Library Services and Health Care Administration

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ABSTRACT

THIS ARTICLE REVIEWS THE PROGRESS made in meeting the information needs of health care administrators within a health care environment that is continuing to undergo major changes. Health care economics, a shifting power structure within the industry, and quality improvement initiatives are discussed in light of their shaping of the health care environment. Also discussed are the library's role in providing information for administrative decision making, how that role has been communicated to administrators, and the partnerships between health care librarians and administrators that can ensue. Future research needs are identified including: (1) improving the understanding of the administrator's information needs; (2) identifying their information-seeking and using patterns; (3) developing specialized services to meet these needs; and (4) developing indicators to measure the provision of quality library services.

INTRODUCTION

The health care industry and the libraries operating within it have changed significantly over the past twenty years. Change is not always synonymous with progress as the following exchange illustrates: "'But, my dear,' said the Hatter, 'Was there progress?' 'Well,' said Alice earnestly, 'There was change'" (Dunkin, 1968, p. 367). This article will focus on the progress made in providing library services to health care administrators. The 1970s were years of

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collaboration, expansion, and diversification in the health care industry. As resources shrank in the 1980s, competition for patients accelerated and the number of multihospital systems increased. Meanwhile, health care costs skyrocketed in spite of voluntary as well as federal regulatory initiatives such as the prospective payment system (PPS). At the same time, hospitals came under fire from consumers and accrediting agencies for declining quality. In response, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) initiated, in 1986, a move toward continuous quality improvement which was called the Agenda for Change.

These developments set the stage for a fundamental change in the structure, funding, and management of health care. According to a Harris Poll, ninety percent of Americans now believe that the U.S. health care system should be restructured (Healthcare Forum Leadership Center, 1992). Controlling costs while at the same time expanding access to affordable health care was a major platform in federal and state political campaigns of the early 1990s. The winner of the 1992 presidential election pledged to make sweeping reforms in the health care industry (Clinton, 1992). How extensive these reforms may prove to be and when they will be implemented depends on many factors. One thing is clear. These changes, and their impact, will certainly affect the next twenty years of health sciences librarianship and services to health care administrators.

Because preparing for the future first requires examining the past, this article will review the health care administration environment of the past twenty years and the ways libraries sought to serve that environment. It will also identify emerging questions and new developments in the health care industry. Proactive health science librarians understand and are sensitive to these directions in order to focus clearly on future needs of health care administration. While librarians understand their fundamental role in clinical health care decisions, their understanding of administrative information needs is less clear. This article attempts to identify the issues associated with administrative information needs and encourages future research in that area. It may well be that specialized services such as those developed for clinicians are not needed by administrators. Yet health sciences librarians have an important commodity to offer; they just have to learn how to communicate its value to the health care system.

Health Care and Library Environments

Health care administrators are found in a wide range of settings and receive information services from many sources, including hospital and university libraries and the American Hospital Association (AHA). Other types of hospital associations also provide

library services to health care administrators and their organizations. Poole's (1982) survey of local, state, regional, and national hospital associations found at least twenty that offered some type of regular library services.

Since the majority of service to health care administrators is provided by the hospital library, basic descriptive data on hospital libraries may be helpful in understanding the context in which the librarian strives to serve the administration. In 1973, the American Medical Association identified 1,957 health sciences libraries in hospitals and 144 in other nonhospital, health care organizations (Crawford & Dandurand, 1974). The 1989 survey, conducted by the American Hospital Association Resource Center (1991) identified 2,167 U. S. hospitals (out of 6,853 registered in January 1990) with on-site libraries meeting the American National Standards Institute definition of a library: (1) organized collection; (2) trained staff; (3) established schedule when services are available; and (4) existence of appropriate physical facilities.

Since 1990, the AHA has collected data on libraries through its Annual Survey of Hospitals. Wakeley and Foster (1993) report on the AHA survey in the context of environmental issues facing hospitals in the 1990s and identify challenges and opportunities for hospital libraries. The 1991 annual survey reported 6,634 registered hospitals and 2,602 libraries—39.2 percent (American Hospital Association [AHA], 1992). Although longitudinal comparisons are not possible with the above surveys, the 1989 AHA survey provides a snapshot of hospital libraries. The *Survey of Health Sciences Libraries in Hospitals, 1989: Executive Summary* (American Hospital Association Resource Center, 1991) includes various facts about the hospital library respondents. Table 1 provides a selective list of data. Of particular note is the fact that almost all respondents identified administrators as a user group for the library.

