitals are required to have a strategic plan in order to qualify for accreditation (7). If this is the case for your hospital, the question of change or how best to direct your hospital's strategic plan may be mitigated by external requirements.

Strategic planning is not an easy endeavor. It takes time, energy, effort, and integrated employee engagement. The majority of hospitals have some type of strategic plan in place (7). Some strategic plans are more advanced and elaborate than others, but the key to having a successful strategic plan is having one that fits your hospital needs, vision, and future direction.

These five steps outlined in this article are at the heart of the strategic planning process. How extensive each step becomes is dependent upon the engagement of hospital leadership, employees, and needs of the hospital. When beginning the strategic planning process, remembering the fundamental steps, as represented by the mnemonic B.E.G.I.N., will serve as a guide for developing a thorough, helpful, and usable strategic plan that will fit your hospital needs.

BIOGRAPHIES

Whitney Blondeau, PhD, MBA, is currently Director of Health Education and Communication at United Family Healthcare. She has extensive experience with organizational behavior and evaluation. With numerous peer-reviewed publications, grants, and presentations at national and international conferences, Dr. Blondeau is an accomplished speaker and academic.

Benoit Blondeau, MD, MBA, FACS is currently Chief Medical Officer and Chair, Department of Surgery at United Family Intermed Hospital in Ulaanbaatar, Mongolia. He is Board Certified in Surgery and Palliative Care Medicine. Dr. Blondeau has numerous international and national presentations, a book- chapter and peer-reviewed publications.

References

1. Argyris C. (1993). Knowledge for Action: A guide to Overcoming Barriers to Organizational Change. Jossey-Bass, Inc, Publishers.

2. The Philippine Department of Health and The Philippine Hospital Association (1993). The Philippine Hospital Strategic Planning Workbook: H108.47 P53.

3. Kaissi AA, Begun JW. (2008). Strategic planning processes and hospital financial performance. Journal of Healthcare Management 53: 197-208.

4. Wells R, Lee SD, McClure J, Baroner L, Davis L. (2004). Strategy development in small hospitals: stakeholder management in constrained circumstances. Health Care Management Review 29: 218-228.

5. Kaplan RS, Norton DP (2007). Using the Balanced Scorecard as a strategic management system. Harvard Business Review 7(1).

6. Herrmann P, Nadkarni S. (2014). Managing Strategic Change: The duality of CEO personality. Strategic Management Journal 35: 1318-1342

7. Saleh S, Kaissi A, Semaan A, Natafgi NM. (2013). Strategic planning processes and financial performance among hospitals in Lebanon. International Journal of Health Planning and Management 28: e34-e45.

The seven common pitfalls
of customer service in hospitals

RENE T. DOMINGO
PROFESSOR OF OPERATIONS MANAGEMENT
AT THE ASIAN INSTITUTE OF MANAGEMENT, PHILIPPINES

ABSTRACT: Operating simultaneously like a repair shop, prison, and hotel, hospitals are prone to seven common pitfalls in customer service. Patient care is often fragmented, inscrutable, inflexible, insensitive, reactive, myopic, and unsafe. Hospitals are vying to be more high-tech, rather than high-touch even though staff engagement with patients rather than facilities and equipment strongly influence patient satisfaction. Unless processes, policies, and people are made customer-centered, the high quality of the hospital's human and hardware resources will not translate into high patient satisfaction and patient loyalty.

INTRODUCTION. Hospitals may have very dedicated and competent workers, but they are not known for outstanding customer service we find in service institutions with less skilled personnel. Quality is about improving service and people, not merely acquiring technologies and competencies. (1) Yet hospitals are locked in a medical "arms race", trying to out-invest each other in technology and facilities. According to one survey, the top two factors important to patient quality are "immediate attention" and "care first". "Knowledgeable personnel" is third while "state of the art equipment" a distant eleventh factor. (2) The soft skills of workers, rather than their hard skills and facilities, strongly influence patient satisfaction. Doctors and nurses account for 34%, 43%, and 50% of the overall experience ratings of inpatients, emergency patients, and outpatients respectively. (3) Without proper quality planning, hospitals are prone to common pitfalls or seven "bad habits" in customer service. But before management can address these, it should first understand the triple character of hospitals to appreciate the complexity and challenges of increasing patient satisfaction.

REPAIR SHOP-PRISON-HOTEL

Hospital managers are virtually running a repair shop, a prison, and a hotel at the same time. Hospitals mainly serve as treatment centers for patients referred by primary care facilities. While this "repair" role of hospitals within the health system make them expectedly reactive in clinical care, this impersonal outlook often extends to the delivery of services. Patients are treated as cases like "jobs", "back jobs" or problems to be solved rather than customers whose needs have to be anticipated and whose over-all experience matters. This repair function gives hospitals their reactive, impersonal, and fragmented character.

Patients are not ordinary customers. They are often dangerous to others and themselves. They could be frail, infectious, and not fit to move about within the hospital facilities that are dangerous and infectious by themselves. They have to be "confined", "isolated", or "quarantined", subject to visiting hours, rules, and sameness in uniforms, rooms, procedures, and meals. This controlled "prison" environment accounts for hospitals' inflexibility, insensitivity, and lack of transparency.

Patients encounter and understand the most the hospital's hotel-like services – triage ("reception"), admission ("check-in"), discharge ("check-out"), housekeeping, etc. Patient satisfaction is influenced more by these services than by medical processes whose quality patients often cannot judge. The admission and discharge processes together account for 35% of inpatient satisfaction. (3) Management's lack of experience in running service-oriented establishments may explain why most patient complaints come from failures of the hospital's hotel processes.

THE SEVEN HABITS

Multiple handoffs

Because of multiple handoffs, service in hospitals is often discontinuous and fragmented. An inpatient gets in contact with numerous staff – doctors, nurses, trainees, technicians, housekeeping staff, cashiers, and volunteers. Some handoffs between shifts are unavoidable because of the 24/7 hospital operations. With handoffs, nobody "owns" the patient and sees his needs and condition in totality. This fragmented view of patients is aggravated by the turf mentality of medical departments, disconnected hospital information systems, and medical records which are case-based instead of patient-based. The dual management structure of many Asian hospitals - doctors reporting to the medical director and the rest reporting to the hospital administrator – also necessitates handoffs between clinical and service processes. (4) Patient handoffs can be reduced. The redundant assessment of

patients by different hospital personnel can be eliminated. 10% of information discussed during patient handovers by nurses are not relevant to patient care. (5) A US hospital created a cardiac center within the hospital that integrated cardiology and cardiac surgery services under one roof. Another re-located its radiation equipment, pharmacy, and laboratory in one floor to create a convenient one-stop center for its cancer patients and staff.

Lack of transparency

Hospitals keep patients largely uninformed of the inconveniences and risks they would undergo. The standard patient education may not be sufficient to assure them of a worry-free and comfortable stay. Many hospital processes as well as people lack transparency. As a consequence of multiple handoffs, inpatients also do not get to know the numerous front liners who enter their rooms. According to a study of waiting line psychology, the more valuable the service – and health care is valuable – the longer the customer is willing to wait. (6) But if kept uninformed of the reasons for waiting, the patient may eventually lose his patience. Uncertain waits also feels longer than known waits while unexplained waits are perceived longer than explained waits. (6) During visits to the physician office, the top two determinants of outpatient satisfaction are: "patient kept informed of reasons for wait" and "ease of getting someone to help with billing questions". "Waiting time in office" is the seventh and last. (7) "Problem resolution" is just as highly correlated to inpatient loyalty as "kept you informed of delays". (8)

One-size-fits-all

Hospitals rarely give patients choices. If Henry Ford admonished picky Model-T buyers with "You can have it any color you want as long as it is black", hospitals would say "as long as it is white" – bed sheets, patient gown, staff uniform. There is also a "one-size-fits-all" policy on patient apparel, meals, and facilities. Unlike in banks, there is little privacy in the regimented processing of patients. During triage and admission, the next patient and others can overhear sensitive patient information being exchanged. There are still opportunities to be flexible and more personal. Some hospitals have introduced more colors to uniforms and patient gowns, especially in pediatric wards where white is a dreaded color. To accommodate obese patients, a US hospital came out with bigger beds, wheelchairs, CT scan machines, operating tables, slippers, and gowns– even wider doorways and longer needles that can penetrate fat. (9) During admission, a US hospital asks patients to choose the painting on the wall they would be looking at from their beds. Many Asian hospitals catering to medical tourists have multi-lingual staff and restaurant like-menu. To reduce my anxiety during an MRI scan in a Philippine hospital, I was asked to wear headphones and listen to my favorite music.

Lack of empathy

Without empathy, hospitals and their staff may miss the real quality patients perceive and rate. The floor may be clean, but a patient thinks the room is dirty if he sees spider webs on the ceiling while lying in bed. (10) In one survey, patients rated poorly pureed food that looked unappetizing, though the hospital staff confirmed its high quality. (11) The hospital may define X-ray turnaround time as the patient's time inside the X-ray room, but the patient may see it starting from time he gets the doctor's order to the time he is wheeled back to his room after the procedure. The director of a large Asian hospital related to me how a critically-ill patient whose life the hospital saved rushed to his office upon discharge to complain about the substandard amenities in his room. Instead of berating the patient for ingratitude and frivolity, the director realized that patient care quality extends beyond being cured, and decided to launch a TQM Program in the hospital. A survey showed that patients consulting doctors without empathy felt the visit was two minutes shorter than it actually was, while those visiting doctors with empathy felt it was two minutes longer. (12) The nurse's ability to calm the patient's fear is highly correlated to inpatient satisfaction. (13) The doctor's non-verbal communication with patients – eye contact, hand gestures, shoulder shrug – can affect patient satisfaction and compliance with orders. (12) To train its new doctors on empathy, a US hospital requires them to get admitted incognito with fake illnesses to experience the inconveniences patients suffer like the late arrival of doctors.

Reactive approach

A study shows that "nurses anticipated needs" is strongly correlated to patient loyalty. (8) Hospitals seldom anticipate problems and needs, and would rather respond, react, and resolve these after receiving complaints or urgent requests from patients. Many hospitals have policies like answering the phone within 3 rings or responding to nurse calls within 30 seconds. I once coached a team of nurses in a Philippine hospital working on a quality improvement project on nurse calls. The team's chosen objective was "to respond faster to the calls" since patients were complaining of slow response. I asked them why not change the goal to "reduce the number of calls". After data gathering, they discovered that 40% of calls were requests for extra linen. Providing the extra items upon admission freed the nurses to do more productive work. The staff in a US hospital do regular "comfort rounds", visiting patients, inquiring about their comfort and items they may need to stay comfortable. Similarly, the staff of another US hospital regularly calls or visits former patients to anticipate future needs and maintain relationships - a proactive form of "after sales service". Anticipating the frequently asked questions of patients, doctors can prepare the answers or provide them before the questions are asked to increase patient satisfaction. (14)

Failure to serve the patient's extensions

Patient satisfaction is not exactly customer satisfaction. Customers are not just the recipients of service but also

decision-makers like the patient's relatives. These extensions of patients may be responsible for repeat purchases and word-of-mouth endorsements. Hospitals usually have a myopic view of patient care, ignoring the needs of their non-patient customers. Many sleep on hallways especially in overcrowded hospitals and are treated indifferently by the staff whose time and training are focused on patient care. Hospitals rarely send their staff to waiting rooms to ease the anxiety of the patient's companions. Like unexplained waits, anxiety makes waits seem longer. (6) Aside from just face lifting lobbies to look like hotels with concierge services and fine restaurants, hospitals should also make their processes and policies visitor-friendly. While facilities account for 48% of hotel guest satisfaction, they account only for 19% of patient satisfaction. (3) A Philippine hospital realized that patient satisfaction increased when its doctors made two rounds daily, a practice that also made it convenient for the patients' relatives to catch and confer with the attending physicians.

Overworked staff

While the FAA maximum flying time for pilots is 8 hours, there are weak or no regulations worldwide on maximum working hours for hospital staff. One would hesitate to board a plane if he knew the pilot had only 2 hours of sleep, but would unquestioningly go under the knife even if the surgeon had been working 24 hours. In a survey, 70% of surgeons agreed that "fatigue does not affect performance", while only 26% of pilots did. (15) Hospitals routinely overwork and overload their staff to cut costs, ignoring the adverse effects of fatigue and high attrition on patient safety and satisfaction. (16) In a survey of US nurses, 69% reported exhaustion from work with 43% claiming they are given more work that they could safely handle. (17) Another showed that nurse shift hours beyond 13 hours led to higher patient dissatisfaction. (18) Moreover, the risk of nurses making mistakes more than doubles if the shift

length is 12.5 hours or more. (19) Mortality rates of critically ill patients are also higher when admitted on understaffed weekends than on weekdays. (20) There is a suggestion to use non-nurse personnel like housekeeping to collect customer feedback since patients may fear retaliation from nurses who in their overworked condition may not welcome poor ratings. (21)

CONCLUSION

Outstanding customer service is seamless, transparent, flexible, empathetic, proactive, customer-centric and safely delivered by highly motivated personnel. Hospitals cannot change their triple nature and stressful environment, but they can avoid the common pitfalls in customer service by aligning policies, reengineering processes, and re-orienting their people to be more customer-centric. Aside from enhancing facilities and going high-tech, hospitals should also strive to be caring high-touch service providers with adequate manpower that can serve patients efficiently and safely and create a positive patient experience that enhances loyalty. Increasing customer loyalty by 5% can increase profits by 25% - 85%. (22)

BIOGRAPHY

Rene Domingo is a professor of operations management at the Asian Institute of Management in the Philippines. He holds a BS in Industrial Engineering from the University of the Philippines and an MS in Management Engineering from Nagoya Institute of Technology (Japan). He trained on the Toyota Production System in Toyota, Japan. He is the author of "Quality Means Survival" published by Prentice Hall. He serves as technical consultant of the World Health Organization – Western Pacific Region on Hospital Management. He has assisted hospitals in improving customer service, patient flow, and patient safety.

References

1. Domingo, Rene. 1997. *Quality Means Survival.* 1st ed. Singapore: Prentice Hall.

2. Cunningham, Lynne. 1991. *The Quality Connection in Health Care.* 1st ed. San Francisco: Jossey-Bass Publishers.

3. "Patient Satisfaction Influenced More by Hospital Staff than by the Hospital Facilities."
www.jdpower.com/press-releases/2012-national-patient-experience-study.

4. Domingo, Rene. "Leadership and Change Management in Hospitals." www.rtdonline.com.

5. Sexton AJ et al. "Nursing handovers: do we really need them?" *Journal of Nursing Management*, Volume 12, Issue 1, January 2004: 37–42.

6. Maister, David. (1985) "The Psychology of Waiting Lines." http://davidmaister.com/articles/the-psychology-of-waiting-lines.

7. "Patient Satisfaction Starts in the Waiting Room." 15 February 2005. www.gallup.com/poll/14935/Patient-Satisfaction-Starts-Waiting-Room.aspx.

8. "Dissecting Patient Loyalty." 29 March 2005. www.gallup.com/poll/15445/Dissecting-Patient-Loyalty.aspx.

9. "Hospitals groan under weight of heavy patients." USA Today. 30 March 2006.
http://usatoday30.usatoday.com/news/health/2006-03-31-obesity-hospital_x.htm.

10. "Do Patients Equate Cleanliness With Quality?" 10 September 2002. www.gallup.com/poll/6784/Patients-Equate-Cleanliness-Quality.aspx.

11. "Hospital Food: Ingredient in Patient Satisfaction?" 19 November 2002. www.gallup.com/poll/7249/Hospital-Food-Ingredient-Patient-Satisfaction.aspx.

12. Indiana University. "You Don't Say: Patient-doctor Nonverbal Communication Says A Lot." Science Daily. 30 January 2006. www.sciencedaily.com/releases/2006/01/060130155029.htm.

13. "The Fear Factor and Patient Satisfaction." 26 November 2002. www.gallup.com/poll/7288/fear-factor-patient-satisfaction.aspx.

14. "Key to Office-Visit Satisfaction? See the Doctor." 13 August 2002. www.gallup.com/poll/6580/key-officevisit-satisfaction-see-doctor.aspx.

15. Sexton, Bryan et al. "Error, stress, and teamwork in medicine and aviation: cross sectional surveys." *British Medical Journal*, Volume 320 March 18, 2000: 745-749.

16. Domingo, Rene. "Managing and Keeping Healthcare Professionals." www.rtdonline.com.

17. Kishi, Aileen. "Recruitment and Retention of Nurses in the Workforce." *Texas Center for Nursing Workforce Studies*, September 2006: 1-4.

18. Stimpfel, Amy Witkoski et al. "The Longer The Shifts For Hospital Nurses, The Higher The Levels Of Burnout And Patient Dissatisfaction." *Health Affairs*, November 2012: 2501-2509.

19. Scott LD et all. "Effects Of Critical Care Nurses' Work Hours On Vigilance And Patients' Safety." *American Journal of Critical Care*, January 2006, Volume 15, No. 1: 30-37.

20. Bell, Chaim and Donald Redelmeier. "Mortality Among Patients Admitted To Hospitals On Weekends As Compared With Weekdays." *New England Journal of Medicine*, Vol. 345, No. 9, August 30, 2001: 663-668.

21. "Problem Resolution: A Key to Loyal Patients." 25 February 2003. www.gallup.com/poll/7864/Problem-Resolution-Key-Loyal-Patients.aspx.

22. Reichheld, Frederick and W. Earl Sasser, Jr. "Zero Defections: Quality Comes to Services." *Harvard Business Review*, Sept. 1990: 105-111.
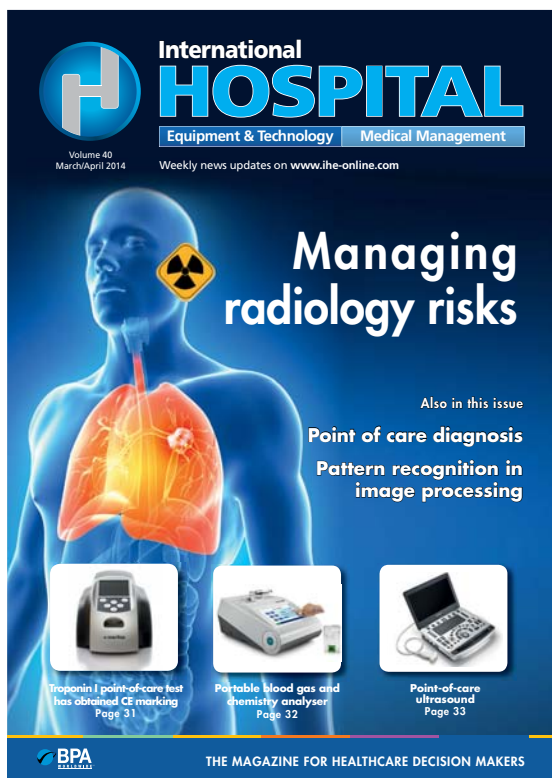
La Unió is a health provider association representing 117 social and healthcare organisations, 500 centres and 60,000 professionals in Catalonia.

The associated organisations provide public health and social services coverage for a population of 7 million Catalans.

Associated members work in the following public and private areas:

* Acute care hospitals and clinics.
* Primary care.
* Long-term care facilities.
* Rehabilitation, lab and image diagnosis.
* Mental health.
* Social care and home care.

Through the Fòrum d'Associats Col·laboradors, La Unió also brings together and represents 20 industries that provide services for the social and healthcare fields.

Strategic focus:

* To advocate for a healthcare and social model of public coverage and public financing in which civil society participation is crucial; a model based on management autonomy, excellence in operations and strict ethical behaviour.

    * To promote quality and excellence in health care and business results to guarantee the sustainability of the centres, whether they are publicly or privately owned.

    * To actively take part in labour relations, acting as a permanent social dialogue advocate and representing the associated organisations in collective bargaining, thereby building trust for social and healthcare sector agreements.

    * To represent and defend the rights of our members before health authorities and stakeholders.

    * To act as an institutional lobby.

    * To promote public-private partnerships and the establishment of strategic alliances between our associates and also with the Fòrum d'Associats Col·laboradors.

* To provide continuous learning for professionals and executives.

* To encourage benchmarking as a means for improvement.

La Unió fosters knowledge and management excellence through La Fundació Unió, and provides:

* Data protection in the social and healthcare sector (Codi Tipus).
* Executive education.
* Strategic planning.
* Public relations and corporative social responsibility.
* Accreditation and benchmarking.
* Clinical research ethics committee.
* Sectorial studies.

La Unió unites members, enabling them to achieve together what they cannot accomplish on their own, strengthening the value of working together and sharing knowledge and contributions.

La Unió
Associació d'Entitats
Sanitàries i Socials

FUNDACIÓ UNIÓ

@uchcat
www.uch.cat
Carrer Bruc, 72 1r
08009 Barcelona
0034 93 209 36 99

Prosocial motivation and physicians' work attitudes.
Effects of a triple synergy on prosocial orientation in a healthcare organization

YOUNG SHIN KIM
PHYSICIAN – FAMILY MEDICINE, BEIJING UNITED FAMILY HOSPITAL AND
CLINICS – UNITED FAMILY HEALTHCARE - CHINA

ABSTRACT: Employees' work attitudes are key determinants to organizational performance. This article proposes a model integrating servant leadership, prosocial motivation, and corporate social responsibility (CSR) in order to explain a mechanism through which prosocial motivation plays a central role in enhancing physicians' work attitudes. A cross sectional survey from a sample of physicians indicates that (1) prosocial motivation can be shaped from servant leadership when physicians perceive high value fit with their supervisors, (2) prosocial motivation improves physicians' job satisfaction. Its effects is strengthened when physicians perceive high CSR, and (3) job satisfaction improves organizational commitment. The results provide meaningful insights that a triple synergy of prosocial orientation among physicians, supervisors and organization enhances physicians' work attitudes.

