Comparing Electronic and Face-to-Face Communication in the Success of a Long-Term Care Quality Improvement Collaborative

Priscilla A. Arling, College of Business, Butler University, Indianapolis, IN, USA
Edward J. Miech, Health Services Research Division, Regenstrief Institute, Indianapolis, IN, USA
Greg W. Arling, Department of Medicine, Indiana University School of Medicine, Indianapolis, IN, USA, & Indiana University Center for Aging Research, Regenstrief Institute, Indianapolis, IN, USA

ABSTRACT

Researchers have long debated the effectiveness of electronic communication for getting work done in organizations, with many arguing that face-to-face interaction is key to high quality work and desired outcomes. Yet in healthcare quality improvement (QI) collaboratives, membership is frequently comprised of individuals from different, geographically dispersed organizations. This study examines the relationship between electronic and face-to-face interaction and the outcomes of a specific QI collaborative, the Empira Fall Prevention project in Minnesota. Outside of regularly scheduled meetings, the level of electronic communication reported by participants was associated with better outcomes in terms of reducing the percentage of new falls in facilities, along with other measures of effectiveness. In-person communication outside of meetings was related to subjective measures of success. The findings suggest ways in which collaboratives and members can leverage different modes of communication to maximize the benefits derived from participation.

Keywords: Collaborative, Communication, Electronic, Empira Fall Prevention Project, Nursing Home, Quality Improvement

DOI: 10.4018/ijrqeh.2013010101
INTRODUCTION

Researchers have long debated the effectiveness of electronic communication for getting work done in organizations. Some have stated that electronic interaction is a poor replacement for face-to-face and can lead to misunderstandings and damaged personal relationships (Hinds & Bailey, 2003; Nardi & Whittaker, 2002). Others argue that despite the drawbacks, electronic communication is essential, particularly when work involves group members that are physically or temporally dispersed (Olson & Olson, 2000). Such dispersed groups are common in healthcare settings, where shift work and multidisciplinary patient care mean that caregivers are seldom together at the same place at the same time. In addition the increasing complexity and drive to improve the quality of healthcare has given rise to increasing use of one type of healthcare group, comprised of members from dispersed organizations, the quality improvement collaborative.

In quality improvement (QI) collaboratives members share knowledge and act as resources for each other, with the goal of improving implementations of evidence-based practices (Newton, Davidson, Halcomb, Denniss, & Westgarth, 2006). The collaborative provides a formal structure through which individuals build networks of support and gain access to expertise in implementation areas. A central feature in many collaboratives is holding scheduled conferences where participants attend in person and learn about problem-solving techniques as well as evidence-based practices specific to their focus area. The sharing of member experiences is also a key function of these meetings. Other tools used in collaboratives can include site visits, written reports and sharing of data via electronic methods (Nembhard, 2009). Multiple studies have reported collaborative successes in improving processes, including studies in the areas of colorectal, perinatal, and diabetes care (Gould, 2010; Hicks et al., 2010; Jackson et al., 2010). Others, however, have suggested that collaboratives have only modest effects on outcomes and have concluded that little is known about the specific components that affect a collaborative’s effectiveness (Schouten, Hulscher, van Everdingen, Huijsman, & Grol, 2008). In particular there has been a call for further research on the behaviors of collaborative participants and the effect on outcomes (Lindenauer, 2008).

We sought to better understand how different modes of communication employed by individual participants affected measurable, objective outcomes of a fall prevention project carried out by Empira, a quality improvement collaborative of Minnesota nursing homes.

BACKGROUND

Quality Improvement Collaboratives and Communication

In quality improvement collaboratives, members from multiple organizations work together to share information on effective interventions and ways to overcome barriers to implementations (Cretin, Shortell, & Keeler, 2004; Kilo, 1998). A central premise underlying success is that participants learn and benefit from each other and experts via a variety of communication methods. Prior research has found that inter-organizational communication is a key differentiator in terms of whether or not collaborative participation benefits specific members and organizations (Nembhard, 2009).

The inter-organizational communication between collaborative members is likely to occur both face-to-face and electronically, since participants typically come from geographically dispersed locations. Both collaborative organizers and members have a choice as to the mode by which they communicate and the extent to which they communicate via that mode. In addition to hosting face-to-face learning sessions, collaboratives often provide participants with a mix of communication modes including collaborative-specific websites (called extranets), phone calls, and written reports (Kilo, 1998; Nembhard, 2009). While studies have reported the benefits of in-person learning sessions and
CRM Index Development and Validation in Indian Hospitals

www.igi-global.com/article/crm-index-development-validation-indian/67992?camid=4v1a