TABLE 1
SELECTED CHARACTERISTICS OF HOSPITAL LIBRARIES—1989

- 69.3% are separate departments
- 53.7% of library managers have a master's degree in library/information science
- 77.8% reported increases in use of services
- 57.2% reported budget increases
- 13.3% reported staffing increases (71.7% reported no change)
- 50% reported square footage of 1,083 sq. ft. or less; the largest number of respondents clustered between 2,000-3,000 sq. ft.
- 98.4% are used by administrative staff, 98.8% by technical staff, and 95% by other hospital personnel
- 34.1% formally participate in the institution's quality assurance program

Source: American Hospital Association Resource Center. (1991). *Survey of health sciences libraries in hospitals, 1989: Executive summary.* Chicago, IL: AHA.

Over the years, various regional surveys, typically funded through the National Library of Medicine's National Network of Libraries of Medicine, have described changes in libraries serving health care administrators (Van Toll & Calhoun, 1985; Glitz et al., 1992). Review of several of these survey reports will provide the reader with additional insight into the change associated with hospital libraries.

Economic pressures have affected hospital libraries in various ways. The development of cooperative relationships, such as library consortia, was considered a positive trend of the 1970s (West Suburban Hospital Association, 1975). The long-term effects on hospital libraries of the current economic retrenchment are not yet known. Several studies have investigated the short term effects of these changes. Wos and Oddan (1987) surveyed multihospital systems formed from mergers, finding that of fifty-three respondents only one library was eliminated. Stevens (1990) surveyed Michigan hospital libraries to investigate changes in staff size and services between 1985 and 1988. Among the eighty-two respondents, total library full-time equivalent (FTE) employees decreased 6.1 percent.

Several key external factors have influenced the health care environment over the past twenty years and have affected how libraries provide services to their users, especially nonclinical users. Writing specifically about the development of hospital libraries, Wolfgram (1985) identified several environmental forces behind library trends: (1) government action; (2) scientific advances and the growth of publications; and (3) rising health care costs.

Librarians writing about the past twenty years consistently point to several driving forces that have influenced the development of health sciences libraries. Walker and Due (1986) credit the National Library of Medicine and its Regional Medical Library Program (now called the National Network of Libraries of Medicine), the Integrated Library System, the Integrated Academic Information Management System (IAIMS), and microcomputer technology. These influences have enabled health sciences librarians to respond to the environmental pressures transforming the health care industry by creating new ways to serve library users.

The use of the computer may have done more during the 1970s and 1980s to enhance the development of libraries within hospitals than any other trend. On-site MEDLINE and other databases provide access, even by small rural facilities, to resources found typically only in a large medical center library. The hospital librarian running a MEDLINE search was viewed as a highly trained professional at the leading edge of this new technology. "Overnight the librarian could contribute directly to the growth area in health care: the application of computers to medicine" (Hardy et al., 1985, p. 43).

More fundamental than the computer though is the concept of an integrated information system, called an Integrated Academic Information Management System by Matheson and Cooper (1982). In 1986, the Rhode Island Hospital became the first hospital library (and still the only one as of this writing) to be awarded an IAIMS grant by the National Library of Medicine. Klein (1989) reported on the use of existing technology to adapt the IAIMS concept to a hospital setting. Other implementation examples in hospitals are summarized by Buchanan and Fazzone (1985).

Within this issue of *Library Trends,* several chapters discuss these trends more fully. The reader is referred to the article by Weise for a review of the programs and initiatives of the National Library of Medicine and to the article by Roderer for a discussion of the IAIMS concept. Marshall, also in this issue, discusses the effect of these trends on the delivery of services to the health sciences library's other main client group, clinicians.

The factors identified earlier influenced library services to health care administration over the past twenty years. Currently, three major trends have emerged to shape health care for the next twenty years. These are health care economics, the shifting power structure within the health care industry, and the quality improvement movement.

Health Care Economics

Various authors have reviewed the historical antecedents for the U.S. government's involvement in health care, charting developments since World War II (Atkinson, 1987; Messerle, 1987). Based on the recent analysis by the American Hospital Association (1992) of trends affecting U.S. hospitals, it seems likely that economics will continue to shape the health care industry.