INTRODUCTION. Work attitudes such as job satisfaction, and organizational commitment represent important work outcomes and are significantly correlated with job performance. At the same time, they are symptomatic of potential problems. For example, low job satisfaction may be a symptom of an employee's intention to quit. It thus is important for organizations to understand how to improve these key work attitudes.

For the improvement of work attitudes, motivation has been at the center of attention in various organizational research. (Deci 1971, Amabile 1993, Barnett, Carr et al. 1998, Deci, Koestner et al. 1999, Wright and Beasley 2004, Lambrou, Kontodimopoulos et al. 2010) Recently, with the advancement in motivational theories, researchers have begun to highlight the roles of prosocial motivation (Shamir 1990, Meglino and Korsgaard 2004, Wright and Beasley 2004, Grant 2007, Grant 2008a, Grant and Ashford 2008, Grant and Sumanth 2009, Ilies, Peng et al. 2013) - the desire to help other people or social collectives. (Batson 1987, Grant 2007) Researchers suggest that prosocial motivation enhances organizational commitment, (Grant 2008b) affiliative citizenship behaviors, (Grant and Mayer 2009) performance, (Grant 2008a, Grant 2008c, Grant and Sumanth 2009) and productivity (Grant 2008a) across various tasks and jobs by enabling commitment to the people who benefit from one's efforts. (Grant 2007) However, substantial variability in the relationship has been found across studies. (Konovsky and Organ 1996, Alonso and Lewis 2001) One explanation for these mixed results is that there are boundary conditions along which the relationship between prosocial motivation and the outcomes can vary. Therefore, employees' prosocial motivation may not necessarily lead to positive outcomes without supportive environments. (Barrick and Mount 1991, Grant 2008a, Grant 2008c) If this is the case, insufficient information on the boundary condition may limit the development of actionable knowledge that organizations may use to improve employees' work attitudes. For example, it is important to assess how contextual factors moderate the work attitudes effects of prosocial motivation.

In the current study, we aim to investigate whether and when physicians' prosocial motivation can strengthen job satisfaction. In order to make further advancements, we also examine whether and when prosocial motivation can be cultivated by leadership, and whether job satisfaction can improve organizational commitment.

We develop and test a theoretical model that integrates professional values and contextual factors across core levels in the organization, which are framed in terms of prosocial motivation, servant leadership, corporate social responsibility (CSR), and person (i.e. physician)-supervisor fit (PS fit). Our study examines that (1) servant leadership is more likely to promote prosocial motivation when supervisors and individual physicians are congruent on values, (2) the influence of prosocial motivation on work attitudes is stronger when physicians perceive the organization as high in CSR rather than low, and (3) job satisfaction improves organizational commitment.

Figure 1 depicts these relationships.

FIGURE 1: INTEGRATIVE MODEL OF PROFESSIONAL VALUES OF HEALTHCARE ORGANIZATION TO IMPROVE JOB SATISFACTION AND ORGANIZATIONAL COMMITMENT
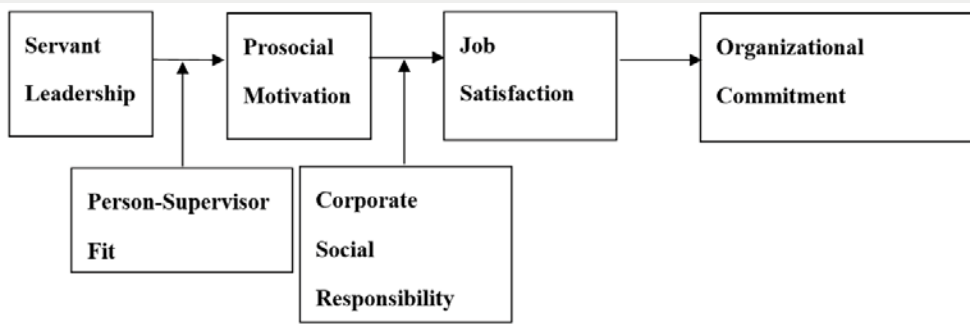
THEORETICAL BACKGROUND

Job satisfaction and organizational commitment

The concept of job satisfaction has been defined in many ways. However, the most-used definition of job satisfaction in organizational research is "a pleasurable or positive emotional state resulting from the appraisa1 of one's job or job experiences". (Locke 1976) As noted here, *affect* is central to any definition of job satisfaction, or job attitudes more generally.

Organizational commitment reflects the extent to which an individual identifies with an organization and is committed to its goals. (Robert Kreitner 2010) It is an important work attitude because committed individuals are expected to display a willingness to work harder to achieve organizational goals and a greater desire to stay employed at the organization. In this article, we focus on *affective* component, which refers to the employee's emotional attachment to, identification with, and involvement in the organization. (Meyer and Allen 1991)

Our decision to emphasize the affective aspect is consistent with a growing interest in the employees' affective experiences and reciprocal interaction among affect, cognition and behavior in shaping their motivation, satisfaction and commitment. (Latham and Pinder 2005, Pinder 2008, Seo, Taylor et al. 2012) However, since affective reactions are likely to be fleeting and episodic, state-like variables rather than consistent and chronic, trait-like variables, maintaining and even enhancing job satisfaction and organizational commitment requires a supportive environment, which will be discussed in a later section of this paper.

Prosocial motivation

Motivation denotes an inner desire to make an effort, (Dowling and Sayles 1978) which involves the psychological processes that direct, energize, and sustain action. (Latham and Pinder 2005) Prosocial motivation is the desire to benefit other people or groups. While intrinsically motivated employees feel naturally drawn, or pulled, toward completing their work, and the decision to expend effort is based on personal enjoyment and is thus fully volitional, prosocially motivated people are more likely to push themselves towards completing their work, and the decision to expend effort is less autonomous, as it is based more heavily on conscious self-regulation

and self-control to achieve a goal. (Gagne and Deci 2005, Grant 2008a)

However, the desire to benefit others can be autonomously supported by feelings of identification and value congruence or can be coerced by feelings of pressure and obligation. (Ryan and Connell 1989, Gagne and Deci 2005) This distinction may have critical implications for understanding when prosocial motivation can be cultivated, and can more effectively and sustainably promote positive work outcomes. (Grant 2008a)

Previous studies have shown that if the behavior is more congruent with their personal values, people will feel greater autonomy, and the prosocial motivation and the subsequent activities will become more self-determined, consistent and sustainable. (Williams and Deci 1996, Black and Deci 2000, Gagne and Deci 2005) In this regard, a more autonomy-supportive environment or interpersonal relationships may facilitate more autonomous and more persistent prosocial motivation, and thus enhance positive work outcomes. We suggest the level of 'other-oriented' value congruence would play as a meaningful contextual factor.

Servant leadership

Broadly speaking, servant leadership focuses on increased service to others including employees, customers and community, rather than to oneself. (Kreitner and Kinicki 2010) Although a link between prosocial motivation and servant leadership rarely has been made explicitly, based on the notion that servant leadership and prosocial motivation have 'other-oriented' values in common, we posit that servant leadership may play an important role in shaping prosocial motivation.

According to social learning theory, people learn by modeling the attitudes, values, and behaviors of role models in their environment. (Brown, Treviño et al. 2005, Brown and Trevino 2006) Therefore, a servant leader's humble service is often mimicked by followers (Graham 1991) and may also be reciprocated through the process of social exchange in which followers return the service they receive in kind. (Wood and Bandura 1989) Followers desire to mimic their leader's behavior, which is more likely if leaders are viewed as *credible* role models. (Brown, Treviño et al. 2005) Thus, we posit that the effects of servant leadership on prosocial motivation is strengthened under environments which promote leader's trustworthiness, and that value congruence between physicians and their supervisors may provide such environments as explained below.

Person-supervisor fit and value congruence

Value congruence refers to the similarity between values held by individuals and environment, such as organization, supervisor and

group. (Meglino, Ravlin et al. 1991, Kristof 1996, Edwards and Cable 2009) In this article, we focus on *subjective* person-supervisor fit (PS fit), which involves the compatibility between an employee's own values and those of supervisor's. (Cable and DeRue 2002, Kristof-Brown, Zimmerman et al. 2005, Edwards and Cable 2009).

Studies on value congruence have revealed that shared value influences the outcomes mainly through the mutual understanding and trust in relationships. (Enz 1988, Meglino, Ravlin et al. 1991, Jehn and Mannix 2001, Edwards and Cable 2009) Value congruence can promote trust by sharing basic assumptions about what is right and wrong. (Mayer, Davis et al. 1995, Jones and George 1998) Therefore, employees are more likely to embrace similar moral standards, and this value-based trust is more likely to facilitate the internalization of servant leaders' values and goals resulting in enhanced autonomy-supportive environment. (Dirks and Ferrin 2002, Zhang, Wang et al. 2012).

Based on this reasoning, we posit that PS value fit serves as a critical link between individuals and their supervisors to strengthen the influence of servant leadership on the prosocial motivation.

Corporate social responsibility

Corporate social responsibility (CSR) is defined as the expressed commitment to solving problems in society as a whole such as philanthropy and community contributions. (Brammer, Millington et al. 2007) Social identity theory states that individuals see themselves as members of social categories, including the organizations they are affiliated to. Employees often attempt to identify with and commit to organizations that have positive organizational values and reputation, (Peterson 2004) so as to establish or enhance their positive self-concept. (Ashforth and Mael 1989) The enhanced self-esteem, in turn, motivates employees to show greater positive attitudes toward the organization and subsequently produce better work outcomes.

CSR by creating prosocial environment at the organizational level may play a critical role in affecting employee's job satisfaction (Bauman and Skita 2012) and organizational commitment. (Peterson 2004, Brammer, Millington et al. 2007) When prosocially motivated employees perceive their organization as high in CSR as well, this congruence on prosocial orientation may satisfy employees' prosocial needs, and thus enhance their satisfaction and commitment to working in their organizations.

METHOD

Participants

This is a cross-sectional, self-reported survey. Data were collected from 126 active physicians working in a single healthcare organization with multicultural background in China. Participation was voluntary. The survey was conducted in April-May 2014.

Measures

This study employed and modified previously-validated scales. The complete list of items used in this study is shown in the Appendix 1. Responses were made on a 7-point Likert-type scale with anchors of 1 (strongly disagree) to 7 (strongly agree).

Prosocial motivation

Prosocial motivation was measured with 4-items scale as adapted in the previous study (α = .91). (Grant 2008a) An introductory question asked "Why are you motivated to do your work?".

Servant leadership

Servant leadership was measured by using Ehrhart's 14 items (Cronbach's α=.98) with the exception that the referent in the items referred to "my supervisor" and "member of my work unit" instead of "my department manager" and "department employee", respectively. (Ehrhart 2004).

Person-supervisor fit

To assess PS Fit, 3-item scale was adapted from the previous research (α = .91) (Cable and DeRue 2002) with the exception that the referent in our study referred to "my immediate supervisor" instead of "my organization".

Corporate social responsibility

We measured CSR with 3-item scale adapted in the prior study (α = .74) with the exception that the referent in the items referred to "our organization" instead of "top management". (Goll, Zeitz et al. 1991).

Job satisfaction

Physicians' overall level of job satisfaction was measured with a 4-item scale as adapted by Grant (α =.81) (Grant 2008a) from Quinn and Shepard's study (α = .72). (Eisenberger, Cummings et al. 1997).

Affective organizational commitment

Affective organizational commitment was measured with 5-item scale adapted from the original 8-item scale (α = .88). (McGee and Ford 1987) This 5-item scale was tested in the previous study and showed good reliability estimate (α = .86). (Kim, Aryeeb et al. 2013)

Control variables

To avoid alternative explanations for the employee outcomes, we checked for the employees' age, sex, tenure and participants' leadership status. (Hall, Schneider et al. 1970, Organ and Ryan 1995)

ANALYSES

Confirmatory factor analyses.

To assess the discriminant validity of the measures, we conducted confirmatory factor analyses (CFAs) using comparative fit index (CFI), Tucker-Lewis index (TLI) and Standardized Root Mean Square Residual (SRMR). Researchers suggest that levels of 0.90 or higher for CFI and TLI and levels of 0.06 or lower for SRMR indicate that a model appropriately fits the data. (Kim, Aryeeb et al. 2013)

Moderation Analyses and Regression slopes

To examine the moderating effects, we followed the procedures recommended by Aiken and West using centered independent variables, centered moderator, and interaction term. (Aiken and

TABLE 1: MEANS (M), STANDARD DEVIATIONS (SD), AND CORRELATIONS:

Variables	M	SD	1	2	3	4	5	6	7	8	9	10
1. Servant leadership	5.12	1.18	(.95)									
2. Prosocial motivation	5.95	0.88	-.02	(.86)								
3. Job satisfaction	5.40	1.03	.28***	.34***	(.83)							
4. Organizational commitment	4.92	1.23	.27**	.15	.55***	(.89)						
5. Person-Supervisor fit (PS fit)	4.91	1.23	.70***	.03	.39***	.33***	(.94)					
6. Corporate social responsibility (CSR)	5.23	1.17	.26**	.05	.38***	.55***	.24**	(.95)				
7. Age (year)	42.23	7.31	-.26**	.07	-.11	-.26**	-.26**	-.26**	-			
8. Sex	0.56ᵃ	0.49	.06	.04	-.03	-.08	.02	.21*	-.10	-		
9. Tenure as a physician (year)	15.75	7.23	-.23**	.08	-.08	-.12	-.25**	-.08	.82***	.04	-	
10. Leadership role	0.71ᵇ	0.45	.13	-.02	.02	.11	.03	.22*	-.28**	.16	-.12	-

Note. N=126, Reliabilities (Cronbach's alphas) for multi-item scales appear in parentheses across the diagonal.

Significance (2-tailed) ***< .001, **< .01, *< .05

ᵃ Male: 0, Female: 1

ᵇ Leadership role Yes: 0, No: 1

West 1991, Cohen, Cohen et al. 2003) To facilitate the interpretation of moderation effects, we plotted the simple slopes at one standard deviation above and below the mean of moderator, and performed regression analyses predicting outcomes. (Aiken and West 1991)

RESULTS

Response rate

We administered an individual-level survey to 192 physicians and received usable surveys from 126 participants (response rate 65.5%).

Confirmatory factor analysis

Confirmatory factor analysis was conducted to assess the discriminant validity of the four variables used in this study (i.e. servant leadership, prosocial motivation, job satisfaction, and organizational commitment). In contrast to a one-factor model, a four-factor model displayed very good fit with the data, $X2$ (318, N = 126) = 629.86, CFI = .877, TLI = .864, SRMR = .073, thus providing support for the discriminant validity of the construct used in this study.

Descriptive statistics, reliability estimates, correlations

Descriptive statistics, reliability estimates, and correlations for all measured variables are displayed in Table 1. The sample was 56% female with a mean age of 42.23 years (SD ±7.31). Reliabilities ranged from .83 to .95, well above the .70 criterion as the acceptable level of reliability suggested by Nunnally. (Nunnally 1978)

Servant leadership and prosocial motivation: Moderating effect of PS fit

As indicated in Table 2, neither servant leadership nor PS fit independently predicted prosocial motivation. However, the interaction

TABLE 2: REGRESSIONS PREDICTING PROSOCIAL MOTIVATION WITH SERVANT LEADERSHIP:

Moderating effect of P-S fit

Variables	Prosocial motivation β	Prosocial motivation t
Servant leadership	.08	.62
Person-Supervisor fit (P-S fit)	.15	1.16
Servant leadership X P-S fit	.28	3.47***

Note. All significance tests are two-tailed.

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$.

between servant leadership and PS fit (Servant leadership X PS fit) was a significant predictor of prosocial motivation. To facilitate the interpretation of these findings, we plotted the simple slopes for the relationship of servant leadership with prosocial motivation (Figure 2). Tests of these slopes indicated that servant leadership was positively associated with prosocial motivation when PS fit was high.

Prosocial motivation and job satisfaction: Moderating effect of CSR

The results of moderation regression analyses displayed in Table 3 showed that prosocial motivation and CSR significantly predicted job satisfaction. The interaction between prosocial motivation and CSR (Prosocial motivation X CSR) was a significant predictor of job satisfaction. Tests of simple slopes (Figure 3) indicated that the effect of prosocial motivation on job satisfaction was greater when CSR was high than low.

Job satisfaction and organizational commitment

Simple regression test between job satisfaction and organizational commitment showed that job satisfaction significantly predicted organizational commitment ($\beta = .62$, $p < .001$).

DISCUSSION

We proposed and examined a model that integrated professional values of healthcare organization represented by servant leadership, prosocial motivation and corporate social responsibility to improve physicians' job satisfaction and organizational commitment. The findings that servant leadership was more likely to enhance prosocial motivation when physicians perceived high value fit with their supervisors emphasizes the importance of the quality of the relationship between leaders and followers in achieving mutually rewarding outcomes.

Since the positive effect of prosocial motivation on job satisfaction was stronger when physicians perceived their organization as high in CSR rather than low, it can be inferred that the highest job satisfaction and ultimately, organizational commitment can be achieved when leaders, physicians and organization are congruent (i.e., triple synergy) on their prosocial orientation.

In general, the findings highlight the utility of integrating professional values in our understanding of the employment relationship and physicians' work attitudes.

Research implications

This study provides several contributions to existing literature. Firstly, while previous research has primarily examined prosocial motivation at the level of individual employee, (Grant 2007, Grant 2008a) our study expands this line of work by connecting prosocial motivation and leadership. These joint effects demonstrate how prosocial motivation can be enhanced by leadership under the influence of value congruence. This is a meaningful response to the call from the previous studies by presenting how organizations initiate and maintain prosocial motivation by connecting other-oriented values of physicians and their supervisors. (Grant and Berg 2011)

Secondly, prior research has focused on two dimensional fit such as value fit between employees and supervisors, or between employees and an organization. (Kristof-Brown, Zimmerman et al. 2005) Few studies that we know of have paid attention to effects of congruence among employees, supervisors, and an organization at the same time. Our study introduced triple synergy and demonstrated its effects as a contextual factor on the physicians' work attitudes.

TABLE 3: REGRESSIONS PREDICTING JOB SATISFACTION WITH PROSOCIAL MOTIVATION:

Moderating effect of CSR

Variables	Job satisfaction	
	β	t
Prosocial motivation	.40	4.45***
Corporate Social Responsibility (CSR)	.32	4.29***
Prosocial motivation X CSR	.18	1.87*

Note. All significance tests are two-tailed.

*** p < 0.001, ** p < 0.01, *p < 0.05.

FIGURE 2: REGRESSION SLOPES OF PROSOCIAL MOTIVATION ON SERVANT LEADERSHIP AT LEVELS OF PERSON- SUPERVISOR FIT (PS FIT)
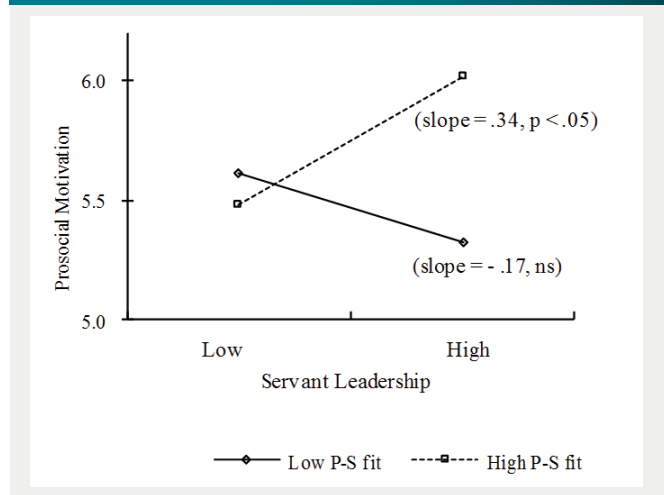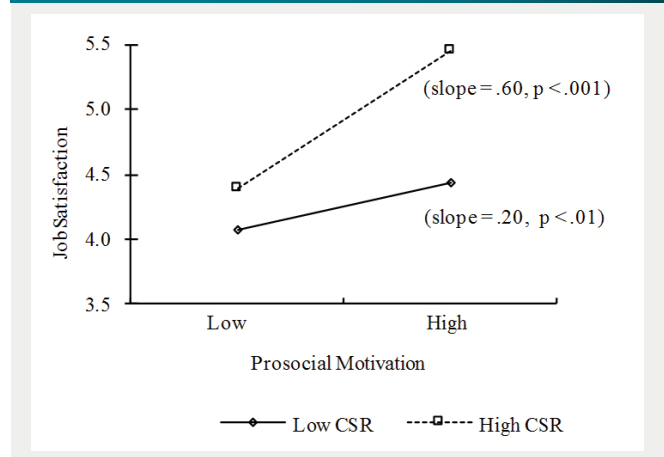

FIGURE 3: REGRESSION SLOPES OF JOB SATISFACTION ON PROSOCIAL MOTIVATION AT LEVELS OF CORPORATE SOCIAL RESPONSIBILITY (CSR)

Thirdly, while most CSR research focused on its effects on external stakeholders, few studies have investigated the impact of external CSR strategies on internal stakeholders. (Brammer, Millington et al. 2007) Furthermore, there is emerging literature that argues for the psychology of CSR, which considers how employees perceive and subsequently react to CSR. (Greening and Turban 2000, Jones 2010) Therefore, our study also contributes to the growing literature on the micro-level impact of CSR by providing the evidence that organizations' external CSR indeed has a positive impact on internal stakeholders' work attitude.

Practical implications

Our study also provides several practical implications. First of all, the relationships between prosocial orientation and employee outcomes have been rarely examined in multicultural organizations. In the management of culturally diverse workforces, it is important to understand how prosocial orientation affects physicians' work outcomes. The logic behind the prediction about the relations between prosocial orientation and work attitudes may not be culture bound especially in healthcare settings because prosocial orientation, i.e., helping and caring for others is a prime value and universal moral principle in healthcare professionals and organizations. Therefore, this notion can bridge cultural gaps that may exist in a multicultural organization, and our current study enhances the generalizability of the linkage between prosocial value congruence and physicians work attitudes.