An article in *Newsweek* reported that health care expenditures have been greater than expenditures for defense since 1973. In 1992, the Pentagon's part of the Gross National Product (GNP) was 6 percent while health care had increased to 13 percent, the largest per capita share of any country in the world. In 1990, hospital spending roughly equaled the Pentagon's budget (Easterbrook, 1992).

Strategies to address the high cost of health care have included shifting the delivery of care to less costly delivery mechanisms and developing fee schedules for hospitals as well as physicians. Because hospitals account for the largest percentage of total health spending, initial cost controls have focused on ways to shift consumers' use of health care services to less expensive alternatives such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). By 1990, 43 percent of employer-sponsored plans were either HMOs or PPOs (American Hospital Association, 1992).

An early strategy to control the rapid rise of hospital costs was the shift from retrospective reimbursement by third party payers to a prospective payment system. With implementation of PPS for inpatient Medicare patients in 1984, health care facilities were paid based on preapproved budgeted charges rather than on their actual costs of providing the service. Since physician services account for an increasing percentage of health spending, Medicare recently extended its prospective payment system to physicians. Under the resource-based relative-value scale (RBRVS) that became effective in January 1992, all physicians are paid by Medicare based on a national fee schedule. This funding change is projected to have a profound effect on academic medical centers and large tertiary care centers that have traditionally charged more for physician services in order to subsidize the cost of medical education and to compensate clinicians for the longer time that is required with more seriously ill patients (Sandrick, 1992).

Shifting Power Structure Within the Health Care Industry

Power shifts are underway throughout the health care industry, driven largely by conflicts over costs and quality. Messerle (1987) discusses the shift from physician power to growing administrative control. Holst (1991) suggested that it was the clinical rather than the administrative side of the dual authority found in hospitals that was generally responsible for the establishment of hospital libraries.

Other changes relate to the health care delivery system itself. The delivery point of health care is changing as a result of economic pressures. Hospitals are no longer the sole delivery point and health care administrators are no longer associated just with hospital settings. Today, growing numbers of administrators are found in diverse settings—HMOs, hospices, nursing homes, and home health care agencies. Yet hospitals remain the largest segment of the health care industry and retain the focus and the power. Although the number of hospital closings has slowed recently, 603 hospitals closed between 1980 through 1991 (Burda, 1992). In order to survive, however, hospitals began merging in the 1980s to form multihospital systems and, by 1990, 48 percent of all community hospitals were part of a multi-unit system (Johnson, 1992).

Quality

The third trend affecting the future is the health care industry's focus on quality. While this mirrors the current global emphasis on quality, health care organizations have a long tradition of concern with quality. This is partially a natural outgrowth of the search to improve health conditions. But the health care industry has also used self regulation to counteract consumer criticism of rising health

expenditures coupled with a perceived decline in quality. These quality initiatives have taken the form of national standards as well as initiatives at the local provider level.

Standards

Various forms of standards have affected libraries in hospitals and other types of provider organizations. A comprehensive list of organizations sponsoring standards and guidelines for hospital library services appeared in *Hospital Library Management* (Foster, 1983). The Medical Library Association (1984) also developed quantitative standards covering hospital libraries (these are currently under revision). Of all these organizations, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO; previously called Joint Commission on Accreditation of Hospitals—JCAH) has played the most influential and pivotal national role.

During the past twenty years, the role of the Joint Commission on Accreditation of Healthcare Organizations in the development and molding of hospital library services has been indirect but pervasive. The first hospital library standards developed by the commission in 1953 described library services as desirable rather than as a requirement for accreditation (Foster, 1983). In 1975, Koughan, a hospital administrator, remarked on the "unimpressive and virtually meaningless state of the current standard. It lacks both quality and substance" (p. 589). JCAHO standards for "Professional Library Service" have been strengthened since those of the early 1970s. Various actions by JCAHO have addressed Koughan's issues of quality and substance for hospital library standards (see Table 2).

TABLE 2
TRENDS IN JCAHO STANDARDS FOR PROFESSIONAL LIBRARY SERVICE

1978:	Accreditation manual included revised standards for hospital libraries
1989:	1) Hospital library standard was identified as a key factor in the accreditation process
	2) The on-site responsibility for surveying the library was transferred from the physician surveyor to the administrator surveyor
1992:	Accreditation manual identified additional library standards as key factors in the accreditation process
1993:	Standards added relating to patient and family education, staff training and education, and responsibilities of department directors
1994:	New information management standards will become effective

In 1978, revised standards for hospital libraries became effective, and the accreditation manual was revised accordingly. Among the substantive changes was the definition of a qualified medical librarian. In the 1980s, various steps were taken within the profession

to expand JCAHO's knowledge of the role of the hospital library and to open formal communication channels between JCAHO and the profession. As an example, the Medical Library Association (MLA) developed the "JCAH Guide to Professional Library Services for Surveyors" (1980). As an outgrowth of MLA's strategic plan, collaboration with various external agencies was emphasized and responsibility for standards was placed with each special interest section. The Hospital Library Section of MLA, supported by the MLA headquarters, developed strong proactive linkages with JCAHO (Medical Library Association, 1987).

In 1989, the hospital library standard was identified as a key factor in JCAHO's accreditation process and the on-site responsibility for surveying the library was transferred from the physician surveyor to the administrator surveyor. This was followed in 1992 by changes in the accreditation manual that targeted additional library standards as key factors in the accreditation process. Although not exclusive to the library, new JCAHO standards added in 1993 have the potential to affect library services and relate to patient and family education, staff training and education, and responsibilities of department directors.

An outgrowth of MLA's continued proactive communication was an invitation by JCAHO to participate with representatives from the medical records and information systems disciplines in designing new accreditation standards. The information management standards will become effective in 1994 (Doyle, 1993). Koughan stated in 1975 that standards serve as an indicator to the hospital administrator of the relative importance of a hospital service. The projected 1994 standard is the culmination of a series of accreditation changes that have affected hospital libraries over the past twenty years. The 1994 standard will change profoundly how hospital administrators perceive the library during the next twenty years. Jones (1991) has provided an overview of these changes and defined the librarian's potential contribution to quality improvement.

While JCAHO standards have continued to emphasize the role of the library in serving clinical and administrative decision making, others have not. The other major standard that affected libraries since the 1970s was that of the Health Care Financing Administration (HCFA) which regulates Medicare and Medicaid funding. Since 1966, hospitals seeking Medicare/Medicaid funding were required to maintain a medical library to meet the needs of the hospital. Despite protest from various health care groups, including librarians, HCFA eliminated that requirement in its 1986 regulations (Health Care Financing Association, 1986). Individual states are now free to reduce or eliminate similar library requirements. Most librarians have

recognized that the quality indications needed to measure information services go well beyond a requirement based on physical facilities. Still, the potential impact of the regulation change may be substantial in those organizations where health care administrators have not understood the added value the library contributes to the organization's bottom line.

Local Quality Improvement Initiatives

Beginning in the 1980s, the health care industry began to investigate the use of quality improvement processes found in manufacturing and the military, often called total quality management (TQM). This search was intensified when the Joint Commission on Accreditation of Healthcare Organizations announced its Agenda for Change and outlined a philosophy of continuous quality improvement (CQI). As an additional encouragement of the quality movement, the first national health care award for quality, the Healthcare Forum/Witt Award, was presented in 1988. By 1992, in a survey published in *Hospitals,* almost 60 percent of responding hospital chief executive officers reported having TQM/CQI programs in operation. Seventy-five percent of those who had not implemented TQM/CQI programs indicated an intention to begin one within a year (Grayson, 1992).

While various definitions and versions of TQM and CQI exist, several common components are typically found. Included are a customer focus, continuous improvement using data and facts, and employee empowerment or involvement in decision making, often in teams. It is the continuous improvement aspect that emphasizes an information management process. The process is information intensive, forcing managers and employees alike to collect, compare, and monitor information relating to key organizational processes. Library managers within such a quality improvement environment have recognized this opportunity to position the library as an integral part of the health care information management process needed to support the institution's quality improvement processes. The next section will discuss specifically the library's role and value in providing services to health care administrators.

The Library's Role and Value

The role and value of the hospital library has been discussed in general in a wide range of sources since 1974, primarily from the management perspective. Representative are MLA's *Hospital Library Management* (Bradley et al., 1983) and the guide published by the Midwest Health Science Library Network, *Basic Library Management for Health Science Librarians* (Wakeley & May, 1982). Most of these

texts have recognized parallel lines of authority within the health care institution.