Secondly, shedding light on prosocial motivation-based employment relationship as a source of competitive advantage, supervisors and team physicians may be more successful if supervisors cultivate their own servant leadership style, and at the same time, if both supervisors and physicians improve the quality of their relationship through mutual understanding.

Thirdly, our findings also suggest that organizations may benefit not only externally but also internally by being socially responsible. Thus, organizations should foster a prosocial culture by actively engaging in socially responsible activities, and at the same time, by training and educating both supervisors and employees to be more attentive to the prosocial aspects of work, in order to create a synergy effect. Organizations should also raise the awareness of their employees in their CSR activities by providing information on how the organizations contribute to the community and how external stakeholders benefit from these activities, as our findings indicate that it is the perception of CSR that matters in promoting employees' organizational commitment.

Limitations and future research

Despite the important contribution, our study has several limitations. First of all, the use of a cross-sectional research design raises questions about causality. Our predictions were based on the logic that for example, interaction of servant leadership and PS fit develops prosocial motivation, but it is equally plausible that prosocial motivation and behavior can influence leadership effectiveness. Second of all, our data was collected from a single healthcare organization. Consequently, we are uncertain about the extent to which our findings can be generalized to physicians working in other organizational culture. Further research should collect data from multiple healthcare organizations to cross-validate the relationships in different organizational environments.

Thirdly, all data was self-reported and collected at a single time raising questions about the common method variance issue. (Podsakoff and Organ 1986) However, consistent with existing literature, (Edwards and Cable 2009) self-report measures are appropriate for our theoretical model since we focused on employees' attitudes which are subjective, and more difficult to observe by supervisors or other raters. Furthermore, we adopted post hoc CFA analyses which demonstrate that common-source bias does not pose a serious threat to our findings. However, future research could collect data from different sources to supplement self-report data.

Lastly, we examined employees' perception of CSR rather than the objective CSR on the organizational level. Since we did not measure the actual organizational involvement in CSR activities, there might be a gap between the perception and the reality. However, as previous studies in the fit literature (Kristof-Brown, Zimmerman et al. 2005) and CSR literature (Turker 2009) have shown, subjective perception might be an even more important determinant than objective measures of organizational social performance, regardless of the accuracy of the employee's perception.

CONCLUSION

In the face of insufficient actionable knowledge of prosocial motivation, our study explains how this type of motivation can be shaped by the leadership and linked to the positive work attitudes in a healthcare organization. Our findings accentuate the synergy effects among physicians, their immediate supervisors, and the organization on the prosocial orientations in fostering physicians' prosocial motivation, job satisfaction and organizational commitment. This is consistent with the notion of positive organizational scholarship which emphasizes positive processes and values that can benefit individual and organizational outcomes. (Dutton and Glynn 2008) In addition, this article brings a contemporary perspective to the field of healthcare management by relating prosocial orientation to affective aspects of work attitudes. (Latham and Pinder 2005Latham and Pinder 2005)

ACKNOWLEDGEMENTS

BIOGRAPHY

Dr. Young Shin Kim is a US board-certified Family Medicine physician currently serving at United Family Healthcare in China. She completed a residency training at State University of New York (SUNY) Downstate Medical Center in the US, and received a Master's Degree in Health Administration at Flinders University in Australia.

Appendix 1: Survey Items

Servant leadership

1. My supervisor spends the time to form quality relationships with members in my work unit
2. My supervisor creates a sense of community among members in my work unit.
3. My supervisor's decisions are influenced by the input of members' in my work unit.
4. My supervisor tries to reach consensus among members in my work unit on important decisions.
5. My supervisor is sensitive to members' responsibilities outside the work place.
6. My supervisor makes the personal development of members in my work unit a priority.
7. My supervisor holds employees in my work unit to high ethical standards.
8. My supervisor does what he or she promises to do.
9. My supervisor balances concern for day-to-day details with projections for the future.
10. My supervisor displays wide-raging knowledge and interests in finding solutions to work problems.
11. My supervisor makes me feel like I work with him/her, not for him/her.
12. My supervisor works hard at finding ways to help others be the best they can be.
13. My supervisor encourages employees in my work unit to be involved in community service and volunteer activities outside of work.
14. My supervisor emphasizes the importance of giving back to the community.

Prosocial Motivation

"Why are you motivated to do your work?"

1. Because I care about benefiting others through my work.
2. Because I want to help others through my work.
3. Because I want to have a positive impact on others.
4. Because it is important to me to do good for others through my work.

Job satisfaction

1. If a good friend of mine told me that he/she was interested in working in a job like mine, I would strongly recommend it.
2. All in all, I am very satisfied with my current job.
3. In general, my job measures up to the sort of job I wanted when I took it.
4. Knowing what I know now, if I had to decide all over again whether to take my job, I would.

Affective organizational commitment

1. I would be very happy to spend the rest of my career with this organization.
2. I enjoy discussing my organization with people outside of it.
3. I really feel as if this organization's problems are my own.
4. This organization has a great deal of personal meaning for me.
5. I feel emotionally attached to this organization.

Person-Supervisor fit

1. The things that I value in life are very similar to the things that my immediate supervisor value.
2. My personal values match my immediate supervisor's values and culture.
3. My immediate supervisor's values and culture provide a good fit with the things that I value in life.

Corporate Social Responsibility

1. Our organization believes and values monitoring new opportunities which can enhance the company's ability to solve social problems.
2. Our organization believes in performing in a manner consistent with the philanthropic and charitable expectations of society.
3. Our organization's philosophy emphasized viewing philanthropic behavior as a useful measure of corporate performance.

References

Aiken, Leona S., and Stephen G. West. 1991. *Multiple Regression: Testing and Interpreting Interactions.* Newbury Park, CA: Sage.

Alonso, Pablo. and Gregory B. Lewis. 2001. "Public service motivation and job performance: evidence from the federal sector." *American Review of Public Administration* 31 (4): 363-380.

Amabile, Teresa M. 1993. "Motivational synergy: Toward new conceptualizations of intrinsic and extrinsic motivation in the workplace." *Human Resource Management Review* 3 (3): 185-201.

Ashforth, Blake E., and Fred Mael. 1989. "Social identity theory and the organization." *Academy of Management Review* 14: 20-39.

Barnett, R. C., P. Carr, A. D. Boisnier, A. Ash, R. H. Friedman, M. A. Moskowitz and L. Szalacha 1998. "Relationships of gender and career motivation to medical faculty members' production of academic publications." *Academic Medicine* 73 (2): 180-186.

Barrick, Murray R., and Michael K. Mount 1991. "The Big Five personality dimensions and job performance: A meta-analysis." *Personnel Psychology* 44: 1-26.

Batson, C. Daniel. 1987. Prosocial motivation: Is it ever truly altruistic? *Advances in experimental social psychology.* 20: 65-122.

Bauman, Christopher W., and Linda J. Skita. 2012. "Corporate social responsibility as a source of employee satisfaction." *Research in Organizational Behavior:* 24.

Black, Aaron E., and Edward L. Deci. 2000. "The effects of instructors' autonomy support and students' autonomous motivation on learning organic chemistry: a self-determination theory perspective." *Science Education* 84: 740–756.

Brammer, Stephen, Andrew Millington, and Bruce Rayton. 2007. "The contribution of corporate social responsibility to organizational commitment." *International journal of Human Resource Management* 18: 1701-1719.

Brown, Michael E., Linda K. Treviño and David A. Harrison. 2005. "Ethical leadership: A social learning perspective for construct development and testing." *Organizational Behavior and Human Decision Processes* 97 (2): 117-134.

Brown, Michael E. and Linda. K. Treviño. 2006. "Ethical leadership: A review and future directions." *Leadership Quarterly* 17 (6): 595-616.

Cable, Daniel M., and D. Scott DeRue. 2002. "The Convergent and Discriminant Validity of Subjective Fit Perceptions." *Journal of Applied Psychology* 87 (5): 875-884.

Cohen, Jacob, Patricia Cohen, Stephen G. West, and Linda S. Aiken. 2003. *Applied Multiple Regression/Correlation Analysis for the Behavioral Sciences* Mahwah, NJ: Erlbaum.

Deci, Edward L. 1971. "Effects of extrinsically mediated rewards on intrinsic motivation." *Journal of Personality and Social Psychology* 18 (1): 105-115.

Deci, Edward L., Richard Koestner, and Richard M. Ryan. 1999. "A meta analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation." *Psychological Bulletin* 125: 627-668.

Dirks, Kurt T., and Donald L. Ferrin. 2002. "Trust in leadership: Meta-analytic findings and implications for research and practice." *Journal of Applied Psychology* 87 (4): 611-628.

Dowling, William F., and Leonard R. Sayles. 1978. *How managers motivate: The imperatives of supervision.* 2nd ed. New York: McGraw-Hill.

Dutton, Jane E., and Mary A. Glynn. 2008. Positive Organizational Scholarship. In *The SAGE Handbook of Organizational Behavior, ed J. Barling* and C. L. Copper, 693-712. Thousand Oaks, CA: Sage.

Edwards, Jeffrey R., and Daniel M. Cable. 2009. "The value of value congruence." J*ournal of Applied Psychology* 94 (3): 654-677.

Ehrhart, Mark G. 2004. "Leadership and Procedural Justice Climate as Antecedents of Unit-Level Organization Citizenship Behavior." *Personnel Psychology* 57 (1): 61-94.

Eisenberger, Robert, Jim Cummings, Stephen Armeli and Patrick. Lynch. 1997. "Perceived Organizational Support, Discretionary Treatment, and Job Satisfaction" *Journal of Applied Psychology* 82 (5): 812-820.

Enz, Cathy A. 1988. "The role of value congruity in intraorganizational power." *Administrative Science Quarterly* 33 (2): 284-304.

Gagne, Marylene, and Edward L. Deci. 2005. "Self-determination theory and work motivation." *Journal of Organizational Behavior* 26 (4): 331-362.

Goll, Irene, and Gerald Zeitz. 1991. "Conceptualizing and Measuring Corporate Ideology" *Organization Studies* 12 (2): 191-207.

Graham, Jill W. 1991. "Servant leadership in organizations: Inspirational and moral." *The Leadership Quarterly* 2 (2): 105-119.

Grant, Adam M. 2007. "Relational job design and the motivation to make a prosocial difference." *Academy of Management Review* 32 (2): 393-417.

Grant, Adam M. 2008a. "Does Intrinsic Motivation Fuel the Prosocial Fire? Motivational Synergy in Predicting Persistence, Performance, and Productivity." *Journal of Applied Psychology* 93 (1): 48-58.

Grant, Adam M. 2008b. "Giving Commitment: Employee Support Program and the Prosocial Sensemaking Process." *Academy of Management Journal* 51 (5): 898-918.

Grant, Adam M. 2008c. "The significance of task significance: Job performance effects, relational mechanisms, and boundary conditions." *Journal of Applied Psychology* 93 (1): 108-124.

Grant, Adam M., and Susan. J. Ashford. 2008. "The dynamics of proactivity at work " *Research in Organizational Behavior* 28: 3-34.

Grant, Adam M,. and Justin M. Berg. 2011. Prosocial motivation at work: When, why, and how making a difference makes a difference. In *Oxford handbook of positive organizational scholarship, ed. K. Cameron* and G. Spreitzer, 28-44. New York: Oxford University Press.

Grant, Adam M., and David M. Mayer. 2009. "Good Soldiers and Good Actors: Prosocial and Impression Management Motives as Interactive Predictors of Affiliative Citizenship Behaviors." *Journal of Applied Psychology* 94 (4): 900-912.

Grant, Adam M., and John J. Sumanth. 2009. "Mission Possible? The Performance of Prosocially Motivated Employees Depends on Manager Trustworthiness." *Journal of Applied Psychology* 94 (4): 927-944.

Greening, Daniel W., and Daniel B. Turban. 2000. "Corporate social performance as a competitive advantage in attracting a quality workforce." *Business and Society* 39 (3): 254-280.

Hall, Douglas T., Benjamin Schneider and Harold T. Nygren. 1970. "Personal factors in organization identification." *Administrative Science Quarterly* 15 (2): 176-186.

Ilies, Remus, Ann C. Peng, Krishina. Savani and Nikolaos Dimotakis. 2013. "Guilty and helpful: An emotion-based reparatory model of voluntary work behavior." *Journal of Applied Psychology* 98 (6): 1051-1059.

Jehn, Karen A., and Elizabeth A. Mannix. 2001. "The dynamic nature of conflict: A longitudinal study of intragroup conflict and group performance." *Academy of Management Journal*, 44 (2): 238-252.

Jones, David A. 2010. "Does serving the community also serve the company? Using organizational identification and social exchange theories to understand employee responses to a volunteerism programme." *Journal of Occupational and Organizational Psychology* 83 (4): 857-878.

Jones, Gareth R., and Jennifer M. George. 1998. "The experience and evolution of trust: Implications for cooperation and teamwork." *Academy of Management Review* 23 (3): 531-546.

Kim, Tae-Yeol, Samuel Aryeeb, Raymond Loic, and Sang-Pyo Kim. 2013. "Person–organization fit and employee outcomes: test of a social exchange model" *The International Journal of Human Resource Management* 24 (19): 3719-3737.

Konovsky, Mary A. and Dennis W. Organ. 1996. "Dispositional and contextual determinants of organizational citizenship behavior." *Journal of Organizational Behavior* 17 (3): 253-266.

Kreitner, R. and A. Kinicki. 2010. Leadership. In *Organizational behavior* 477-487. New York: McGraw-Hill Irwin:.

Kristof-Brown, Amy L., Ryan D. Zimmerman, and Erin C. Johnson. 2005. "Consequences of individuals' fit at work: A meta-analysis of person–job, person–organization, person–group, and person–supervisor fit." *Personnel Psychology* 58 (2): 281-342.

Kristof, Amy L. 1996. "Person–organization fit: An integrative review of its conceptualizations, measurement, and implications." *Personnel Psychology* 49 (1): 1-49.

Lambrou, Persefoni, Nick Kontodimopoulos, and Dimitris Niakas. 2010. "Motivation and job satisfaction among medical and nursing staff in a Cyprus public general hospital" *Human Resources for Health* 8: 26.

Latham, Gary P., and Craig C. Pinder. 2005. "Work motivation theory and research at the dawn of the twenty-first century." *Annual Review of Psychology* 56: 495-516.

Locke, Edwin A. 1976. The nature and causes of job satisfaction. In *Handbook of industrial and organizational psychology, ed. Marvin D. Dunnette*, 1304, Chicago, IL: Rand McNally.

Mayer, Roger C., James H. Davis, and F. Davis Schoorman. 1995. "An integrative model of organizational trust." *Academy of Management Review* 20 (3): 709-734.

McGee, Gail W., and Robert C. Ford. 1987. "Two (or More?) Dimensions of Organizational Commitment: Reexamination of the Affective and Continuance Commitment Scales" *Journal of Applied Psychology* 72 (4): 638-642.

Meglino, Bruce M., and M. Audrey Korsgaard. 2004. "Considering rational self-interest as a disposition: Organizational implications of other orientation." *Journal of Applied Psychology* 89 (6): 946-959.

Meglino, Bruce M., Elizabeth C. Ravlin, and Cheryl L. Adkins. 1991. "Value congruence and satisfaction with a leader: An examination of the role of interaction." *Human Relations* 44 (5): 481-495.

Meyer, John P., and Natalie. J. Allen. 1991. "A three-component conceptualization of organizational commitment." *Human Resource Management Review* 1 (1): 61-89.

Nunnally, Jum C. 1978. *Psychometric theory New York*: McGraw-Hill

Organ, Dennis W., and Katherine Ryan. 1995. "A meta-analytic review of attitudinal and dispositional predictors of organizational citizenship behavior." *Personnel Psychology* 48 (4): 775-802.

Peterson, Dane K. 2004. "The relationship between perceptions of corporate citizenship and organizational commitment." *Business and Society* 43 (3): 296-319.

Pinder, Craig C. 2008. Human Nature: Affect and emotions as motives to work. In *Work motivation in organizational behavior*. 107-143. New York: Psychology Press.

Podsakoff, Philip M., and Dennis W. Organ. 1986. "Self-reports in organizational research: Problems and prospects." *Journal of Management* 12 (4): 531-544.

Robert Kreitner, A. K. 2010. *Organizational Behavior*. 3rd ed.New York: McGraw-Hill..

Ryan, Richard M., and James P. Connell. 1989. "Perceived Locus of Causality and Internalization: Examining Reasons for Acting in Two Domains" *Journal of Personality and Social Psychology* 57 (5): 749-761.

Seo, Myeong-gu, M. Susan Taylor, N. Sharon Hill, Xiaomeng Zhang, Paul E. Tesluk, and Natalia M. Lorinkova. 2012. "The role of affect and leadership during organizational change." *Personnel Psychology.* 65 (1): 121-165.

Shamir, Boas. 1990. "Calculations, values, and identities: the sources of collectivistic work motivation." *Human Relations* 43 (3): 313-332.

Turker, Duygu. 2009. "Measuring corporate social responsibility: A scale development study." *Journal of Business Ethics* 85 (4): 411-427.

Williams, Geoffrey C., and Edward L. Deci. 1996. "Internalization of biopsychosocial values by medical students: a test of self- determination theory." *Journal of Personality and Social Psychology* 70 (4): 767–779.

Wood, Robert, and Albert Bandura. 1989. "Social cognitive theory of organizational management." *Academy of Management Review* 14 (3): 361-384.

Wright, Scott M., and Brent W. Beasley. 2004. "Motivating Factors for Academic Physicians Within Departments of Medicine." *Mayo Clinic proceedings* 79 (9): 1145-1150.

Zhang, Zhen, Mo Wang, and Junqi Shi. 2012. "Leader-follower congruence in proactive personality and work outcomes: the mediating role of leader-member exchange." *Academy of Management Journal* 55 (1): 111-130.

Development, empowerment and accountability of front line employees

MRADUL KAUSHIK
DIRECTOR-OPERATION & PLANNING,
BLK SUPER SPECIALTY HOSPITAL,
NEW DELHI – INDIA

VIVEK GUPTA
CLINICAL PHARMACOLOGIST,
BLK SUPER SPECIALTY HOSPITAL,
NEW DELHI – INDIA

SANJAY MEHTA
MEDICAL SUPERINTENDENT,
BLK SUPER SPECIALTY HOSPITAL,
NEW DELHI – INDIA

AJAY SINGH
DEPUTY MANAGER-QUALITY,
BLK SUPER SPECIALTY HOSPITAL,
NEW DELHI – INDIA

PRASHANT SINGH
DEPUTY GENERAL MANAGER-IT,
BLK SUPER SPECIALTY HOSPITAL,
NEW DELHI – INDIA

ABSTRACT: Facilitating patient-focused, cost-effective care throughout the continuum is a challenge that requires creativity of healthcare administrators. At BLK Super Specialty Hospital, a Guest Relationship Executive (GRE) and Patient Care Coordinator (PCC) role was developed to improve communication and linkage among clinical and non-clinical departments. Management also innovated various other processes which needed improvement for facilitating the improvement of services provided to the patients. Empowering PCC and GRE to take the initiative, make decisions and take actions to prevent and resolve service issues has elevated service levels and lead to an enhanced patient experience.

INTRODUCTION. Medical care is a people and detail-intensive business, focused on providing quality patient care, servicing endless patient needs and operating in an efficient and cost-effective manner. There are countless details that must be handled daily to provide the high levels of quality care that patients require and expect. A clinical team comprising of doctors and nurses cannot do and monitor everything alone. On the other hand management cannot reach out to each patient and provide personalized care. There was always a tangible need for employees who can think and act in alignment with the hospital's mission, vision and values, along with carefully defined management guidelines. This paper presents a short overview of the strategy employed by BLK Super Specialty Hospital to facilitate continuity of care to its patients.

BLK rolled out a comprehensive Patient Feedback Program in 2013 in an endeavor to gauge the patient satisfaction levels with various services of the Hospital. This program revealed that most of the patients' concerns were anchored on non-medical services like F&B, Maintenance, Billing, Admission & Discharge processes, etc.

Conventionally, Nurses had been the custodians and the first point of contact for indoor patients for all their needs – medical or non-medical. Consequently, Nurses had been spending a significant amount of their time in responding to non-nursing / non-medical queries of patients. This was leading to dissonance on multiple counts:

- Over-worked nursing staff
- Potential for nursing errors
- Delays in nursing services
- Dissatisfied patients
- Perceived below-par administrative service levels of the Hospital.

Keeping the above mentioned problems in mind, a core team comprising heads of various non-medical and medical administrative services of the Hospital was constituted. This team's defined charter includes the ownership of BLK's delivery and service commitment to the patients. As a part of performance review, the team identified the issue of patient satisfaction levels with respect to the non-medical functions like Food, Billing, Admission time, Discharge time, etc.

Further analysis revealed that the primary concern is based on

the fact that nursing teams were expected to resolve such non-medical requirements of the patients. The core team developed the blueprint of the overall plan for the delivery of appropriate services with the help of ownership by below mentioned staff:

- **Patient Care Coordinators (PCC):** PCCs are specifically recruited, trained and oriented to be the 'Single' point of contact for patients for all their needs, complaints, queries or requests

- **Guest Relationship Executives (GRE):** GREs are equivalent to super-specialists in patient care and manage the 'Handle with care' patients (beyond the Vulnerable patients, i.e. elderly, physically or mentally-challenged and children, as defined in NABH and JCI guidelines) (1-2).

While PCC have been in place in the hospital sector for some time, the key differentiator in BLK's case has been the Empowerment and Accountability of the teams, wherein:

- Each PCC is expected to reach out to any and all service departments (including medical) to seek the response / service that are sought by the patient

- Instead of being Information Coordinators, PCCs have to ensure the actual delivery of service by the relevant departments to the patients

- 'Escalation mapping' allows any PCC to reach out to AMS, MS, Director-Medical Services and CEO within pre-set timelines (24 hrs in total) in case of delayed service / revert to the patient.