Holst (1991) described the outcome of dual lines of authority (medical staff versus administration): "Variations aside, it is safe to conclude that hospital libraries owe their origins to the clinical side of the equation" (p. 3). These roots of origin help to explain why libraries have rarely developed specialized services for the other side of the equation.

According to Langner (1974), one of the distinguishing characteristics of health sciences libraries is their emphasis on personalized assistance to library users. She recognized that these types of services were "especially evident in clinical areas where emergency 'spoon-fed' service was offered to busy practitioners in their patient care activities" (p. 14). The 1974 *Library Trends* issue that emphasized health sciences libraries recognized the shifts in funding support and authority governing health sciences libraries and the broadening user base in health care libraries (Brodman, 1974). Publications prior to that, while acknowledging that the library is used by a variety of users, emphasized the physician user (Cunningham, 1943).

The first edition of *Hospital Library Management,* published in 1983, recognized the need for hospitals to

> provide a variety of information services needed by the hospital in all aspects of its organizational operation. Providing total information services, however, means extending the standard library services beyond the subject matter of the health sciences to include any information needed by hospital personnel in the performance of their jobs. (Bradley, 1983, p. x)

Librarians extending services to health care administrators have been enabled by the American Hospital Association in accomplishing the above purpose. A number of services and products targeting the information needs of health care administration have been developed by the American Hospital Association and its Resource Center.

The Resource Center provides a wide range of services and products to administrators and to the health sciences libraries that serve them, including reference and referral services and document delivery. Most notable of its accomplishments is the production, in cooperation with the National Library of Medicine, of the Health Planning and Administration database (HEALTH), introduced in 1978, and the publication since 1945 of the *Hospital Literature Index,* a quarterly author-subject index to the periodical literature of health care administration. Access to HEALTH enhanced the librarian's ability to respond quickly to administrative information requests with an impact similar to that of moving from *Index Medicus* to MEDLINE for clinical questions.

Staff of the Resource Center have also prepared for administrators a list of resources to use in planning information services. The guide covers standards, organizing services, innovative and specialized services, collections, and facilities (Wakeley et al., 1985). Publications to aid in the development of health care administration collections have also been prepared (Kiger, 1985; American Hospital Association Resource Center, 1989). In addition to its current comprehensive collection of materials in the field of health services administration, the Resource Center also offers historical materials through its Center for Hospital and Healthcare Administration History.

Although a few reports have occurred in the literature or in presentations at professional conferences, the development of specialized services for health care administration has been largely ignored during the past twenty years. Few specialized services, comparable to those offered to clinicians (e.g., clinical medical librarianship, LATCH, and GRATEFUL MED), have been designed for busy health care administrators. All too often, products and services have been simply an extension of traditional general health sciences library services. Promotion of health science library services to health care administrators has focused on selective dissemination of information (SDI) or expanding the clinical collection to include health care administration. Health science libraries are beginning to realize this should change.

Communicating the Role and Value of Library Services

Serving a diverse user population, including administration users, requires developing multiple communication channels to carry the message of the library's role. Logsdon (1970) acknowledges that: "One of the very special aspects of librarianship in relation to users of libraries is that almost every user very soon considers himself an expert fully capable of running the show better than the establishment" (p. 2873). In addition, most students in a master's program in health care administration (MHA) do not learn about the health science library and its role in clinical and administrative decision making; training and education of staff; patient or consumer health services; and recruitment of new physicians to the medical staff. In addition, most texts to which administrators might refer, such as Goldberg and Buttaro's 1990 text, *Hospital Departmental Profiles*, are all too often silent about the library.

In this lack of awareness lies an opportunity. Usually the librarian and library department are seen as "low risk." Assertive but tactful librarians have helped these "novice" administrators become knowledgeable about how health care organizations work. One

administrator has been direct and asked the hospital librarian to "help me not look stupid." To do this, the librarian had to understand the viewpoint of the health care administrator and that the administrator is in a high risk role. Seeing the organization through the administrator's eyes has helped librarians to find better ways to communicate the benefits of the library. When that happens, administrators begin to understand the library's role in keeping the organization in business, "the timeliness of their service creates the advantage I need to effectively communicate with various publics such as vendors, physicians, and senior managers" (Margaret Sullivan quoted in Teschke, 1990). Strong administrative support and respect is evident in those situations where a working partnership has emerged between the administrator and the librarian.