Management also innovated various other processes which needed improvement for facilitating the improvement of services provided to the patients.

The various areas of **concern** before management were:
1. Waiting Time for patient admission
2. Period for Discharge Process
3. The process of Patient Feedback
4. Manual communication process of Dietary Services for the patients
5. TAT of inter-department Complaint Redressals
6. Quality of Care provided by the nursing staff.

The various challenges identified in the service delivery were addressed in a systematic way which involved various innovations both at the level of stakeholder as well as end user.

The following initiatives were taken:

1. QUEUE MANAGEMENT:
The process of queue management was introduced in the admission and sample collection process to reduce the waiting time of admission. **Token display software** was installed at: TPA/CGHS/ESI/PSU, OP / IP Billing counters, Admission desk and Sample Collection area.

2. STREAMLINING AND IMPROVING THE DISCHARGE PROCESS:
The following initiatives were taken:
- System for capturing expected Date of Discharge at the time of admission and planning discharge a day prior
- Ward wise discharge Coordinators and ward secretaries were deployed
- Emphasis on docket preparation along with pharmacy returns on the previous night
- Identified a dedicated **Bed Manager** (within the system) who would intelligently capture & disseminate information.

3. PATIENT FEEDBACK:
The following initiatives were taken:
- Metrics changed to make questionnaire customer friendly
- All feedback forms are now put in the patient files at the time of admission
- Patient Care Coordinators (PCCs) / Nursing / Ward Secretaries given the task to capture the maximum feedback forms
- Feedback forms handed over to the Department of Quality Management on a daily basis for entry into the Analysis Sheet
- System driven quantitative analysis of patient feedback with 'flagging' of concerns to relevant departments
- All metrics in each category are now being quantitatively analyzed in all categories.
- **Analysis of forms** with qualitative negative remarks, **'Poor rating'** and **'No to BLK'** carried out at the Top Management Level
  - **All 'No to BLK'** feedback forms are **contacted by MS office / AVP Administration**
  - As a part of the process, BLK PCCs and GRE teams actually reach out to patients who give negative feedback to resolve their concerns.
- **Thank you Letter to patients** – appreciating the services.

4. FOOD & NUTRITION SERVICES
The following initiatives were taken:
- Automated Communication of Diet Information between Nursing-Dietetics-F&B through HIS
- Option of Type of Diet (Diabetic/Non Diabetic, Hypertensive/Normal Diet) and also the frequency of diet required with exact time of delivery made available in HIS
- HIS based orders ensure that no order is missed.

5. HELP DESK MANAGER
In order to address the complaints, an application has been developed in the HIS where inter-departmental feedback/compliants can be lodged by the internal customers.
The various steps followed are mentioned below:
1. Various Service Departments of the organization were identified as:
   a. Engineering
   b. Bio-Medical Engineering
   c. House Keeping
   d. Information Technology
   e. Food & Beverages (F & B)
   f. Front Office etc.

2. In order to provide better service, further functional sub-departments were identified for each department

3. For each of department a Draft Feedback form was prepared in Excel format that can be uploaded in system

4. Thereafter, the 'Escalation Matrix' of the Service Departments was gathered for each Sub-department.

6. **<u>NURSING:</u>**

The nursing department also implemented the following nursing innovations:

1. Appointment of Floor wise Nursing In charge

2. Streamlining of the inventory practices at Nursing Sub Stores

3. Better Practices for managing bed sore by abolishing the practice of keeping water filled gloves under the heel of the patient and introducing foot care, massaging the heels, along with using the assistance of family members for the nursing care of bed ridden patients.

RESULTS

Typical of multi-specialty hospitals, the BLK had to grapple with the 'morning-rush' of In-patients, i.e. overlap in the admission and discharge timing for the patients. Earlier the Hospital was forced to maintain a buffer of about 5% of bed capacity to churn the patients during the morning-rush. Imputed value of such buffer capacity was close to Rs 1.25 crores per month or Rs 15 crores per year.

Besides the enhanced patient satisfaction levels as well as upgrading to best intra service standards, PCCs and GREs also helped in reducing this buffer bed capacity level to the current 'Nil' for the Hospital. Consequently waiting time for admission has been reduced to less than 1 hour (Figure 1).

FIGURE 1: WAITING TIME FOR ADMISSION (IN MINUTES)
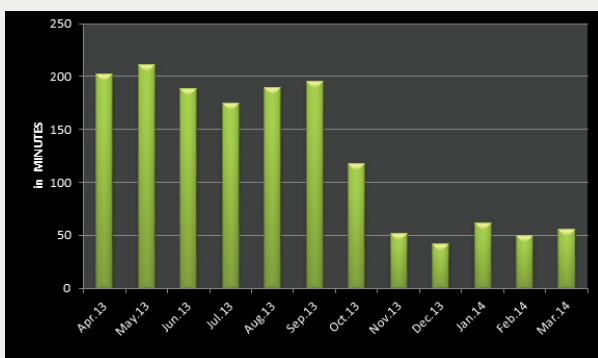
Along with managing the patient concerns, complaints and queries, PCCs also act as nodal points for maintaining patient files. This team ensures that all patient records including doctor notes, discharge summaries, billing reconciliation, etc. are compiled on the evening prior to the patients' discharge day. Today, [90%] of IP discharges are completed before 11:00 a.m. at BLK vis-à-vis [40%] in 2012-13. It also results in reduction of length of discharge process from an average of 4 hours to less than 2 hours (Figure 2).

FIGURE 2: LENGTH OF DISCHARGE PROCESS (IN MINUTES)
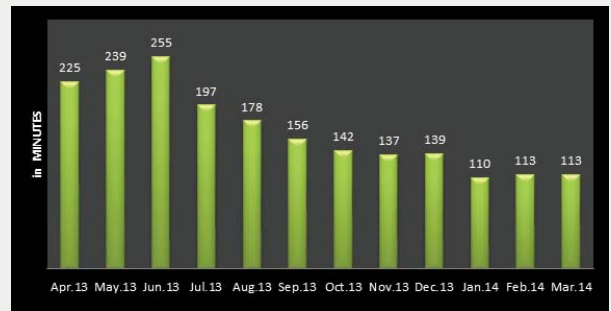
Since the introduction of PCCs and GREs, BLK's patient satisfaction levels have increased from ~60% (2011-2012) to 97% (2013-2014) (Figure 3).

FIGURE 3: OVERALL PATIENT SATISFACTION (IN PERCENTAGE)
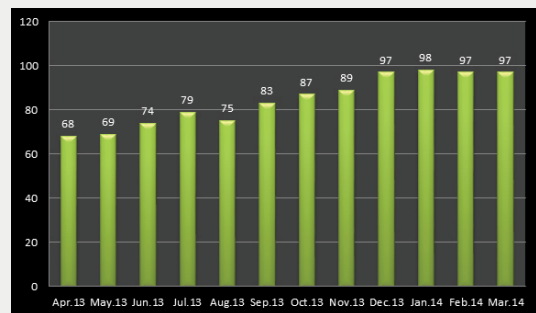
The strengthened Patient feedback mechanism ensure that all services are mapped holistically to capture correct feedback and Service Recovery mechanism instituted thereby building up the confidence in patients (Figure 4). Management also gets the real feedback by constituting Proactive Approach.

FIGURE 4: DESK MANAGER COMPLAINT REDRESSAL ANALYSIS (IN PERCENTAGE)
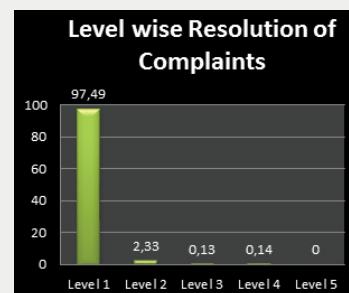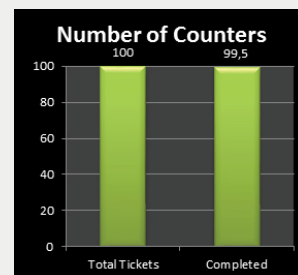
We had 20372 counters tracked through this system and we resolved 20270 complaints i.e. 99.47% success rate within its turnaround time. Of this number, we resolved 97.49% complaints at level one only. As per the departments concerned we have resolved 97.45, 98.20, 49.7 and 92 percent complaints within the TAT of Engineering, Housekeeping, IT and Biomedical Engineering departments respectively.

The dietary initiatives have been the HIS based Tickets which have brought about Paper Reduction as well as the Chance of Mixing of diets have been reduced. There has been an Elimination of the communication errors and Enhancement of the efficiency with better TAT (Figure 5). As a result of this the **COST SAVING** from Jul.13 to Mar.14 has been almost Rs 1, 31,737/year (Figure 6).

FIGURE 5: TAT OF DIETARY SERVICE (IN MINUTES)
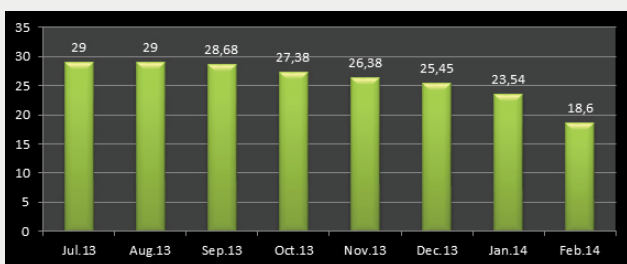
FIGURE 6: PATIENT DIET STATIONARY COST (IN RS)
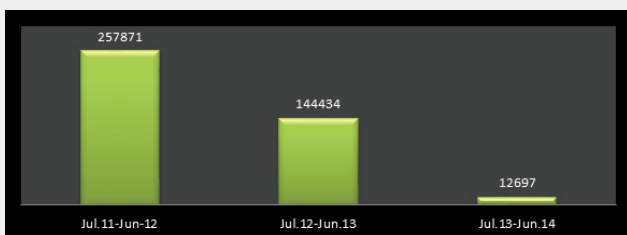
Freeing nurses from non-medical tasks allows them to focus on the clinical needs and services of the patients. While obviously leading to better service standards, this also creates much better work environment for the nurses. The improved **Quality of Nursing care** has helped in various ways which include reduction of **Medication errors, Incidents of Patient falls, reduced Hospital Acquired Infections and decreased Incidents of Bed sores** (through Better training for the Nursing staff and Abolishing the use of water filled Gloves to manage Sores).

From patient standpoint, along with the enhanced medical care and improved service levels, the timely admission and discharge process also led to enhanced patient satisfaction and reduced overall hospitalization costs.

Consequently, patients get more coordinated care in a healthier environment. This also reduced the stress that patients or their attendants typically go through while staying in the hospital. PCCs / GREs are seen as buddies by patients, with whom they can share all functional and emotional concerns, during the course of their stay at the Hospital.

CONCLUSION

The cadres of PCC and GRE have been established as permanent positions in the BLK's Human Resource plan. Also, the Organization Structure connects these teams directly with the Medical Superintendent; this allows the PCCs and GREs to escalate any exigent concerns / critical patient feedbacks to the top management in the shortest possible time. Based on the positive outcomes of these efforts, BLK is now further strengthening these teams to manage, along with the In-patients, some of the day-care areas like Labs, Radiology, Physiotherapy, etc.

BIOGRAPHIES

Mradul Kaushik is Director, Operation and Planning of BLK Super Specialty Hospital, New Delhi. He has played a vital role in conceptualizing, implementing and monitoring various patient safety and quality initiatives throughout the hospital. He is an assessor for the National accreditation Board for Hospital and Healthcare provider.

Sanjay Mehta is Medical Superintendent of BLK Super Specialty Hospital, New Delhi. He has vast experience of 15 years in hospital administration and quality. He is also an assessor for the National accreditation Board for Hospital and Healthcare provider.

Prashant Singh has more than 17 years of experience 15 years of which are purely in healthcare IT. Healthcare experience includes the commissioning and operationalization of the Information Technology setup of greenfield hospitals like Paras Hospitals and Sri Balaji Action Medical Institute along with revamping of the IT in Tirath Ram Shah Hospital and BLK Super Specialty Hospital.

Vivek Gupta is Clinical Pharmacologist at BLK Super Specialty Hospital, New Delhi with over 5 years of experience. He is instrumental in bringing various medication safety drives in the hospital.

Ajay Singh is Deputy Manager Quality at BLK Super Specialty Hospital, New Delhi. He is an accreditation coordinator for NABH & JCI. He has undergone a certification course in Tools and Technique of Quality Improvement by NABH.

References

1. Joint Commission International Accreditation Standards for Hospitals, 5th Edition

2. NABH Accreditation Standards for Hospitals, 3rd Edition.

Saving lives together

ALIYAH KAREN
CEO OF THE MAA MEDICARE
CHARITABLE FOUNDATION (MEDICARE) – MALAYSIA

ABSTRACT: Established 20 years ago with a single dialysis center assisting only 20 patients with 6 hemodialysis machines, Medicare has grown leaps and bounds to assist thousands of poor patients to obtain a highly subsidized rate for quality treatment. Millions of ringgit raised via various fundraising projects and events have been well utilized to serve the growing number of kidney patients in Malaysia who simply cannot bear the exorbitant cost of treatment. Staying true to its mission, Medicare extends its assistance to needy kidney patients and their families, who indirectly have become part of the Medicare family.

INTRODUCTION. Kidney failure is known as the 'rich man's disease', simply because of its exorbitant cost, a lifelong requirement to stay alive hooked on to a machine 3 times a week for 4-5 hours each session, should one fall prey to this illness. In Malaysia, unlike other countries the scenario is different when one is diagnosed with ESRF (End Stage Renal Failure).

Approximately 0.001% of a country's population will be diagnosed with some sort of kidney disorder each year. With 29 million Malaysians, the number of new cases diagnosed that are related to kidneys should range between 3,000 – 4,000 cases. However, the current number of new cases in Malaysia has gradually increased in the last few years and has surpassed 6,200 new cases in 2013. (Figure 1)

FIGURE 1: NEW DIALYSIS PATIENTS FROM 2004-2013 IN MALAYSIA
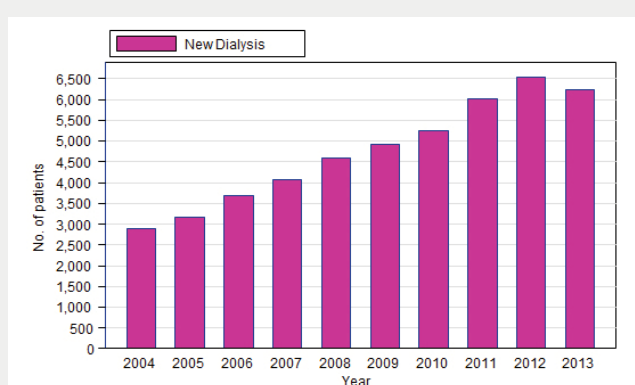
Source: 21st Report of the Malaysian Dialysis and Transplant Registry 2013. Chapter 1 All Renal Replacement Therapy In Malaysia. *Figure 1.1: Stock and flow of RRT, Malaysia 2004-2013 (a), New dialysis and transplant patients*, by Lim Yam Ngo, Ong Loke Meng, Goh Bak Leong and Lee Day Guat.

Currently 32,000 kidney patients are on dialysis in Malaysia.

Close to 29,000 of these patients are on hemodialysis, the more popular choice of treatment. The main cause of kidney failure is non-other than diabetes followed by hypertension. (Figure 2)

FIGURE 2: PRIMARY CAUSE OF RENAL DISEASES
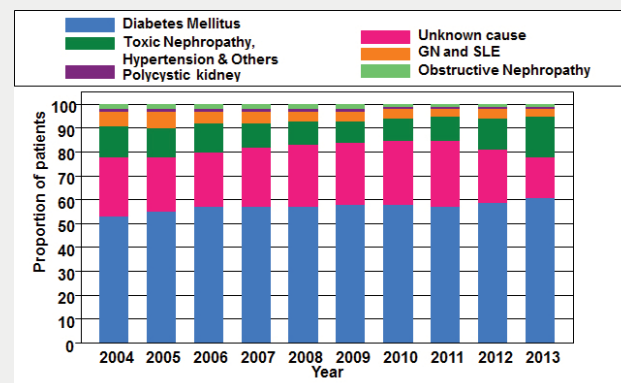
Source: 21st Report of the Malaysian Dialysis and Transplant Registry 2013. Chapter 2 Dialysis In Malaysia. *Figure 2.1.8: Primary Renal Diseases for New Dialysis Patients 2004-2013*, by Goh Bak Leong, Lim Yam Ngo, Ong Loke Meng, Ghazali Ahmad and Lee Day Guat

Although the numbers are worrying and the Ministry of Health (MOH) is deeply concerned, the irony of it is that Malaysia is a country without a health plan for its citizens. Simply meaning, when one is diagnosed with kidney failure, all cost must be borne by the individual, unless they are still serving or have retired from the civil sector. If they have contributed to the social security service while employed for a minimum of 3 years, then the patient is eligible for subsidy. Patients who come from a lower income group / poor are subsidized RM50 for each treatment by the Ministry of Health. Medicare cares for 12% of the patients categorised under the NGO category. (Figure 3)
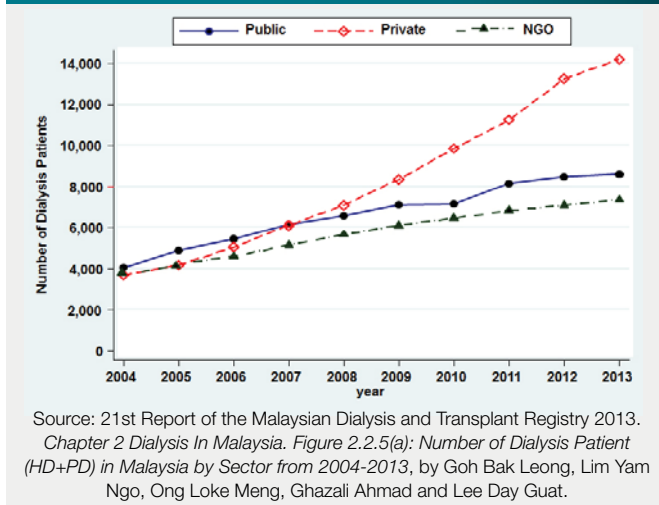
While the rich can afford treatment at private healthcare facilities, the poor depend on to the Government for assistance, which in reality cannot cope with the demand to provide such services to a large and growing number of patients.

The Establishment

Realizing the need and unable to turn a blind eye towards this cause, MAA Medicare Kidney Charity Fund (Medicare) was established in 1994 to provide highly subsidized treatment at a nominal cost, mainly to kidney patients from the lower income group. Back then, services were either scarce or exorbitant in cost. Medicare's sole intention was to make dialysis accessible, affordable and available to especially poor patients, who otherwise would be further burdened because they could not afford or obtain available treatments.

Poor patients who have no access to government hospitals and facilities due to space constrain would be referred to Medicare, which is also the medical panel or referral point for related agencies and sponsors.

As Medicare is a non - profit organization, the target was to raise funds, pledges and sponsorships to establish centers, where needed to continue its mission and goals.

The aim was to keep as many patients alive, on quality care treatment; four hours each session, three times a week for the rest of their lives;

regardless of their age, income, gender, race or religion at each center established.

Today Medicare is the 2nd largest non-profit dialysis treatment provider in Malaysia, caring for over 850 patients at 12 centers nationwide at 9 out of the 14 states (Appendix A).

40% of these patients are currently receiving the RM50 subsidy. Societies, corporate donors, statutory and religious bodies largely sponsor the remaining RM60. 60% of its patients either pay a subsidized fee of between RM60-RM110 per treatment or are sponsored by agencies and corporate companies. Private facilities charge between RM160-RM250 per treatment. These charges are mainly for treatments using re-use dialyzers.

In line with the requirements by the MOH, all 12 of Medicare's centers have been relocated to new, larger more strategic locations and have obtained licenses. Each treatment center has been equipped with the latest medical machinery and equipment. Ramps, call buttons, larger wash-rooms and low sinks are fitted to cater for the disable, blind and elderly.