The development of partnerships between librarians and health care administrators has been inhibited for several reasons. First, in some ways librarians seem to be afraid of administrators. According to White (1989), writing about the corporate political process:

> Librarians are usually not participants in the corporate political arena but, like innocent bystanders at a bank holdup, they sometimes get shot in the process. Despite our frequently expressed paranoia, librarians do not have enemies in the corporate decision battles. They have no power base and, lacking this they are not considered important enough to attract enemies. They are the victims who do not control and, largely, do not even understand." (p. 146)

Fear inhibits the development of partnerships. Hospital librarians who view administrators as colleagues find it easier to develop partnerships with administrators—and be viewed as colleagues in turn (R. Ben-Shir, personal communication, June 1992). As an example, a case study profiling the partnership between the library staff and administration at MacNeal Hospital describes how together they tackled the issue of a new "off-campus" location for the library (LaRosa, 1992).

Second, failure to understand the information needs of administrators inhibits the development of partnerships. Three tools have improved knowledge of the health care environment, offering a framework for the development of specialized services. Librarians interested in understanding the context within which they operate might review AHA's annual environment assessment (American Hospital Association, 1993). The "News You Can Use" column appearing in *National Network* published by the Hospital Libraries Section of MLA, provides a summary of the latest articles dealing with issues affecting health care administrators and, therefore, librarians. Beginning in 1992, *Medical Reference Services Quarterly* began a special column targeting hospital and corporate information

services. Jajko (1992) explained that the column would focus on strategies for success and providing services to decision makers.

Developing and communicating partnerships between librarians and administrators requires placing librarians beyond the "operational box" in which librarians are commonly regarded. One program that addressed how to develop and communicate partnerships between librarians and administrators was produced by LaRosa (1992b) and funded by Mead Data Central, Inc. Entitled "The Information Partnership: Communicating with Upper Management," the educational videocassette was designed to help information professionals "in acquiring and sharpening the communication skills needed to win management support for information center programs and services." Techniques used by three special librarians for positioning, packaging, and presenting information are discussed.

A useful tool to aid the librarian in promoting the library's role and potential services is the American Hospital Association's (1991) management advisory, *Library and Information Services.* Profiled in the advisory is the library's role in management decisions in such areas as marketing, purchasing, and organizational restructuring. The advisory indicates that the "importance of library services to the hospital lies in the ability to cost-effectively identify information needs and provide timely access to relevant information in a useful format" (p. 1).

The JCAHO standards serve as another way to communicate the role of the library to administrators. However, as Koughan (1975) pointed out, to be effective (to get and keep the administrator's attention), good standards must be "coupled with careful public relations by the librarian" (p. 590).

Foster, Poole, and Wakeley (1987) have increased the role of the library as well as the administrator's awareness of the library by writing specifically to the administrator audience. Their chapter in *Health Care Administration* summarizes for the administrator reader the roles and complexities of the modern health sciences library. It also includes a list of additional readings which offers an indication of the depth and creativity of how libraries manage what the authors call the organization's corporate information assets. Although reaching administrators on both local and national levels has been a problem for librarians, several articles focusing on the services libraries provide to health care administrators have been published in administrative journals. Representative are those by Ben-Shir (1989) in *Hospitals* and Palmer (1991) in *Hospital Topics.* A series written by Buchanan and Englander (1990-1991) in *HIMSS News* (a publication of the AHA's Hospital Information Management and

Management Systems Society) targeted the health care information systems executive. Topics covered included library resources of interest to the society's membership, hospital applications of IAIMS concepts, and local area networks implemented in the hospital library.

In 1989, the director of the National Library of Medicine (NLM) communicated directly to hospital administrators to promote NLM's GRATEFUL MED and product (D. A. B. Lindberg, personal communication, November 2, 1989). This awakened hospital librarians to the need to communicate and promote directly to administrators the role and value of the library. Several audiovisual products are now available to do that. The MLA slide program, "The Library's Contribution to Quality: The Bottom Line," (Smith & Grossman, 1992) was designed specifically for use with various types of user groups, including administrators and hospital boards, to promote the role of the library in decision making. The National Library of Medicine sponsored satellite broadcasts on October 22 and November 5, 1992 that profiled the critical roles that health information professionals play in improving hospital quality and cost effectiveness. Health care administrators and physicians were the target audience. This four-hour program, produced by the Healthcare Informatics Telecom Network, Inc. (1992) is now available in a package that includes videocassettes, transcripts, and CME credit from the American Academy of Medical Administrators, American Medical Association, and the Medical Library Association.