Treatment types

Dialyzer reuse is commonly practiced in Malaysia in light of its cost saving benefits for the dialysis provider and the patient. However, 70% of Medicare's patients are on single use dialyzer treatments. Single use decreases rates of infection, conversions and cross infection, likelihood of errors and accidents, and risks associated with exposure to germicides and denatured blood products. Although the cost is higher at RM180 per treatment, Medicare remains committed in providing the best quality treatment

APPENDIX A: LOCATION OF MAA MEDICARE'S DIALYSIS CENTERS IN MALAYSIA

Source: MAA Medicare Charitable Foundation.
http://maa-medicare.org.my/centres/
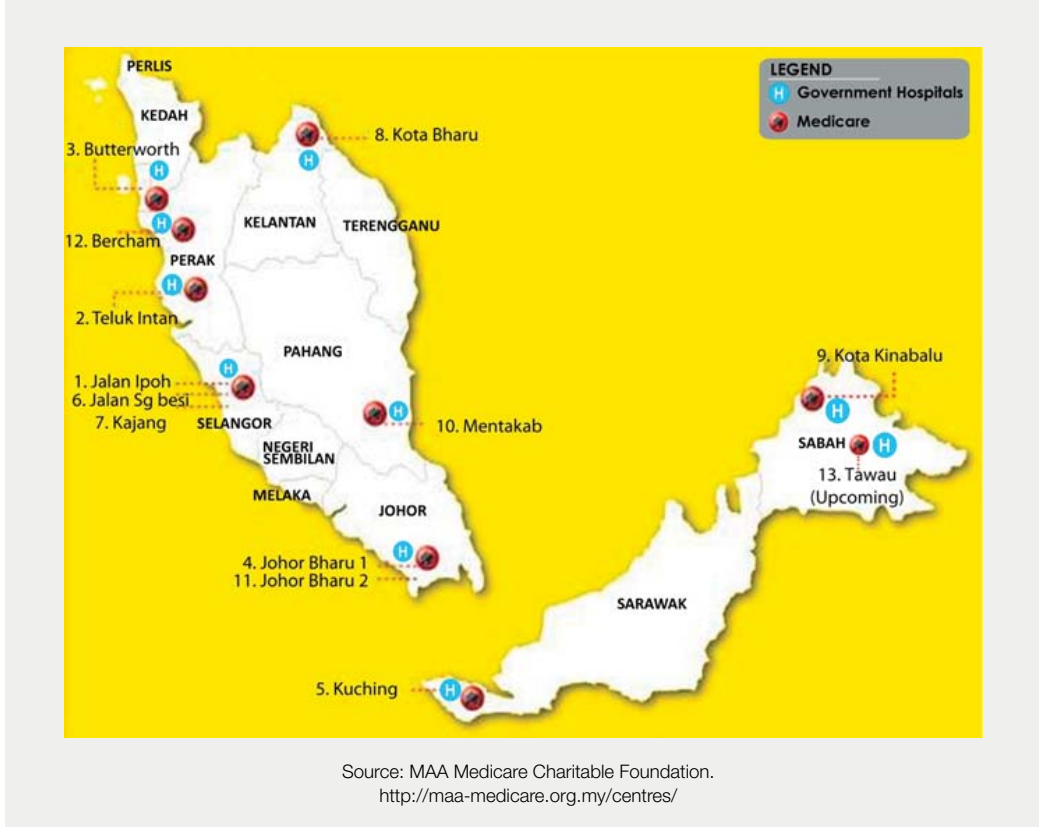
FIGURE 4: MAA MEDICARE VS GOVERNMENT HOSPITALS : NUMBER OF DIALYSIS PATIENTS AND MACHINES

Dialysis Centres in every state	MAA Medicare			Government Hospitals		
	Number of Patients		Number of Machines	Number of Patients		Number of Machines
	Normal	Hepatitis B & C		Normal	Hepatitis B & C	
Jalan Ipoh	44	21	18	50	62	28
Jalan Sg Besi	48	7	12	0	0	0
Butterworth	30	22	12	40	5	12
Johor Bharu 1	81	24	19	101	0	21
Johor Bharu 2	44	4	11	0	0	0
Kuching	141	29	30	100	8	18
Bercham	37	6	11	65	32	40
Kajang	41	12	12	34	11	14
Kota Bharu	46	17	12	80	13	16
Kota Kinabalu	53	9	15	59	32	33
Mentakab	33	0	9	42	11	17
Teluk Intan	58	10	12	48	9	13

Source: MAA Medicare Charitable Foundation. 2015. "Monthly Report-Feb 2015"

FIGURE 5: MAA MEDICARE: DIALYSIS CENTERS' CAPACITY

Centers	Jalan Ipoh	Jalan Sungai Besi	Kajang	Butterworth	Teluk Intan	Johor Bahru 1	Johor Bahru 2
No. Machine in use							
Normal	12	10	9	8	10	14	10
Hep B	2	1	1	2	1	2	0
Hep C	4	1	2	2	1	3	1
Total running machine	18	12	12	12	12	19	11
Normal patients	44	48	41	30	58	81	44
Hep B patients	7	3	5	10	4	12	0
Hep C patients	14	4	7	12	6	12	4
Total patients	65	55	53	52	68	105	48
Running capacity percentage	60%	76%	74%	72%	94%	92%	67%

Centers	Kota Bharu	Kuching	Kota Kinabalu	Mentakab	Bercham	Total
No. Machine in use						
Normal	8	24	12	9	9	134
Hep B	2	3	2	0	1	17
Hep C	2	3	1	0	1	21
Total running machine	13	30	15	7	11	172
Normal patients	46	141	53	33	37	656
Hep B patients	9	15	5	0	4	74
Hep C patients	8	14	4	0	2	87
Total patients	63	170	62	33	43	817
Running capacity percentage	88%	94%	69%	46%	65%	77%

Source: MAA Medicare Charitable Foundation. 2015. "Monthly Report Feb-2015"

to patients and mitigating the risk at all cost.

In addition Medicare provides 100% single use treatments in separate rooms for hepatitis patients to avoid cross infection.

Collective data shows Medicare vs. Government facility in terms of numbers of patients at each center, status and number of running machines. (Figure 4)

Since many of its patients have been on dialysis for more than 10 years, Medicare took a bold step to purchase Hemo Dialysis Filtration (HDF) machines to provide better quality care for these patients, although the costs of the machine and disposables are exorbitant. The majority of its patients are also on high flux dialyzers.

The yearly increase in number of patients in Malaysia has spurred the growth in terms of machines and centers, making it sustainable to further expand Medicare's facilities in the near future.

Currently Medicare is running at 77% capacity and forecasted to hit a 95% capacity by end 2015. (Figure 5)

Partners and associates

5 of Medicare's 12 centers have associated partners, which are community based social bodies. They have pledged financial aid and support, especially to the patients at their respective locale. They play a crucial role in patient selection, counseling, talks, organizing gatherings, events and activities and conducting home visits; all of which are beneficial to patients' healthcare and of huge assistance to the team at Medicare.

Fundraising

As Medicare's medical services are provided at highly subsidized rates, it largely is dependent on donations and contributions from the generous public and corporate sector as the main source of income. Approximately RM4million is incurred annually to sustain its operating expenses. These include the cost of subsidized fees, blood tests, medicine and medical equipment, educational training, CAPEX, overhead and maintenance cost. To ensure a continuous flow of income, Medicare regularly organizes its own fundraising events. Such events provide an avenue to create awareness among the public.

The most effective and sustainable fundraising project is its direct mail appeal (DMA) to the general public to appeal for donations.

Many of our activities involve the local community, social groups, religious bodies and clubs. University and college students are often roped in; all with the intention that they become 'future ambassadors', who will instill healthy living habits and lifestyle to the younger generation; that social values and community living are not forgotten. Simply put, a constant reminder that each individual can play a significant role in society to help ease the burden of someone who is in need.

Over the years the funds raised have been wisely spent, with 97% being utilized to sustain its operations and patients' treatment programs. (Figure 6)

FIGURE 6: TOTAL EXPENDITURE AND SUBSIDIES 2014(RM 20,225,636)

Fundraising & Management Expenditure RM1,196,725 (6%)
(*Administrative Expenses - RM505,396 (2.5%)*)

Training & Development & Staff Welfare (Medical & Insurance etc) RM345,723 (2%)

Dialysis Operations / Maintenance of Machine / Equipment / Premises RM2,333,291 (12%)

Medical Disposables RM6,959,380 (34%)

Subsidies RM2,644,520 (13%)

CAPEX RM2,654,631 (13%)

Doctors & Nursing Salary & Allowance / EPF & Socso RM4,091,366 (20%)
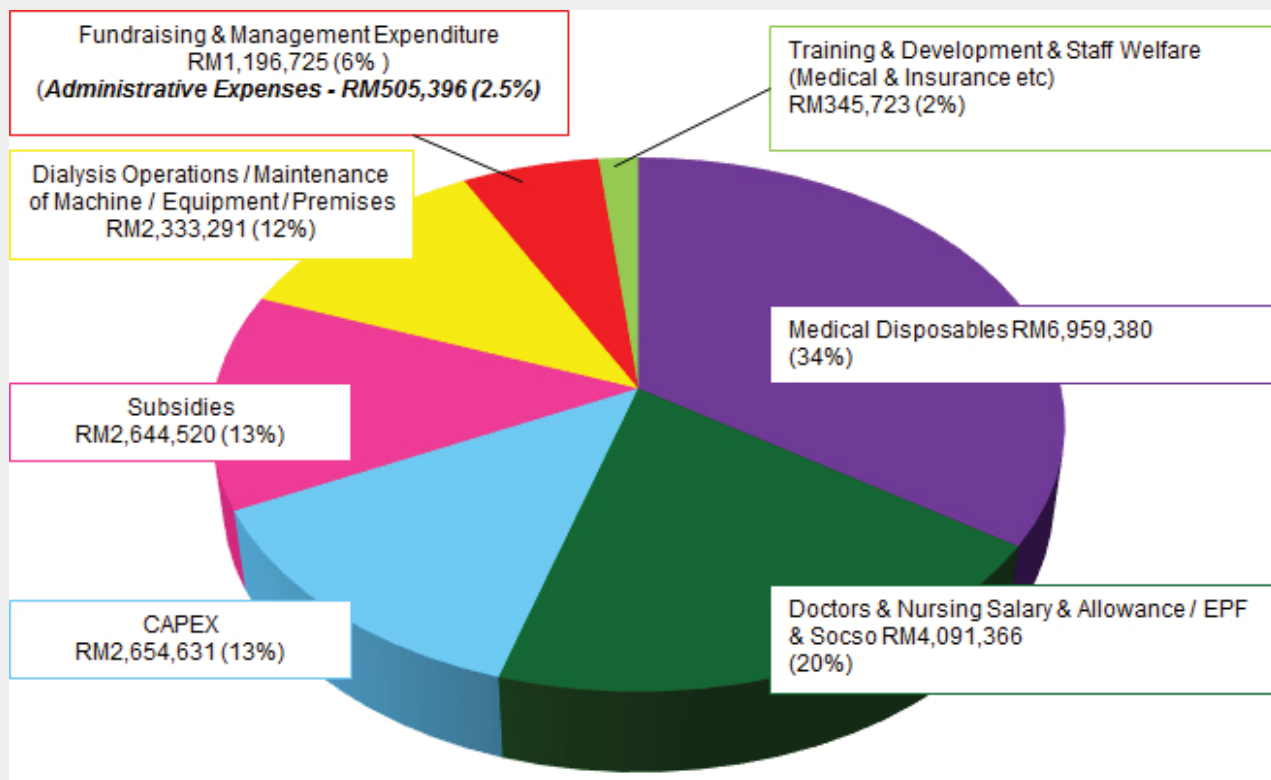
Source: MAA Medicare Charitable Foundation. "Audited Expenditure 2013." in MAA Medicare Annual Report: 2013, 7.
http://maa-medicare.org.my/wp-content/uploads/2014/07/Annual-report-2013.pdf

Medicare believes in transparency and financial accounts are audited and shared with the general public annually via reports on its website www.maa-medicare.com.org

This has gained trust amongst its donors, who constantly support Medicare and have indirectly contributed to its 20-year success.

The Patients' Welfare Fund Program (PWF)

To further assist needy poor patients, the PWF was established in 2009 to provide additional subsidies including medication, injections, monthly groceries, transportation and extra treatments for FREE. Currently 15% of its patients are under this program.

PWF is focused on assisting patients to live well and not worry about the financial burden. Festive celebrations, mothers and fathers day, outings, talks, events and activities are conducted often to cheer these patients. Some families are given monthly groceries so as to ease their financial burden.

Over the years the PWF has subsidized more than RM1million; money well worth spending to put some cheer and happiness in the lives of these poor patients.

The Kids@Medicare program

Most of Medicare's patients are from the lower income group. They are burdened with various medical and daily living cost. Their kids rarely get to enjoy the simple things in life such as: outings, games, holiday programs, drawing contests and activities.

As such, this program, established in 2009 is aimed to put a smile on the kids' faces. To date, over 1,000 kids have benefitted from various exciting programs, which includes outings, games, holiday programs, drawing contests and activities. In addition, 'back to school assistance' in the form of new school supplies including shoes, bags and books are given. To witness these gleeful faces at each gathering is a huge reward.

CARE program (Care and Respect the Environment)

2014 witnessed the launch of the CARE project as a reminder to all patients and staff to continue caring for the environment. Eco friendly products are used and waste is disposed efficiently and effectively. Bottles, canisters, boxes and paper are recycled and turned into saleable items. Income earned is channeled back to the respective centers.

Potted plants using recycled material have been introduced at all centers and kids@medicare have also been introduced into using recycled items to expand their creativity. We see a need to instill culture and good habits amongst these young ones, as they are our future generation.

Prevention programs

Sadly Malaysians believe that kidney failure is commonly diagnosed amongst the elderly. On the contrary statistics from the Malaysian Renal Registry indicates that out of 6,000 new cases, more than 3,000 patients are under the age of 45.

It's an uphill battle to educate the community on awareness and prevention of kidney disease. 60% of the cause of kidney failure has been linked to diabetes. (Figure 2) In the last 2 years Medicare's public awareness program entrails:

- Public talks throughout March in conjunction with world kidney month.
- Early detection and prevention program at health check booths.
- Health forum on social media (Prompting open communications between public and medical personnel)
- Diet talks (better understanding on types of food to avoid and its content)
- Real life stories of patients shared at dinners and events as a reminder that prevention is better than cure.
- Open day sessions at all our 12 existing centres for the public.
- FREE medical checks and sharing of patients' experiences.

With the above steps taken towards awareness, Medicare aspires a society free from illnesses such as diabetis and hypertension; the two main causes of kidney failure.

Medicare at its best.

Medicare is no longer known as a common dialysis centre but as a 'home' to kidney patients and their family members. The growth, care and transparency are evident to the general public. Hence, the publics' support via activities, funding, volunteerism and various other assistance has been overwhelming.

With a total of 110 nursing staff, 20 administrative staff and 13 visiting nephrologist, Medicare has gone beyond providing basic dialysis treatment to a full spectrum of holistic treatment and assistance, which includes counseling, home visits, celebrations, outings, motivation talks. This assistance and activity has been extended also to the family members of these patients.

In 2012, Medicare won the 1st runner-up for best NGO in Malaysia accredited by the International Workshop on Resource Mobilization (IWRM) in United Kingdom.

In 2013, Medicare became the first NGO in the country to introduce the "Buttonhole Cannulation" - A research paper and methodology was shared in the Malaysian Society of Nephrology (MSN) to increase patient comfort and relief, preserving the Arteriovenous Fistula.

In 2014, Medicare was the first NGO and sole Malaysian to win the GOLD award, for the CSR category at the HMA held in Cebu City, Philippines.

Medicare can only be and do its best with the support and assistance from caring Malaysians. In the past few years it has gained International exposure with the recognitions. The CEO is a speaker on fundraising and management topics, which is an added feather in the cap.

"We cannot guarantee how long they will live, but we can guarantee that we will do our best for them while they live!"

ALIYAH KAREN

BIOGRAPHY

Aliyah Karen has been involved with non-profit work for the past 20 years. Her passion has always been for medical assistance and children. She is also a speaker and a writer who focuses on raising funds for many charitable causes.

GET A FULL OVERVIEW OF
THE EUROPEAN HEALTH IT MARKET

e Health
week

11 - 13 MAY 2015
RIGA, LATVIA
www.eHealthWeek.org

Organised by

Ministry of Health
of the Republic of Latvia

meHEALTH

European
Commission

W•HIT
Conference
& Exhibition
HIMSS Europe

@eHealthWeekEU #eHW15

mHEALTH
SUMMIT | EUROPE
TECHNOLOGY + BUSINESS + RESEARCH + POLICY

@himsseurope #mhealthEU

ENERGIZING THE mHEALTH AGENDA IN EUROPE

11-12 MAY 2015 | RIGA, LATVIA | SAVE THE DATE
www.mhealthsummit.eu

In conjunction with

Presented by

e Health
week

HiMSS
Europe

Personal Connected
Health Alliance

Quality improvement initiatives by Aga Khan Health Service in the mountains of northern Pakistan

KASHIF JASSANI
HEAD OF QUALITY ASSURANCE, AGA KHAN
HEALTH SERVICE, PAKISTAN

NADEEM ABBAS
CHIEF EXECUTIVE OFFICER,
AGA KHAN HEALTH SERVICE, PAKISTAN

ROZINA ROSHAN ALI ESSANI
CHAIRPERSON, QUALITY ASSURANCE
COMMITTEE, AGA KHAN HEALTH SERVICE,
PAKISTAN

RASHIDA AHMED
CHAIRPERSON, AGA KHAN HEALTH SERVICE,
PAKISTAN

ABSTRACT: Improving health care quality in a resource constraint environment in an emerging economy that is in a hard-to-reach geographic terrain can become a challenge especially when it has to follow the international standard which AKHS, P envisions to implement across the nation in all of its health facilities. Healthcare of the nation is a responsibility which is shouldered by both the government and the private sector. Private sector, however, remains under pressure as its resource size is limited and it remains subject to stringent regulation and quality control requirements regardless of whether it is in the remotest corner of the country where proper land routes are either lacking or not safe.

This article shares the unique experience of AKHS, P in achieving ISO 9001:2008 International Quality Management System Certification. Particularly at one of the world's highest valleys –situated at Gilgit Baltistan at an altitude of 13,083 ft. above sea level in Northern Pakistan. The experience was unique in terms of demonstrating and recording how a quality management system can be implemented in one of the most difficult to reach areas where compliance to international quality standards was previously unthinkable.

Staff need to cross the snow covered mountains and roads to reach their destinations in order to give services to the community

INTRODUCTION. AKHS, P is one of the largest private non-profit healthcare providers in Pakistan with healthcare facilities spread across Pakistan, from the urban metropolis of Karachi to the rural plains of Sindh and Punjab and the rugged and remote mountain terrains of Gilgit Baltistan and Chitral (GBC). Reaching out to approximately 1.6 million patients annually through a wide range of primary and secondary health services AKHS, P takes pride in taking ownership of high quality healthcare institution of Pakistan. At AKHS, P primary care mandate include vaccination, growth monitoring, immunization, reproductive health care, adult health screening health education for the catchment population. At secondary level, AKHS, P provides services including Obs

& Gynae, Peads, Pharmacy, Laboratory, X-Ray, Ultrasound and Surgeries all backed by strong inpatient and outpatient care. The organization is empowered by 1100+ human resources and equal number of passionate and dedicated men and women volunteers spread across Pakistan.

Quality standard across the organization have been the top strategic priority of the board and senior management of the organization, keen on improving the system, through a baseline assessment of identified challenges for quality healthcare at AKHS, P in July 2012. In October 2012, AKHS, P board and management decided to establish ISO 9001:2008 Quality Management System (QMS) as a standard process at AKHS, P. A dedicated Quality Assurance Committee headed by the QAC Chairperson was formed to report to the board and liaise with management to ensure dissemination and implementation of quality standards across the organization. The initiative originated with the commitment of top management including AKHS, P Chairperson of the Board; Chief Executive Officer; Chairperson, Quality Assurance Committee along with Head of the Quality Assurance Department. The vision was to provide internationally standardized patient centered health care across all facilities of AKHS, P.

Establishing, implementing, improving and maintaining international quality standards in the mountains of Northern Pakistan was not an easy task, not only did it require additional resources at the disposal of the organization but it also needed to overcome a key factor – changing the mindset and changing the practice of people to align the organization with this upgrading process of change. As a result of this standardization, a massive change in organization took place. At the heart of this change was a staff that placed untiring efforts and hard work into achieving quality top on the organization's agenda. This milestone was achieved through strong commitment of both medical and non-medical staff at every level of the organization.

REAL WORLD CHALLENGE

The rugged mountains of Northern Pakistan remain a very challenging terrain due to harsh weather throughout the year, frequent landslides, earthquakes and difficult road access. In the context of the altitude at which people of the valley are located, the challenge for accessing, maintaining quality, logistics, infrastructure, human resources and supply chain presents a nightmare of its own. As a strategic vision, quality as an agenda item has always been critically important to AKHS, P but unlike organizations with healthcare facilities located in city areas, obtaining ISO 9001:2008 international quality management certification was perhaps the greatest,-ambitious and daring challenge ever undertaken by the organization

for four reasons.

1. Upgrading management practices of a large, complex and culturally diverse organization.
2. Challenging, hard-to-reach geographic terrains where quality implementation and control is otherwise unthinkable. Transforming all facilities according to defined International Quality Standards, from the urban metropolis of Karachi to the highest valleys of the Northern Areas of Pakistan.
3. Outcomes of standardization must meet high expectations of catchment populations
4. Implementation of International Quality Standards within a record 16 months.

QUALITY AS A MEANS OF ORGANIZATIONAL SELF-REFLECTION

With this vision, management developed a road map, i.e. from January 2013 to May 2014, to improve the health care standards of AKHS, P. Keen on improving their systems, the board of governance and senior management of the organization, through a baseline assessment, identified challenges to quality healthcare in AKHS, P. This exercise also provided an effective avenue for organizing self-reflection. Findings that followed were:

1. Improvement needs in infrastructure,
2. Unavailability of required equipment
3. Unavailability of policies, protocols and guidelines
4. Inadequate staff training
5. Rising dissatisfaction in the community
6. Communication barriers leading to challenges in realization of full utilization potential
7. Need for creating understanding of international quality standards by local staff
8. Most important of all, limited resources - as AKHS, P is a non-profit organization providing quality healthcare on highly subsidized rates.

QUALITY AS A PROCESS FOR BREAKING DOWN PROBLEMS INTO PIECES TO ADVANCE INTO SOLUTION

The process started with ISO awareness sessions among staff

Figure 1: AKHS, P's ISO Implementation Flow Chart
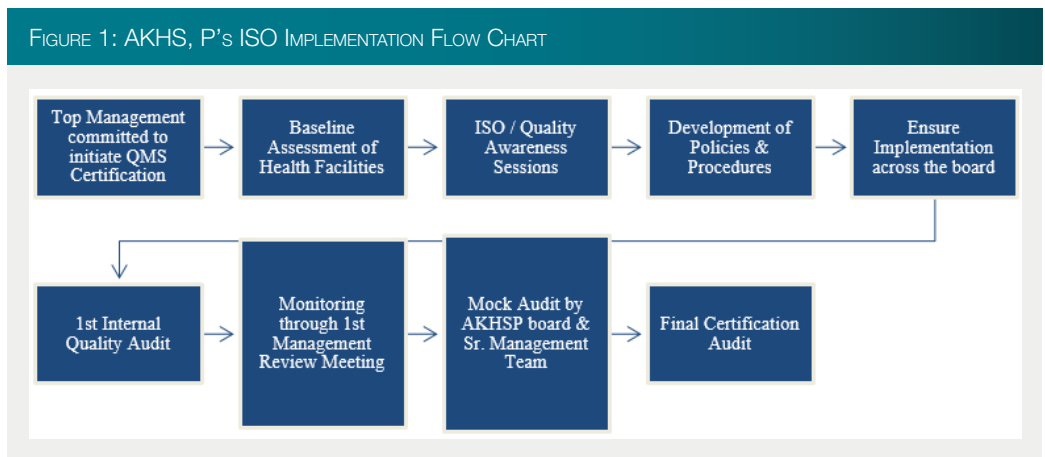
on ISO 9001:2008 standards, development of policies, protocols and procedures, availability of required equipment, improvement in infrastructure, processes, staff training, implementation of infection control practices, ensuring timely availability of supplies including medicines, medical, surgical and general items in the mountainous regions and concomitant implementation of practical safety plan as land sliding, harsh weather and other disasters could create uncertainties.

Direct beneficiaries of this standardization initiative were patients and their attendants in catchment populations where AKHS, P serves.

QUALITY AS A MEANS FOR CONTINUOUS IMPROVEMENT & PROCESS CONTROL

Efficiency and effectiveness were measured through indicators developed for process improvement and improvement of health status in catchment population measured through health status indicators. These indicators were discussed in regular and timely Management Review Meetings. These meetings were conducted as guidelines set by Quality Assurance Committee and conducted on quarterly basis to discuss the outcome analysis of customer feedback and survey results, improvement in quality health indicators, corrective and preventive actions on incident reports, timely availability of medicine for reducing stock outs, timely referral of patients to ensure continuity of care and quarterly Internal Quality Audits to ensure compliance according to International Quality Standards of 9001:2008. Quality improvement efforts ultimately improved patient care, services and patient safety in the mountainous areas within limited resources.

QUALITY AS A TOOL FOR BUILDING ORGANIZATIONAL INTEGRITY (IMPROVING PROCESSES THAT RESULT IN AUTHENTIC OUTCOMES)

Meeting high expectations of catchment population was a challenge for AKHS, P because upgrading healthcare according to 9001:2008 QMS was already a resource intense initiative and yet it had to be implemented in hard-to-reach areas within a 16 month timeframe. Implementation

FIGURE 2: COMPONENTS OF CONTINUOUS QUALITY MONITORING AT AKHS, P

of ISO 9001:2008 Quality Management System standards benefited the community and provided them with the service required at their door step according to the expectation actively shared by them. AKHS, P has a strong culture of incorporating community input in the catchment population where it serves.

Improvement in availability of material and human resources resolved the issues raised by the community in the customer satisfaction surveys and feedbacks. As a natural outcome, this resulted in increased sustainability. Continuous quality improvement was ensured by reviewing the feedbacks and overall progress of health facilities in terms of quality, patients care, patients and staff safety. Moreover, internal quality audits were held on quarterly basis to monitor the process closely. Furthermore, clinical and managerial indicators were properly aligned to focus on areas of clinical improvement to ensure better quality which translates into sustainability.

THIRD PARTY EVALUATION

After implementing ISO 9001:2008 Quality Management Standards, AKHS, P management invited a third party evaluator 'System General Surveillance' (SGS) for ISO audit of AKHS, P health facilities. SGS is an internationally renowned company based in Geneva, Switzerland specialized in conducting ISO 9001:2008 Certification. The certification audit was held in the month of April-May, 2014.

RESULTS

After conducting a detailed audit as per ISO 9001:2008 standards, documentation and organization processes improved and aligned drastically. Processes and documentations included availability of policies, procedures and protocols, staff training, improved growth monitoring, immunization, reproductive health care, health education in community, IMNCI (integrated management of neonatal childhood illness), adult health screening, improvement in nursing practices, infection control, resource management including human resource, facility management including infrastructure, biomedical, maintenance of facility, supply chain management, procurement and pharmacy. Overall client satisfaction rate including incident reporting, quality indicators and monitoring outcomes showed improved results.

After 16 months of intense process driven change supported by the management commitment and highly motivated staff, on 2 May 2014, AKHS, P achieved the most challenging goal of its organizational history by attaining ISO 9001:2008 Quality Management System Certification. This created harmony in standard care taking quality for the healthcare facilities in rugged and mountainous hard-to-reach areas of Gilgit Baltistan and Chitral within a record 16 months. In doing so, as validated by the data, the organization was able to meet high expectations of catchment populations where it is serving.

CONCLUSION

AKHS, P always believes in continuous quality improvement and achieving ISO 9001:2008 Quality Management System certification was just the first step towards a direction of continuous quality improvement. At AKHS, P everyone believes that it is important to sustain the trust and satisfaction level of catchment populations where we serve. In order to achieve the next level, AKHS, P is preparing itself for 1st Surveillance Audit which is scheduled for May, 2015.

Improving quality of life for the people of Pakistan is one of the important goals of Aga Khan Health Service, Pakistan. Today, AKHS, P health facilities are equipped with almost all the required equipment and medicines to fulfill its mandate. Infrastructure has improved including ambiance, and doctors are available 24/7. As a result, health facilities are experiencing increased utilization and improved volumes ultimately resulting in enhanced overall client satisfaction and sustainability. This standardization initiative proved that quality care is possible no matter how challenging the situation is, as long as management is committed and staff is motivated to deliver as per expectations and plans. It also validated our long held hypothesis that improved quality ultimately translates in sustainability and betterment of quality of life of people.

BIOGRAPHIES

Kashif Jassani is a Head of Quality Assurance at AKHS, P with more than 10 years of experience in health care quality assurance. He is a Certified ISO 9001:2008 Quality Auditor and holds a Master's degree in International Relations and Master's degree in Economics. His major achievements include "Gold Award Winner" at Asian Hospital Management Awards, 2014, Cebu city, Philippine.

Rozina Roshan Ali Essani is a Board Director & Chairperson, Quality Assurance Committee (QAC) at AKHS, P in voluntary capacity. She holds RN, BScN & MScN degrees and has around 18 years of experience working at Aga Khan University, Hospital. . Under her expert supervision AKHS, P achieved ISO 9001:2008 Certification and Asian Hospital Management Award, 2014.

Nadeem Abbas is a Chartered Accountant and is associated with AKHS, P as Chief Executive Officer. He has 20 years of experience at senior management level with both national and multinational companies in the field of public health, corporate governance, strategic planning and organizational restructuring.

Dr. Rashida Ahmed is a Chairperson of the AKHSP board, associated as Professor of Pathology at Aga Khan University Hospital. She has completed her M.B.B.S from Dow Medical College and MHPE in the Netherlands. She has 19 years of experience working at Aga Khan University Hospital.

Built environment and wellbeing in italian psychiatric wards

FRANCESCA PLANTAMURA
RESEARCH TECHNICIAN AT POLITECNICO DI
MILANO, DEPARTMENT OF "ARCHITECTURE,
BUILT ENVIRONMENT AND CONSTRUCTION
ENGINEERING", ITALY

ILARIA OBERTI
ASSISTANT PROFESSOR AT POLITECNICO DI
MILANO, DEPARTMENT OF "ARCHITECTURE,
BUILT ENVIRONMENT AND CONSTRUCTION
ENGINEERING", ITALY

STEFANO CAPOLONGO
PROFESSOR AT POLITECNICO DI MILANO AND
TEACHER AT THE POSTGRADUATE SCHOOL
OF HYGIENE AND PREVENTIVE MEDICINE OF
PARMA AND MILAN, ITALY

ABSTRACT: The healthcare built environment has effects on patient's wellbeing. These effects are even heavier on sensitive patient such as psychiatric ones. Therefore the environment design can be a key factor in promoting the patients' well-being and the care process. This paper investigates how this vision is influencing the design of psychiatric facilities in the Italian context, known for its radical innovation of mental health services due to Law 180 (1978). The article identifies the current built environment issues of the psychiatric ward, the design indications available and the possible future actions to meet the needs of users and to improve wellbeing and care process. Keywords: mental care facilities, psychiatric ward, healing environment, healthcare design.

The approach to psychiatric disorder has changed radically since the second half of the '900. Before then, the idea of treatment was based essentially on the containment of the patient in order to achieve social security. The psychiatric hospital, the old asylum, reflected a vision in accordance with social isolation, protection and control, lack of temporal stimulus and liability (Goffman, 1961). Since the middle of last century, a common path has been launched towards the de-institutionalization of mental health services in many Western European countries, with the gradual transition from the old asylums to a network of community-based services, integrated into the local context and with an image as close as possible to the home (WHO, 2008; Gabel et al, 2012). This transformation of facilities is closely linked to the changed purpose of psychiatric treatment: less "containment", more "recovery" (Gilburt et al, 2013; Levin, 2007).

It is clear that the aims of medical treatment affect the design of healthcare environments and vice versa. This mutual influence is demonstrated by the increasing number of studies on the impact of a built environment on: the health perceptions and behaviors of users, the conditions of overall well-being of patients and their caregivers, the therapeutic process outcomes (Codinhoto, 2009; Alfonsi et al, 2014; Buffoli et al, 2014). The built environment plays an important role in the case of sensitive subjects such as psychiatric ones, with impacts on «the beliefs, expectations, and perceptions patients have about themselves, the staff who care for them, the services they receive, and the larger health care system in which those services are provided» (Department of Veteran Affairs, 2010) and effects on patients stabilization, psychosocial well-being and safety of patients and staff (De

Girolamo & Tansella, 2006).

The de-institutionalization trend of mental health services has also characterized the Italian scene, with a particularity: Italy is the only European country where in 1978, thanks to Law 180, psychiatric hospitals have been completely banned. These have gradually been replaced with a network of small specialized services on the territory, such as small psychiatric wards in general hospitals, day hospitals, non-hospital residential facilities (De Girolamo & Cozza, 2000). In this network, a crux is the psychiatric ward within the general hospital, the main Italian facility for acute in-patient care. The Italian intense change was unique and it was defined as "the most comprehensive community-oriented mental health act in the Western industrialized world" (Mosher, 1982). But, what kind of impact did the innovative path have, started by Law 180, on the design of physical care facilities? Is a psychiatric ward able to meet the needs and psychosocial well-being of the patient and staff, to support the current model of care?

Environmental issues in current Italian psychiatric wards

Legislation requires small wards (each unit should have no more than 15 beds) in order to avoid duplicating the asylum system. Despite this aim, some problems remain, particularly for safety and emergency management. In Italy about 80% of psychiatric wards are "behind closed doors", contradicting the larger number of psychiatric wards with open doors in England or in Central Europe. Moreover, almost half of the wards do not have single bedrooms. Many of them have a considerable number of rooms with 3 or 4 beds. Less than two out of three wards have an open space accessible to

patients and about 40% do not have a common room for the patients, other than the dining room, and only about half of those without outdoor space have a living room (De Girolamo et al., 2007). The majority of wards is designed like other hospital wards (except for security windows and locked doors); if on one hand it is de-stigmatizing (placing psychiatry on the same level as other hospital disciplines), on the other it neglects some specific needs such as the need for movement, socialization and therapeutic-rehabilitative activities (Vita et al, 2011). In a study conducted in three psychiatric facilities in the Milan area, patients reported on some experiences in acute care facilities with restrictive security measures and, at the same time, impersonal and sterile spaces and furnishings, conformant to the other hospital wards. In contrast, patients expressed the need for cozy environments, different from the other hospital wards, with a high sanitary level (Plantamura, 2013).

In brief, the Italian psychiatric facilities reproduce in part the old asylum - long corridors, closed doors, etc.- and in part the spaces and the furnishings designed for a "standard hospital patient" - aseptic spaces, hospital beds, neon lights, etc. (Savuto, 2008; Dell'Acqua, 2009). No real effort has been made to develop an architecture that takes into account the new vision of care (De Vito, 2010). There are cases of new and renovated psychiatric wards in which necessary attention was given to user needs and the care process; however the quality of the design is essentially based on the experience and engagement of health professionals (physicians, nurses, department managers) and the designers directly involved. The knowledge, gained in the individual design experiences, is not subsequently formalized nor shared and extended in scientific literature.

Available Design Tools
The Italian context

The lack of research produces a scarcity of technical standards and design guides. The Italian legislation provides some guidance in law "DPR 14.01.1997", on the features of psychiatric facilities. This law provides the "minimum structural, technological and organizational requirements" for the different types of services, including those for mental care. The requirements of psychiatric ward are the same as those for other hospital wards, with some specific differences: a ward with a living room and single room for private talks between patients and staff. The listed structural requirements are very synthetic and cannot be considered as an effective design guide.

Some indications can be found in different national and regional guidelines, such as the "National guidelines for mental health" (Italian Ministry of Health, 2008) that include some suggestions, for example: to locate the residences in the heart of residential areas, to encourage and promote small residences. The national guide "Physical Restraint in psychiatry: a possible strategy for prevention" (GISM, 2010) provides indications to develop a built environment that

helps to reduce and, if necessary, manage violent behavior. A technical group of the Lombardy Region recognizes the mutual influence between the spatial and organizational aspects (Vita et al, 2011). To prevent aggressive behavior and reduce mechanical restraint, it is suggested to focus on environmental safety, livability of all the ward, including attention to specific areas such as spaces for the initial contact between patients and ward. However, these indications are general principles and they do not constitute any real technical support for design activities (Baglioni & Capolongo, 2002).

The international context

International studies have not development as predicted in the 1970s, generating a proliferation of design options not carefully studied (Shepley & Pasha 2013, Chrysikou, 2012). It is possible to identify some specific difficulties which may have held back this field of research: the wide range of types of psychiatric services; the variety of diseases to be treated within the same facility; the difficulty in analyzing the direct needs of psychiatric patients (an activity that requires a multidisciplinary team of professionals that includes, at the least, psychiatric/psychological and design skills) and a fitful correspondence between the needs expressed by patients and those arising from the therapeutic approach (Thiels, 1993).

However, in the international arena (i.e. Northern Europe, USA, Australia) some studies deal with the relationship between psychiatric spaces and patient wellbeing. One of the issues analyzed is the need to support the social dimension of care, a feature of "recovery oriented" treatment (Australian Health Ministers' Advisory Council, 2013). To this end, positive features are proposed, including: locating structures in a local living-context and including public areas in the care spaces, with amenities and equipment than can also be used by local residents (Curtis et al., 2009); the choice of spatial configurations and the arrangement of furnishings that encourage social interaction and aggregation, stimulating patients to get out of a sort of capsule that they create around themselves, as a protection from the outside world (Cherulnik, 1993).

Hospitalized patients feel deeply about their inability to create a personal space and achieve a sufficient level of privacy. Oversized facilities, long interior hallways, no area for small groups or individually customizable space, low environment visual control, interfere with the personal control of the territory. Possible consequence is an increased level of aggression or fear of attacks by other patients (Evans, 2003). The international guidelines propose designing mental health care units with domestic features, avoiding an institutional aspect and, at the same time, responding to therapeutic needs and all the requirements of functionality and safety for patients and staff (NAPHS, 2012).

Safety, combined with livability and domesticity, is one of the most analyzed issues. Several design features intend to minimize the risk of escape and accidents, some

examples are: courtyards instead of external fenced areas or the technology integration to facilitate observation and maintain security in areas not immediately visible by the staff (Department of Veteran Affairs, 2010). Furthermore, the presence of natural light in the common and private areas, noise control, open layouts that minimize barriers between staff and patients can have positive effects in terms of stress reduction, with a consequent reduction of aggressions (Ulrich et al, 2012). The involvement of patients is a safety component too: if the patient feels connected to the medical and nursing staff, it is easier to manage critical situations, preventing or limiting individual crisis and aggressive events. A warm, cozy and familiar place contributes to involvement, instilling a feeling of calm and increasing the relationship between patient and context, a concept defined as "place attachment" (Florek, 2011).

Conclusions and possible future actions

Nearly 40 years have passed (Law 180 - 1978), since the radical change in Italian psychiatric services began, with the abolition of psychiatric hospitals and the development of a community-based services network integrated into the territory. However, this high level of innovation wasn't accompanied by equivalent research on new design criteria for care environments. So, currently, in Italy most places for psychiatric care adopt in part design solutions suited for a "standard hospital patient" and in part solutions that reflect the old asylum model. The psychiatric wards are especially critical, because the major requirements for domesticity and safety seem irreconcilable.

Despite the awareness of the role that care space can play in pursuing the wellbeing and safety of patients and staff, adequate tools are not available to support the psychiatric facilities.

A design support can be found by examining international studies. Multidisciplinary research on psychiatric facilities should be increased in order to understand and use the role that a built environment can play in improving the conditions of well-being of patients and caregivers and in the care process. To this end, possible future steps are the identification and systematization of experience in space-patient-staff interaction gained by healthcare professionals and designers with the results of international research and the needs and expectations of patients, the central player in the care process.

BIOGRAPHIES

Francesca Plantamura, Architect, PhD graduate in "Technology and Design for Environment and Building". She is working as Research Technician at Politecnico di Milano, Department of "Architecture, Built Environment and Construction Engineering". She is member of "Design of Health Facilities. Architecture, Building, Planning, Land" Cluster at Politecnico di Milano. With more than 15 years of research experience and scientific publications relating to the Environmental Design (i.e. sustainable buildings, green rating systems, indoor environmental quality), currently her work is mainly focused on the research topics of supportive healing environments and patient centered design.

Stefano Capolongo, Architect and PhD graduate in Public Health. Associated professor at Politecnico di Milano, teaching in *Environmental Health, Technologies for Construction and Sustainable Development, Social Architecture*. Teacher at the postgraduate School of Hygiene and Preventive Medicine of Parma and Milan. Scientific Officer of Cluster "Design of healthcare facilities. Architecture, Building, Planning, Land " at Politecnico di Milano. Contact Scientific of ASP – Alta Scuola Politecnica for the project "Sustainable planning of hospitals in urban areas." Member of the PhD Programs in "Programming, Maintenance, Rehabilitation of the Building and Urban Systems", "Design and Technologies exploitation for the Cultural Heritage" and "Building Technology" at Politecnico di Milano. Chief of Master "Programming, Planning and Design of Social and Health structure" (Politecnico di Milano, Università degli Studi di Milano and Università Cattolica del Sacro Cuore in Rome). Author of more than 200 scientific publications. Carries out research activities concerning hospital building and environmental hygiene.

Ilaria Oberti, Architect, Doctoral degree in Technical Innovation and Design in Architecture, assistant professor in Architectural Technology at the Politecnico di Milano. Member of Cluster "Design of Health Facilities. Architecture, Building, Planning, Land" at Politecnico di Milano. Topic issues of research activities: sustainable buildings, indoor environmental quality (IEQ), indoor air quality (IAQ) and building design, building products and their impact on indoor environment and on human health. Author of numerous technical and scientific publications relating to the research topics.

References

Alfonsi, E., Capolongo, S. and Buffoli, M. (2014). Evidence based design and healthcare: an unconventional approach to hospital design. *Annali di Igiene*, 26(2), pp. 137-143.

Australian Health Ministers' Advisory Council. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers.* www.health.gov.au

Baglioni, A., Capolongo S. (2002). Ergonomics in planning and reconstruction. *G.Ital Med Lav Ergon.*, 24(4), 405-409

Buffoli, M., Bellini, E., Bellagarda, A., Di Noia, M., Nickolova, M. and Capolongo, S. (2014). Listening to people to cure people: The LpCp – tool, an instrument to evaluate hospital humanization. *Annali di Igiene*, 26(5), pp. 447-455.

Cherulnik, P. D. (1993). *Applications of environment-behavior research: case studies.* USA: Cambridge University Press.

Chrysikou, E. (2012). Mental health design: From a normalization theory to a "fit for purpose" architecture for the mentally ill. *World Health Design.* nr.18, 68-77.

Codinhoto, R. (2009). The impacts of the built environment on health outcomes. *Facilities*, 27(3/4), 138-151.

Curtis, S., Gesler, W., Priebe, S. and Francis, S. (2009). New spaces of inpatient care for people with mental illness: A complex 'rebirth' of the clinic? *Health & Place*, 15(1), pp. 340-348.

De Girolamo, G., Tansella, M. (2006). I reparti psichiatrici in ospedale generale. Problemi e prospettive in Europa. *Epidemiologia e Psichiatria Sociale*, 15, 2.

De Girolamo, G. and Cozza, M., (2000). The Italian Psychiatric Reform: A 20-Year Perspective. *International journal of law and psychiatry*, 23(3–4), pp. 197-214.

De Girolamo, G., Barbato, A., Bracco, R., Gaddini, A., Miglio, R., Morosini, P., Norcio, B., Picardi, A., Rossi, E., Rucci, P., Santone, G. and Dell'Acqua, G. (2007). Characteristics and activities of acute psychiatric in-patient facilities: National survey in Italy. *British Journal of Psychiatry*, 191(2), 170-177.

Dell'Acqua, G. (2009). Incerti luoghi di ospitalità. In: *Scritti sull'esperienza triestina*, http://www.triestesalutementale.it/letteratura/letteratura_scritti.htm

Department of Veteran Affairs. (2010). *Mental Health Facilities Design Guide.* Washington, DC: Office of Construction & Facilities Management.

De Vito, C. G. (2010). *I luoghi della psichiatria*, Fiesole: Polistampa.

Evans, G. (2003). The built environment and mental health. *Journal of Urban Health*, 80(4), 536-555

Florek, M. (2011). "No place like home: Perspectives on place attachment and impacts on city management". *Journal of Town & City Management*, 1 (4): 346–354.

Gaebel, W., Becker, T., Janssen, B., Munk Jorgensen, P., Musalek, M., Rssler, W., Sommerland, K., Tansella, M., Thornicroft, G. and Zielasek, J., (2012). EPA guidance on the quality of mental health services. *European psychiatry,* 27(2), pp. 87-113.