Documentation is mounting on the library's value in clinical decisions. Similar studies on the information needs of health care administrators and the library's value or economic contribution to health care managerial decision making are available. Studies supported by the Special Libraries Association do document the role of the special librarian in managerial decision making. Three studies are based specifically on administrative perception of library services. *Corporate Library Excellence* (Matarazzo, 1990) profiles excellent corporate libraries nominated by chapters of the Special Libraries Association. *Valuing Corporate Libraries* (Matarazzo et al., 1990) presents the results of a survey of 164 companies in which evidence from corporate officials about the value of libraries and information centers was solicited. Marshall's 1992 study of Canadian bank managers studied the financial impact of providing information services to managers. These studies provide models for the health sciences community and point to the need for targeted studies on both the information needs of health care administrators as well as their perception about the value of library services to the health care organization.

The Library's Role in Continuous Quality Improvement

As librarians have recognized that the person on the other side of the administrative desk is a professional colleague faced with making complex high risk decisions, librarians have begun to demonstrate objectively the value of the library to the health care institution in all its facets. Ultimately, librarians have had to demonstrate the value of the library by getting results. The health care librarian has also begun to explain the library's contribution to quality patient care (Jones, 1991) and to corporate decision making. In addition, librarians are learning how to talk about value in ways that are meaningful to the administrator (Menzul, 1993).

One tool currently being adopted by manufacturing as well as health care is called the "cost of quality" (COQ) or "cost of poor quality" (Bemowski, 1992, p. 21). The cost of quality is generally defined as the cost of not doing something right the first time. Its costs are composed of three parts: (1) cost of conforming to customer requirements—sometimes called prevention and detection costs; (2) cost of nonconformance to customer requirements—otherwise known as failure costs; and (3) the cost of lost opportunities. The astute librarian will be able to state value in financial terms of what it will cost the institution not to have timely access to up-to-date information. As more and more hospitals implement total quality management or continuous quality improvement techniques, such tools as COQ will be used and demanded increasingly by the health care administration.

A second communication tool between the librarian and the health care administration is benchmarking. Benchmarking is defined as "the search for industry best practices that lead to superior performance" (Camp, 1989). The advice Koughan gave in 1975 is still pertinent: "An administrator cannot be coerced or clubbed into being interested in library activities by stringent standards or harassment by the librarian" (p. 590). But, because benchmarking is built upon facts that compare outcomes, processes, and costs (stated in terms the administrator can understand), the health sciences librarian may find it more useful than emotionalism in appealing to administrators. Although benchmarking typically is meant to compare processes, few sources of benchmarking data exist for libraries, much less health care libraries or their processes. Using White's (1991) analogy of "hewers of wood and drawers of water" (p. 52), most of the library data that are collected deal with the number of cords of wood cut or the number of pails of water drawn. The benchmarking data that are needed focus on processes and allow comparing how long it took to cut the wood or fill the pail of water.

Readers are referred to the annual statistics of the Association of Academic Health Sciences Library Directors (AAHSLD) (1992) for several examples of performance data that could be used for benchmarking comparison (e.g., gifts and endowments to total recurring expenditures; total collection use to volumes added). Fischer and Reel (1992) offer an example of how to collect customer focused data that can be used for internal and external benchmarking studies.

Without benchmark data, the health sciences librarian must revert to communicating descriptive statistics about libraries and library services. Throughout the library profession, research is needed to determine better generic indicators of the quality and value of library services that would be accepted by both librarians and the institutions they serve. Specific indicators are especially needed as well for libraries serving health care administrators.