Gilburt, H., Slade, M., Bird, V., Oduola, S. and Craig, T., (2013). Promoting recovery-oriented practice in mental health services: a quasi-experimental mixed-methods study. *BMC Psychiatry*, 13(1), pp. 167.

GISM - Gruppo interregionale della salute mentale. (2010). *Contenzione fisica in psichiatria: una strategia possibile di prevenzione.* Roma: Conferenza delle Regioni e delle Provincie Autonome.

Goffmann, E., (1961). *Asylums: Essays on the social Situation of Mental patients and Other Inmates.* Doubleday & Company, Inc.

Italian Ministry of Health. (2008). *Linee di indirizzo nazionali per la salute mentale.* Roma: Ministero della Salute.

Levin, A. (2007). Psychiatric Hospital Design Reflects Treatment Trends. *Psychiatric News*, 42(2).

Mosher, L. R. (1982). Italy's revolutionary mental health law: an assessment. *American Journal of Psychiatry,* 139(2), pp. 199–203

NAPHS. (2012). *Design Guide for the Built Environment of Behavioral health facilities.* Washington, DC: National Association of Psychiatric Health Systems.

Plantamura, F. (2013). Mental care - Patient's contribution to the design of healing environments. In: *Proceedings of the International Conference NES 2013 - Ergonomics for Equality.* Reykjavík, Iceland, August 11th - 14th 2013. pp.1-6.

Savuto, G. (2008). *Riflessioni sul luogo di cura in area psichiatrica – Internal report.* Milano: Lighea Onlus.

Shepley, M., & Pasha, S. (2013). *Design Research And Behavioral Health Facilities.* USA: The Center For Health Design.

Thiels, C. (1993). The assessment of the therapeutic effects on psychiatric patients of a pleasant and congenial environment. *Journal of public health*, 1(4), pp. 328-338.

Ulrich, R.S., Bogren, L. and Lundin, S., (2012). Toward a design theory for reducing aggression in psychiatric facilities, *ARCH 12: Architecture / Research / Care / Health 2012.*

Vita, A., Barale, F., Canzian, V., Cerati, G., Colmegna, V., Lora, A., Magnani, P. A., Mazza, U., Mencacci, C., Moro, C., Nahon, L., Percudani, M., Petrovich, L., Pisapia, D., Radici, S. (2011). GAT SPDC, *Ruolo del Servizio Psichiatrico di Diagnosi e Cura nell'ambito delle attività del Dipartimento di Salute Mentale, del trattamento dell'acuzie e dell'emergenza urgenza psichiatrica.* Milano: Direzione Generale Sanità, Regione Lombardia.

WHO - World Health Organization, (2008). *Policies and practices for mental health in Europe - meeting the challenges.* WHO Regional Office for Europe.

Fast track surgery, a strategy to improve operational efficiency in a high-complexity hospital in Latin America

JUAN DAVID ÁNGEL BETANCUR
CHIEF DEPARTMENT OF SURGICAL SPECIALTIES
AND SURGERY HOSPITAL PABLO TOBÓN URIBE,
MEDELLÍN, COLOMBIA

ANDRÉS FELIPE ESPINOSA JARAMILLO
PROCESS ENGINEER HOSPITAL PABLO
TOBÓN URIBE, MEDELLÍN, COLOMBIA

LILIANA MARCELA BETANCUR MONTAÑO
CHIEF SECTION AND CENTRAL STERILIZATION
SURGERY HOSPITAL PABLO TOBÓN URIBE,
MEDELLÍN, COLOMBIA

CARLOS ENRIQUE YEPES DELGADO
MEDICAL EPIDEMIOLOGIST AT HOSPITAL
PABLO TOBÓN URIBE PROFESSOR UNIVERSITY
OF ANTIOQUIA, MEDELLÍN, COLOMBIA

ABSTRACT: Fast Track surgery is designed to optimize time in low-complexity procedures, thus improving efficiency in care provision, and preserving patient safety. METHOD: Before and after intervention study in a surgical setting, with failure mode and effects analysis, identification and prioritization of improvement opportunities, process measurement before the intervention, improvement implementation, practical application, process measurement after the intervention, and surgical time comparisons. RESULTS: With the Fast Track program, 19% of the operating room capacity available was freed per day; before surgical FastTrack implementation, 50% of the procedures started 23 minutes behind schedule. After the Fast Track program was implemented, procedures start 5 minutes ahead of schedule. Anesthesia induction time was reduced by 50%, and skin-to-skin surgical time dropped by 28%. The number of surgical procedures performed in the day increased by 33-50%. There were no incidents or adverse events. CONCLUSIONS: Fast Track surgery is a useful strategy for improving operating room efficiency and reducing surgical time. Procedures start on time, with increased timely care, patient and practitioner satisfaction, and lower service costs. Key Words: Fast track, Operating room, Safety, Effectiveness, Surgery.

INTRODUCTION. With growing healthcare coverage, a higher degree of information available to patients, and the growth in medical technology, demands on healthcare services have increased significant. Added to the issue of limited resources as far as information and staff are concerned, and given the variability and complexity of the clinical conditions of the patients that need to be scheduled for surgery in high complexity general hospitals, all this creates delays in the healthcare process, lower operational efficiencies and, consequently, higher healthcare costs due mainly to fixed costs involved in this type of service. Indirectly, this results in higher costs for less complex patients, creating a competitive disadvantage for these types of procedures.(1,2)

In view of the above, Fast Track surgery emerged as a strategy for optimizing operating time in the case of low-complexity procedures. It results in shorter care delivery time, improved efficiency of the surgical process, a greater number of procedures performed per day, and optimized

care costs, without a negative impact on patient safety. (3)

Fast Track surgery is based on a practice recommended by The Advisory Board Company (3), a global research and consulting company focused on improving performance and providing solutions to organizational problems. No data was found for Latin America in published literature on the application of Fast Track specifically for procedures performed in the surgical area.

The reality at the Pablo Tobón Uribe Hospital surgery services varies significantly given the types of patients (inpatients and outpatients) presenting different clinical conditions, a wide variety of procedures in terms of complexity and length of surgery, as well as human and technological resource requirements. All these factors create delays in the timing of surgical schedules, leading to increased service costs and dissatisfaction among practitioners, healthcare staff, patients and families. This situation prompted a search for alternatives designed to improve the efficiency of the

surgical process.

The Fast Track strategy was adopted for a selected group of patients taken to low-complexity, short-duration surgical procedures, making sure the main objectives of surgery, namely, efficiency and safety, were respected. (5,6) This multidisciplinary program was setup with the participation of surgeons, anesthetists, nurses, scrub nurses, licensed practical nurses, administrative staff, housekeeping staff and the surgery scheduling service, with a view at improving the efficiency of the healthcare process for surgical patients without affecting care quality and patient safety.

MATERIALS AND METHODS:

The methodology was based on a before-and-after intervention study during the patient care process. The study included patients taken to surgical procedures in two designated operating rooms of the Pablo Tobòn Uribe Hospital, and compared surgical time results before and after the implementation of the FastTrack strategy.

The setting where the strategy was implemented consisted of a high-complexity, 371-bed private hospital specialized in trauma, transplant and oncology care and oncology patients. The hospital has 13 operating rooms and provides operating theatre scheduling of outpatient, inpatient, and emergency procedures by different surgical specialties and subspecialties, with an average of 1000 surgeries per month, 30% of which are outpatient procedures.

The selected patients had to meet the following criteria: outpatients classified as ASA I or II subject to surgical procedures lasting less than three hours. (Classification system of the American Society of Anesthesiologists used for estimating anesthetic risk according to the patient's condition: ASA I [Healthy. Patient with no organ, physiological, biochemical or psychiatric disorder; localized pathological process with no systemic involvement]; and ASA II [Mild systemic disease. Systemic disorder caused by the disease process or another pathophysiological condition].)

The specialties included in the program were orthopedic surgery, urological surgery, pediatric surgery, ear-nose-throat surgery (ENT), general surgery, head and neck surgery, vascular surgery and plastic surgery. The surgeons scheduled for the procedures included those who had a volume that would require working through the entire morning, afternoon or the whole day on patients that met the criteria described above, on a consecutive basis.

The sub-process for the intervention was selected in accordance with the delays in completing the surgical schedule, based on data from literature and the knowledge and experience of the leaders. The selection was made with the help of a prioritization matrix, and critical measurement variables (quantitative measurement) were identified. The failure mode and effects analysis (FMEA) tool was used to identify, evaluate and design improvement strategies for potential failures in the process, and to analyze the effects of those failures, their causes, seriousness, frequency and the possibility of their timely identification. (4,7)

The measurements used included compliance with the time for starting the surgery, completion of the surgical schedule per day, number of procedures performed per workday, among others. Improvement plans were established for each. Fast Track surgery 3 was defined as taking place between 7:00 and 19:00 from Monday to Friday (after analyzing case volumes amenable to this intervention) in two operating rooms with the characteristics required for different procedures of this type (one lead-shielded room and one room for minimally-invasive surgery).

A Head Nurse was assigned to manage the surgical schedule in the Fast Track operating rooms, separately from the general schedule. A predefined service promise delivery was coordinated with the housekeeping staff with the endorsement of the infections prevention committee and the support of a communication system for ensuring prompt response for operating room preparation. The people in charge of scheduling reviewed the daily surgical schedules in order to optimize timing and identify the needs associated with each procedure. Prior and mandatory pre-anesthesia assessments were assigned the day before, confirming the procedure, in order to avoid missed dates and to reinforce pre-anesthesia recommendations for the patients. Pre-operative guidelines were generated and adherence was verified, resulting in standardized work-up test orders according to the type of patient and comorbidities.

For all patients in Fast Track surgery, administrative paperwork and billing were expedited. A room for regional anesthesia with a trained anesthetist was assigned and only residents were allowed to be present as staff in training to assist in the procedure, under supervision.

A baseline measurement of surgical times in the general morning and afternoon schedules was established. The data was obtained from the records documented in the standard forms used by the institution. After implementing the Fast Track strategy,[3] measurements were made through direct observation and recorded in a database for later analysis. The variables taken into account included the number of the operating room where the procedure was performed, the scheduled time for the procedure, the length of the procedure, arrival of the patient and the anesthetist at the operating room, time of initiation of the anesthetic induction, procedure start and ending times, time of arrival to, and discharge from, the recovery room.

RESULTS:

Priority problems were identified as part of the baseline assessment conducted before the implementation of FastTrack strategy in the surgery service. These included: failure to start surgical procedures on time, cancellation of surgeries due to urgent cases, and failure to comply with the overall surgery schedule in a timely fashion. The analysis of the data after the intervention showed time reductions in terms of procedure start time, anaesthesia induction, and

overall length of the procedure from skin incision to skin closure. Likewise, there was an increase in the number of procedures performed per workday.

With the implementation of the Fast Track program, 19% of the available operating room capacity was freed per day. The same result was found when mornings and afternoons were compared (Tables 1 and 2).
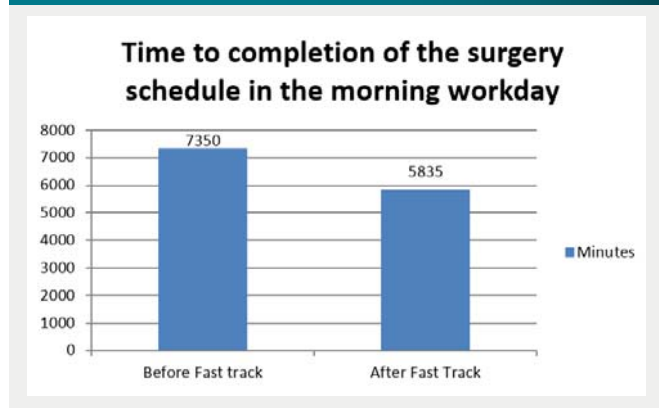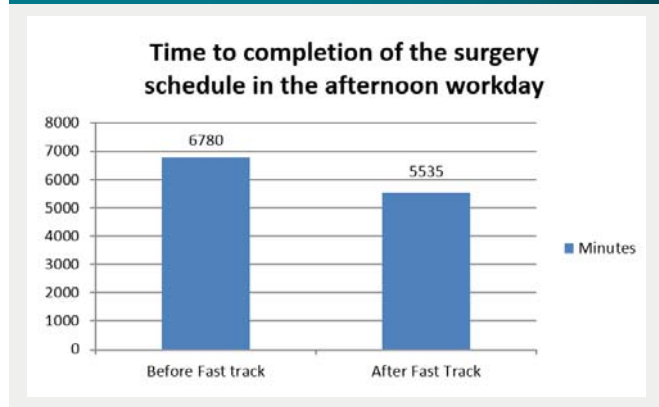

TABLE 1

Time to completion of the surgery schedule in the morning workday

TABLE 2

Time to completion of the surgery schedule in the afternoon workday

The median difference in minutes from the time of induction and the scheduled time for surgery was reduced from +23 to -5 minutes, which means that the procedure was started 5 minutes ahead of time (Table 3). Anaesthesia induction time was cut by 50%, and surgical time from skin incision to closure by the surgeon dropped by 28% (Table 4).

The number of surgical procedures performed per workday increased between 33% and 50%. Urgent surgeries were performed without interfering with the overall surgical schedule. There was a high rate of internal and external customer satisfaction, and patient breakdown by level of complexity within the same surgical unit led to no cancellations due to lack of time or prolongation of previous procedures. There were no delays due to administrative or clinical issues that could have hampered the care process. Because the strategy was implemented with a team of designated individuals, there was assertive, timely and open communication among the caregivers. There were no

adverse or sentinel events among the patients taken to Fast Track surgery.
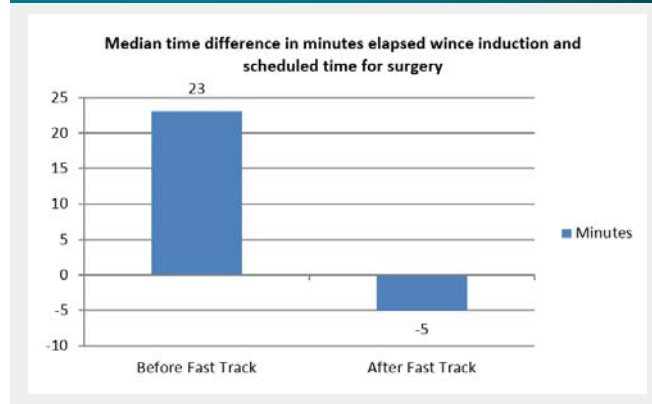

TABLE 3

Median time difference in minutes elapsed wince induction and scheduled time for surgery

TABLE 4

Surgery time comparison
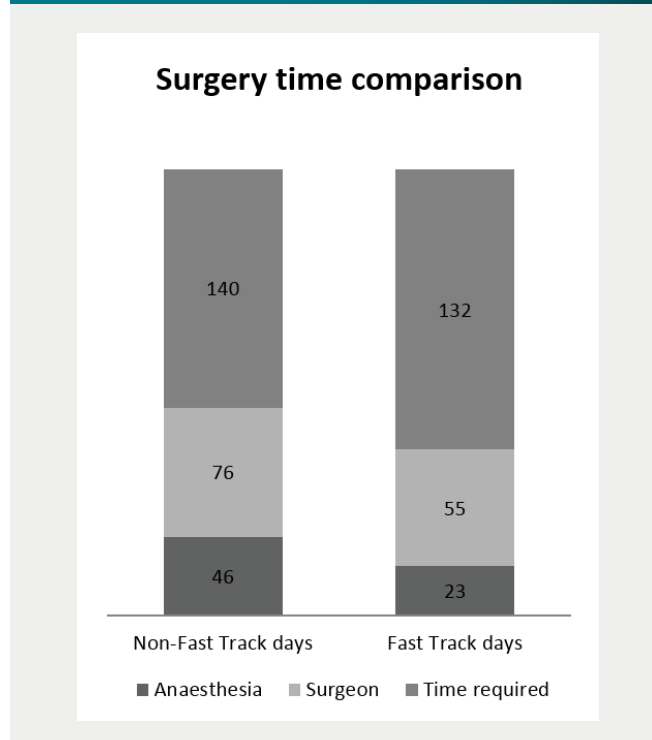
DISCUSSION AND CONCLUSIONS:

Fast Track surgery is a useful strategy for improving operating room efficiency, reducing costs through time management, and enhancing the ability to perform surgical procedures on time. In our case, it led to improved patient and practitioner satisfaction. (3)

The results obtained showed improved surgical time for minor procedures in a high complexity hospital providing care to urgent, hospitalized and elective patients with multiple comorbidities, and covering also transfers between units and clinical administrative work besides patient

care. It was shown that changes in the dynamics and the logistics of the surgical scheduling focused on a group of patients with standardized variables using an exclusive multidisciplinary medical, paramedical and administrative team led to increased operational efficiency in the surgery service.

Fast Track surgery improved operating room efficiency, optimized surgical time in minor, low-complexity procedures, standardized the length of the procedures, reduced anaesthesia time, expedited patient turnover, and improved timeliness in surgical scheduling. All this was achieved ensuring patient safety and without placing patients at risk or requiring major investments that result in higher care costs.

Keys to the success of this model were surgical scheduling, team work, and patient compliance with the instructions provided. All these factors had an impact on the entire care process from the preoperative period, during surgery, and through the course of recovery.

The Advisory Board reports surgical time reductions of 38% and 27%, respectively, in ENT and ophthalmological procedures performed in specialized hospitals, with the number of ENT procedures increasing from 6 to 10 per day and ophthalmological procedures increasing from 7 to 8 per day.[3] It is worth highlighting that the institutions where that practice was performed focus their surgical care only on outpatients with a low level of complexity.

This methodology also encouraged the healthcare staff to improve their surgical productivity and freed time to perform other healthcare tasks in other areas outside the operating theatre.

BIOGRAPHIES

Juan David Angel Betancur is a Physician and Surgeon graduated from the Universidad Pontificia Bolivariana. He has a specialization in Health Audit CES and a Master degree in Quality Care and Patient Safety from the Universidad Miguel Hernandez in Spain.

Liliana Marcela Betancur Montaño is a nurse graduated from the Universidad de Antioquia and has a postgrad in cardiovascular nursing from the Clinica Universitaria Bolivariana.

Andres Felipe Espinosa Jaramillo studied Production Engineering at the EAFIT University and is a postgraduate in Management of Production and Service at the School of Engineering of Antioquia.

Carlos Enrique Yepes Delgado Physician from the University of Antioquia (Colombia), is a specialist in administration, has a Master of Public Health and a PhD in Epidemiology. He is actually a Professor at the Faculty of Medicine of the University of Antioquia and medical epidemiologist at the Research Unit of Hospital Pablo Tobon Uribe. Doctor Yepes Delgado is an advisor in formulation, management and evaluation of research projects and social intervention in areas of Public Health, Epidemiology, Planning, Logical Framework, Qualitative Research, Social Security and Hospital Administration. He has widely published on related fields at national and international levels.

References

1. Christensen, Clayton M.; Grossman, Jerome H.; Hwang, Jason (2008), *The innovator's prescription: a disruptive solution for health care*, New York, New York, USA: McGraw-Hill, ISBN 978-0-07-159208-6

2. Porter E, Michael; Lee H, Thomas. The strategy that will fix health care. Harvard Business Review, October 2013

3. The Advisory Board Company. Low Acute Fast Tracks, Clinical Advisory Board 2007;119-124

4. Recio M, Aranaz JM, Martínez E, Martín A, Aibar C. Gestión y mejora de la seguridaddel paciente. Tutoríal y herramientas de apoyo. Ministerio de Sanidad y Consumo, 2006.

5. Joint Commission International, Accreditation Standards for Hospitals. Estándares de acreditación de hospitales. U.S.A. 2014

6. Joint Commission International, National Patient Safety Goals. Estándares de acreditación de hospitales. U.S.A. 2014

7. De Rosier J, Stalhandske E, Bagian JP, Nudell T. Using Health Care Failure Mode and Effect Analysis™: The VA National Center for Patient Safety's Prospective Risk Analysis System. Journal of Quality Improvement 2002;28(5):248-267

Leadership and Innovation in Asia 2015 Volume 51 Number 1
Résumés en Français

Mettre en place des Plans Stratégiques qui réussissent : Une Formule Simple

La planification stratégique est un processus. Pour penser planification stratégique, il faut imaginer son développement et sa conception comme une structure qui permettra à votre hôpital de naviguer au fil du temps à travers des environnements internes et externes changeants. Bien que le processus de planification stratégique puisse paraître décourageant, il suffit de suivre une formule simple consistant en cinq étapes selon le procédé mnémotechnique B.E.G.I.N. (Begin, Evaluate, Goals & Objectives, Integration, and Next steps) qui permettra de gérer plus facilement le processus de planification, et de favoriser votre réussite.

Les sept pieges classiques du service client dans les hôpitaux

Opérant à la fois comme un atelier de réparation, une prison et un hôtel, les hôpitaux sont sujets à sept pièges classiques en matière de service client. Les soins apportés au patient sont souvent fragmentés, insondables, inflexibles, insensibles, réactifs, peu concernés et risqués. Les hôpitaux ont tendance à devenir plus *high-tech* que high-touch, même si l'engagement du personnel avec les patients plutôt que les équipements et le matériel influence fortement la satisfaction du patient. A moins que les processus, les politiques et les personnes soient centrés sur le client, la qualité élevée des ressources logicielles et humaines de l'hôpital ne se traduiront pas en forte satisfaction du patient ni loyauté du patient.

Motivation pro-sociale et Comportements Professionnels des Médecins
Effets d'une triple synergie sur l'Orientation Pro-sociale dans une Organisation des soins de santé

Les comportements professionnels du personnel sont des éléments clés pour la performance organisationnelle. Cet article propose un modèle intégrant les notions de leadership serviteur, motivation pro-sociale et responsabilité sociétale de l'entreprise (RSE) afin d'expliquer un mécanisme à travers lequel la motivation pro-sociale joue un rôle central dans l'amélioration des comportements professionnels des médecins. Une enquête transversale menée auprès d'un échantillon de médecins montre que (1) la motivation pro-sociale peut être modelée à partir du leadership serviteur quand les médecins ressentent une bonne harmonie avec leurs superviseurs, (2) la motivation pro-sociale améliore la satisfaction professionnelle des médecins. Son effet est renforcé quand les médecins perçoivent une forte RSE, et (3) la satisfaction professionnelle améliore l'engagement organisationnel. Les résultats fournissent un aperçu significatif sur le fait qu'une triple synergie avec une orientation pro-sociale parmi les médecins, les superviseurs et l'organisation améliore les comportements professionnels des médecins.

Développement, Autonomisation et Responsabilisation du Personnel de Première Ligne

Faciliter les soins axés sur le patient et les rendre rentables tout au long du continuum de soins est un défi qui nécessite de la créativité de la part des administrateurs des soins de santé. A l'hôpital BLK Super Specialty Hospital, des fonctions de chargé de relation clientèle (CRC) et de coordinateur des soins (CS) ont été instaurées afin d'améliorer la communication et les rapports au sein des services cliniques et non-cliniques. En matière de gestion, d'autres processus innovants qui nécessitaient des améliorations, ont également été mis en place pour faciliter l'amélioration des services fournis aux patients. Le fait d'encourager le CS et le CRC à prendre l'initiative, à prendre des décisions et mettre en place des actions pour prévenir et résoudre des problèmes liés au service a permis d'accroître le niveau de service et de conduire à une meilleure expérience du patient.

Sauver des vies ensemble

Fondée il y a 20 ans avec un seul centre de dialyse qui assistait seulement 20 patients pour 6 machines d'hémodialyse, Medicare a beaucoup grandi et prend désormais en charge des milliers de patients pauvres et les aide à obtenir un taux fortement subventionné pour un traitement de qualité. Des millions de Ringgit malaysiens récoltés grâce à différents projets de collecte de fonds et événements ont été correctement utilisés pour venir en aide au nombre croissant de patients souffrant d'insuffisance rénale en Malaisie qui ne peuvent tout simplement pas supporter les coûts exorbitants des traitements. Fidèle à sa mission, Medicare étend son aide aux patients nécessiteux souffrant d'insuffisance rénale et à leur famille, qui indirectement sont devenus des membres à part entière de la famille Medicare.

Initiatives pour l'Amélioration de la Qualité par le Service de Santé Aga Khan Health Service dans les montagnes du Nord du Pakistan

Améliorer la qualité des soins de santé dans un environnement aux ressources limitées, avec une économie émergente et sur une zone géographique difficile d'accès, peut devenir un véritable défi notamment lorsqu'il faut respecter les normes internationales que l'AKHS, P prévoit de mettre en place dans tous les établissements de santé du pays. La santé du pays est une responsabilité qui est soutenue à la fois par le gouvernement et le

secteur privé. Cependant, le secteur privé reste sous pression car ses ressources sont limitées et il reste soumis à des exigences de contrôle qualité et des normes contraignantes qui ne prennent pas en compte le fait que l'établissement soit situé dans la zone la plus reculée du pays où les routes terrestres appropriées sont absentes ou non sécurisées.

Cet article fait partager l'expérience unique de AKHS, P pour obtenir la Certification Internationale du Système de Management de la Qualité ISO 9001:2008. En particulier dans une des plus hautes vallées du monde située à Gilgit Baltistan à environ 4000 m d'altitude au nord du Pakistan. Cette expérience fut unique et a permis de démontrer et de décrire comment un système de management de la qualité peut être mis en place dans une des zones les plus difficiles d'accès, où le respect des normes de qualité internationales était auparavant impensable.

Opinion Matters

Environnement bâti et bien-être dans les services psychiatriques italiens

L'environnement bâti dans les services médicaux a un impact sur le bien-être des patients. Ces effets sont d'autant plus prononcés sur les patients sensibles tels que ceux atteints de troubles psychiatriques. C'est la raison pour laquelle la conception de l'environnement peut être un facteur clé pour promouvoir le bien-être et le processus de soins des patients. Cet article permet de comprendre comment cette vision influence la conception des établissements psychiatriques dans le contexte italien, connu pour ses innovations radicales en matière de services de santé mentale suite à la Loi 180 (1978). L'article identifie les problèmes liés à l'environnement bâti actuel dans les services psychiatriques, les solutions de conception adéquates et les possibles actions futures à engager pour répondre aux besoins des usagers et améliorer leur bien-être ainsi que le processus de soins.

La chirurgie Fast Track, une stratégie qui vise à améliorer l'efficacité opérationnelle dans un hôpital de haute complexité en Amérique latine

La chirurgie Fast Track consiste à optimiser les délais dans le cadre d'interventions peu complexes, et par conséquent à améliorer l'efficacité en matière de prestation des soins, et à préserver la sécurité des patients. Méthode: Etude avant et après l'intervention dans un contexte chirurgical, avec analyse des modes de défaillance et de leurs effets, identification et hiérarchisation des opportunités d'amélioration, estimation des procédures avant l'intervention, mise en place des mesures d'amélioration, application pratique, estimation des procédures après l'intervention, et comparaisons des temps d'intervention chirurgicale. Résultats: Avec le programme Fast Track, 19% de la capacité de salle d'opération disponible était libérés par jour; avant la mise en place de la chirurgie Fast Track, 50% des interventions démarraient 23 minutes après l'heure prévue. Après la mise en place du programme Fast Track, les interventions démarrent 5 minutes avant l'heure prévue. Le temps d'administration de l'anesthésie a été réduit de 50%, et le temps d'opération effectif a diminué de 28%. Le nombre

d'interventions chirurgicales réalisées par jour a augmenté de 33 à 50%. Aucun incident ni effet indésirable n'a été signalé. Conclusions: La chirurgie Fast Track est une stratégie utile pour améliorer l'efficacité des salles d'opération et réduire le temps d'intervention. Les interventions démarrent à l'heure, avec des soins plus appropriés, une meilleure satisfaction de la part des patients et des praticiens, et des frais de service réduits.

Resumen en Español

Poniendo en práctica planes estratégicos de éxito: una fórmula sencilla

La planificación estratégica es un proceso. Una forma de pensar en la planificación estratégica es la de prever su desarrollo y su diseño como un marco de referencia que ayudará a su hospital a navegar a través de unos entornos cambiantes internos y externos con el tiempo. Aunque el proceso de planificación estratégica puede parecer desalentador, siguiendo una fórmula sencilla que implica cinco pasos utilizando el mnemotécnico B.E.G.I.N. (Begin, Evaluate, Goals & Objectives, Integration, and Next steps) le ayudará a que el proceso de planificación se sienta más manejable, y le llevará a un mayor éxito.

Los siete errores comunes del servicio al cliente en los hospitales

Operando simultáneamente como un taller de reparación, una cárcel y un hotel, los hospitales son propensos a siete errores comunes en el servicio al cliente. La atención al paciente es a menudo fragmentado, inescrutable, inflexible, insensible, reactiva, miope, e insegura. Los hospitales están compitiendo para tener la más alta tecnología, en lugar tener un más alto contacto a pesar de que el compromiso del personal con los pacientes en lugar de las instalaciones y los quipos influye fuertemente en la satisfacción del paciente. A menos que los procesos, las políticas y las personas se hagan centradas en el usuario, la alta calidad de los recursos humanos y de los equipos del hospital no se traducirá en una alta satisfacción y fidelidad de los pacientes.

La motivación prosocial y las actitudes laborales de los médicos
Efectos de la triple sinergia sobre orientación prosocial en una organización sanitaria

Las actitudes laborales de los empleados son elementos claves para el desempeño organizacional. En este artículo se propone un modelo de integración de liderazgo de servicio, motivación prosocial, y de responsabilidad social corporativa (RSC) con el fin de explicar un mecanismo mediante el cual la motivación prosocial juega un papel central en la mejora de las actitudes laborales de los médicos. Un estudio transversal de una muestra de médicos Indica que (1) la motivación prosocial puede ser moldeado a partir de un liderazgo de servicio cuando los médicos perciben una alta valoración de sus supervisores, (2) la motivación prosocial mejora la satisfacción en el trabajo de los médicos. Sus efectos se

fortalecen cuando los médicos perciben una alta RSEC y (3) la satisfacción laboral mejora el compromiso con la organización. Los resultados proporcionan una perspectiva interesante de que una triple sinergia de orientación prosocial entre los médicos, los supervisores y la organización mejore las actitudes laborales de los médicos.

Desarrollo, empoderamiento y responsabilidad de los empleados de primera línea

Facilitar la atención centrada en el paciente y hacerla rentable a todo lo largo del proceso es un reto que requiere creatividad de los administradores de salud. En el BLK Super Specialty Hospital, se implementaron los cargos de Encargado de la Relación con los Clientes (ERC) y Coordinador de Cuidados del Paciente (CCP) para mejorar la comunicación y los vínculos entre los departamentos clínicos y no clínicos. La gerencia también innovó varios otros procesos que necesitan perfeccionamientos para facilitar el mejoramiento de los servicios prestados a los pacientes. Animar el CCP y el GRE a tomar la iniciativa, a tomar decisiones y tomar acciones para prevenir y resolver problemas de servicio ha elevado los niveles de servicio y conducido a una experiencia mejorada del paciente.

Salvando vidas juntos

Fundado hace 20 años con un centro de diálisis que solo asistía a 20 pacientes con 6 máquinas de hemodiálisis, Medicare ha crecido a pasos agigantados para ayudar a miles de pacientes pobres a obtener una tarifa altamente subsidiada para un tratamiento de calidad. Millones de ringgit malasios recolectados a través de varios proyectos de recaudación de fondos y eventos han sido bien utilizados para atender el creciente número de pacientes renales en Malasia que simplemente no pueden soportar el costo exorbitante del tratamiento. Manteniéndose fiel a su misión, Medicare extiende su asistencia a los pacientes renales necesitados y sus familias, que indirectamente se han convertido en parte de la familia de Medicare.

Iniciativas de mejoramiento de calidad por el servicio de salud del Aga Khan Health Service en las montañas del norte de Pakistán

Mejorar la calidad de la atención de salud en un entorno de restricción de recursos con una economía emergente y en un terreno geográfico de difícil acceso puede llegar a ser un reto, especialmente cuando se tiene que seguir la norma

internacional que AKHS, P prevé implementar por toda la nación en todos sus centros de salud. La salud de la nación es una responsabilidad que es asumida por el gobierno y el sector privado. El sector privado, sin embargo, sigue bajo presión dado que el tamaño de sus recursos es limitado y sigue sujeto a una reglamentación estricta y a unos requisitos de control de calidad que no tienen en cuenta si es el rincón más remoto del país, donde las adecuadas rutas terrestres son inexistentes o inseguras.

En este artículo se comparte la experiencia única de AKHS, P para obtener la norma ISO 9001: 2008 Sistema de Gestión de Calidad Internacional. Especialmente en uno de los valles más altos del mundo-situado en Gilgit Baltistán a una altitud de 3987 mts. por encima del nivel del mar en el norte de Pakistán. La experiencia fue única en términos de demostrar y describir cómo el sistema de gestión de la calidad se puede implementar en una de las más zonas de más difícil acceso en la que el cumplimiento de las normas internacionales de calidad era impensable antes.

Opinion Matters

Entorno construido y bienestar en los pabellones psiquiátricos italianos

El entorno sanitario construido tiene efectos sobre el bienestar del paciente. Estos efectos son aún más fuertes en los pacientes sensibles como los pacientes psiquiátricos. Por lo tanto el diseño del entorno puede ser un factor clave en la promoción del bienestar del paciente y en el proceso de atención. Este artículo investiga cómo esta visión está influyendo en el diseño de las instalaciones psiquiátricas en el contexto italiano, conocido por la innovación radical de los servicios de salud mental debido a la Ley 180 (1978). El artículo identifica los problemas de medio ambiente construidos actualmente en las salas de psiquiatría, las indicaciones de diseño disponibles y las posibles acciones futuras para satisfacer las necesidades de los usuarios y para mejorar el bienestar y el proceso de atención.

Fast Track quirúrgico, estrategia para mejorar la eficiencia operacional en un hospital de alta complejidad de América Latina

Fast Track quirúrgico, busca optimizar tiempo con procedimientos menores de baja complejidad, mejorando la eficiencia en el proceso de atención y velando por la seguridad del paciente. Metodología: Estudio de intervención antes y después en un ambiente quirúrgico, con análisis de modo de falla y efectos potenciales, identificación y priorización de la oportunidad de mejora, medición del proceso antes de la intervención, implementación de mejoras, aplicación de la práctica, medición del proceso posterior a la intervención y comparación de tiempos quirúrgicos. Resultados: El programa Fast Track liberó en un 19% la capacidad disponible del quirófano por día; antes de la implementación de Fast Track quirúrgico el 50% de los procedimientos empezaban 23 minutos después de la hora programada. Con la implementación del Fast Track

se inicia los procedimientos 5 minutos antes de la hora de programación. Se disminuyó el tiempo de inducción anestésica en un 50% y el tiempo quirúrgico de piel a piel en un 28%. Se aumentó el número de cirugías realizadas por jornada entre un 33 y un 50%. No se presentaron incidentes ni eventos adversos. Conclusiones: Fast Track quirúrgico es una estrategia útil para mejorar la eficiencia de quirófanos y disminuir los tiempos quirúrgicos logrando puntualidad para la ejecución de los procedimientos y mayor oportunidad en la atención con gran satisfacción de pacientes y médicos, y disminución de los costos del servicio.

Leadership and Innovation in Asia 2015 Volume 51 Number 1
中文摘要

执行成功的战略计划：简单规则

战略规划是一个过程。考虑战略规划的一种方式，是将其开发和设计视为一个框架，它能帮助您的医院应对随时间出现的内部及外部挑战。战略规划的过程可能看似艰巨。但只要遵循一个五步骤的简单规则，我们将其简称为B.E.G.I.N.以方便记忆。B.E.G.I.N.指的是开始（Begin）、评估（Evaluate）、目标及目的、集成和下一步）。它能帮助规划过程变得更易管理，并让您获得更大成功的机会。

医院客户服务的七个常见问题

像修理厂、监狱和酒店一样，医院在客户服务方面容易出现七种常见的问题。患者护理容易出现分散、难量化、不灵活、反应不足、被动、短视和不安全的问题。工作人员与患者的密切程度极大影响着患者的满意度。但饶是如此，医院越来越高科技化，而不是"接触化"。只有当流程、规定和人员都遵守客户为中心的原则时，医院的高品质人力及硬件资源才能提高患者满意度和忠诚度。

亲社会动机和医生的工作态度
医疗保健组织中亲社会取向上三方协同的效果

员工的工作态度，是决定组织业绩的关键因素。本文提出了一个模型，将服务型领导、亲社会动机和企业社会责任（CSR）整合到一起，来阐释亲社会动机对医生工作态度的改善是如何起到核心作用的这一机制。以一些医生为样本进行的一项横向调查表明：（1）如果医生认为自己同上司有较好的契合度，服务型领导就能催生亲社会动机；（2）亲社会动机能提高医生对工作的满意度。其效用在医生体会到较高的企业社会责任时会更好；（3）工作满意度能增强组织认同感。从研究结果可得出的有用结论是：医生、领导和组织之间在亲社会取向上的三方协同，能够改善医生的工作态度。

一线员工的启用、放权和问责

如何改进整个机构内以患者为核心、高成本效益的护理服务，这一课题需要医疗保健机构管理者通过创新思维来解决。BLK Super Specialty Hospital专科医院，设立了Guest Relationship Executive（GRE，客户关系执行员）和Patient Care Coordinator（PCC，患者护理协调员）岗位，以改善临床部门与非临床部门之间的沟通与联系。管理层还对其他亟待改善的多个流程进行了创造性的改变，以能更好地改进为患者提供的各项服务。通过将权力下放到PCC和GRE，让他们采取主动、制定决策并采取措施预防和解决服务方面的问题，服务水平得以提高，患者体验也得以提升。

共同拯救生命

Medicare成立于20年前。当时，它还只有一个仅有6台血透机的透析中心，供20名患者治疗。今天，Medicare经过飞速发展，已一跃成为数千名经济困难患者的福音，帮助他们获得享受高补贴、进行良好治疗的机会。Medicare通过多种筹资项目和活动，募集数百万马币的资金，将其妥善用于马来西亚数量日益增长的难以负担高额治疗费用的肾病患者。Medicare始终恪守其宗旨，为经济困难的肾病患者及其家庭提供帮助。这些受助的人也成为了Medicare大家庭的一份子。

Aga Khan健康服务机构在巴基斯坦北部山区开展的质量提高行动

在一个处于交通不便的地理位置中的新兴经济体中，以有限的资源来提高卫生保健的质量本身就是一件困难的事情。当这样做的同时还必须遵守AKHS,P希望在自己全国的卫生保健机构中实施的国际标准，就更是困难重重。一个国家的卫生保健事业是应当由政府和私人机构共同承担的责任。然而私人机构一直面临着很大的压力，因为他们拥有的资源有限，需要遵守严格的规章制度和质量控制要求，哪怕是位于陆上交通线路缺乏或不安全的偏远地区。

本论文分享了AKHS,P获得ISO 9001:2008国际质量管理体系认证的经历。特别之处在于，这个机构位于全世界最高的峡谷地带——巴基斯坦北部的吉尔吉特-巴尔蒂斯坦，海拔13,083英尺。这一经历的独特之处在于，它展示和记录了怎样在一个遥不可及的地方达到质量管理系统的标准，而此前在这样的地区通过国际质量标准认证根本就是一件难以想象的事情。

Opinion Matters

意大利精神病房的建设环境和福利

卫生保健的建设环境对病人的福利有深远的影响。对于敏感的精神病人，这样的影响则更深。因此，环境设计成为了提高病人福利和护理水平的重要因素之一。本文研究的对象是，这样的观念会对意大利精神病医院的设计造成怎样的影响，因为，意大利根据180法律（1978年）的规定，在精神健康服务方面的激进革新是远近皆知的。本文指出了目前在精神病房建设环境中所存在的问题、现有设计指标和为达到用户需求和提高福利及护理水平，将来可能采取的行动。

快通道外科手术——拉丁美洲一家高复杂度医院提供手术效率的策略

快通道外科手术的目的是优化复杂度较低程序的时间，从而提高护理效率和保证病人安全性。方法：在手术环境下的干预研究前后，通过故障模式和效果分析、改善机会的发现和排序、干预前过程测量、改善实施、实际应用、干预后过程测量以及手术时间对比。结果：采用快通道计划以后，每天释放了19%的手术室占用率；实施快通道外科手术之前，50%的手术都会在计划时间以后23分钟才能进行。实施快通道计划以后，手术开始时间比计划提前5分钟。麻醉诱导时间缩短50%，有皮肤直接接触的手术时间下降28%。一天中所进行的外科手术数量增加33 - 50%。没有出现事故或不良事件。结论：在提高手术室使用率和降低手术时间上，快通道手术是一项有效的策略。手术准时开始，按时护理有所增加，病人和医生满意度提升，服务成本降低。

IHF events calendar

2015

IHF

39th World Hospital Congress
6-8 October 2015, Chicago, USA
Visit http://www.worldhospitalcongress.org

2016 **IHF 40th World Hospital Congress**
Durban, South Africa
For more information, contact sheila.anazonwu@ihf-fih.org

2017 **IHF 41st World Hospital Congress**
7-9 November, Taipei, Taiwan
For more information, contact sheila.anazonwu@ihf-fih.org

2015

MEMBERS

HONG KONG
Hong Kong Hospital Authority Convention
November 12 - 14, Seoul.
May 18 -19, Hong Kong.
Organized by Hong Kong Hospital Authority
More information http://www.ha.org.hk

JAPAN
65th JHA Congress 2015 Karuizawa
June 18 – 19, Nagano, Japan
Japan Hospital Association

FRANCE
SFC congress (French Cancer Society)
June 22-24 – Paris, Palais des Congrès
FÉDÉRATION FRANÇAISE DES CENTRES DE LUTTE
CONTRE LE CANCER
http://www.congres-sfcancer.com/

ARGENTINA
XXI Congress of the CAES "State Health Policy"
September 16 at the Sheraton Libertador Hotel in Buenos Aires city
Camara Argentina de Empresas de Salud - CAES

SWITZERLAND
H+ Congress
November 11, Berne
H+ Les Hôpitaux de Suisse

KOREA
6th Korea Healthcare Congress 2015
November 12 – 13, 63 Convention Center, Seoul, Korea
Korean Hospital Association

GERMANY
German Hospital Conference
November 16 – 19, Düsseldorf
Deutsche Krankenhausgesellschaft

2015 IHF CHICAGO

39th World Hospital Congress

International Hospital Federation
39th World Hospital Congress

Advancing Global Health & Health Care

Groundbreaking innovations emerge when those at the forefront of health care can gather together. Join visionary health care leaders and decision makers from around the world to exchange experiences, ideas and best practices.

October 6-8, 2015
Hyatt Regency Chicago

Register Today **WorldHospitalCongress.org**

Where World Health Care Leaders Meet

Exchange ideas and best practices with visionary healthcare leaders from around the world.

Come to Chicago— A World-Class City

Home to a vibrant health care market with 116 hospitals in the greater metropolitan area, including 15 teaching hospitals. Congress attendees will get a behind-the-scenes look at several leading health care organizations.

Enjoy top-rated restaurants, museums, entertainment and a shopping district known as The Magnificent Mile.

The Hyatt Regency Chicago—the program site—is a prime location with breathtaking skyline and Lake Michigan views.

More information at

www.worldhospitalcongress.org

save the date!

International Hospital Federation

American Hospital Association

American College of Healthcare Executives
for leaders who care ®