The Future

Society's approach to health is changing as the mysteries of genetics and immunology unfold through developments in biotechnology (Goldsmith, 1992). The health care delivery system itself is changing. Futurist Leland Kaiser (1992) has projected numerous changes by the twenty-first century. Included in his list are: (1) an integrated health care campus with a planned patient care environment; (2) genetic engineering as a product line; (3) nanotechnology centers where noninvasive technology replaces invasive ones such as surgery and radiology; (4) usage of microrobotic computerized diagnosis and holographic imaging; (5) holistic high-touch health care; (6) emphasis on regenerative medicine; (7) focus on lifestyle changes to promote high-level wellness; (8) incorporation of psychoarchitecture into health care facilities design; and (9) virtual realities that influence patient care.

More economic pressures will come from various political levels. As an example, Weissburg and Conn (1992) identify trends in state legislative activity, including the addition of provider taxes, restrictions on self-referrals, and resurgence of cost containment mechanisms.

Within this context, the health care administration is also changing. A national study by the Healthcare Forum Leadership Center, "Bridging the Leadership Gap," has identified the leadership styles and skills that will be necessary in the administrator of the future (The Healthcare Forum Leadership Center, 1992). Key among these competencies are: (1) mastering change; (2) systems thinking; (3) shared vision; (4) continuous quality improvement; (5) redefining health care; and (6) serving public-community. The study also pointed out that the largest gap between current practice and future needs

was found in the areas of mastering change, systems thinking, and continuous quality improvement. These three areas are highly dependent on information and information management to enable the leadership transformation process.

These trends may profoundly affect how librarians feel about their work environment. Holst (1991), in her Janet Doe lecture at the Ninetieth Annual Meeting of the Medical Library Association, discussed reasons why librarians enjoy working in a hospital library: (1) "the service orientation"; (2) "the work environment"; (3) "the nature of the work itself"; and (4) "the people we work with" (p. 7).

Many of these reasons are grounded in a belief by librarians of the altruistic purpose of serving as a member of the patient care team. However, health care today is being treated and is acting more like a business than a service. The work environment has become traumatic and chaotic rather than dynamic and flexible. The nature of the work is changing due to staff reductions from downsizing or "rightsizing" as it is called euphemistically. While in retrospect the promises of the 1970s may not have been realized in the 1980s, the next twenty years do look promising. Computer technology has become affordable for even the small library, thus facilitating access to all forms of information regardless of geographic location. The process of total quality management and its tools and techniques of statistical process control, benchmarking, and cost of quality offer a means to translate library services into a value that is understood by health care administrators. Librarians are learning to use these tools.

Librarians have long emphasized services to meet customer needs. The library has proactively broadened its mission to serve the administrative decision makers along with the patient care decision makers. Patient centered care, an outgrowth of the customer centered service advocated by TQM (Sherer, 1993), offers a model for librarians interested in developing specialized services targeted for administrative users. Even if librarians never develop specialized services, they do offer a valuable unique contribution to health care, and promotion of this role is needed. Librarians in the 1970s gained new knowledge and skills by incorporating marketing concepts into the hospital library. In the pressures of the 1980s, marketing and advertising of library services may have fallen by the wayside as staff tried to maintain service levels in the face of staffing reductions and volume increases (Glitz et al., 1992). Correcting this requires personal accountability by each librarian. The library profession may need to develop additional support mechanisms to enable librarians to do so.

Library service to health care administration has changed, even progressed, over the past twenty years. However, a fundamental problem surfaces. Librarians do not know the needs of the administrative user group as well as they understand the needs of clinical information users. Librarians do not understand the differing information needs of administrators in hospitals, academic medical centers, or HMOs. Wakeley and Foster (1985) surveyed university programs in health administration as a means of identifying ways the AHA Resource Center could better meet information needs of that audience. However, librarians' knowledge of administrative information needs is mostly intuitive rather than factual. Local marketing studies targeting the information needs of administrators seem to be conducted by librarians only rarely. Other empirical studies of health care administrators as a group are absent. A prerequisite to developing specialized services for administrators is to understand their information-seeking and use patterns. Therefore, future research needs to document the information requirements of administrators in the field as they wrestle with the changing health care structure (Kaiser, 1992) and gain the skills they need within their own discipline (The Healthcare Forum Leadership Center, 1992).

Summary

The health care industry continues to offer an energizing and enabling environment in which librarians can practice. Library service to health care administrators has progressed during the past twenty years; librarians are more aware of administrators as a user group with special needs. Future research needs to focus on better understanding the information needs of health care administrators, their information-seeking and use patterns, the development of specialized services to meet these needs, and the development of indicators to measure the provision of quality library services.

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