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Continuous Survey Readiness

The state of continuous survey readiness: Is your facility ready for callers?

'Survey assessment's going to be almost like a QI tool'

Continuous survey readiness isn't just the latest trendy term in accreditation circles — it's become an imperative. Gearing up at the last minute for a survey by the Joint Commission on Accreditation of Healthcare Organizations was never a very good idea. With imminent changes coming in the survey process, it's more important than ever for your facility to be in a state of constant compliance with Joint Commission standards.

Those changes likely will involve surveyors coming to your facility twice as often as before — every 18 months rather than every three years — as well as the use of so-called "data proxies," such as ORYX data, sentinel event data, and information from your survey application, to help surveyors get a better idea of where your organization stands before the survey even begins.

Currently, surveyors use a pre-survey assessment and questionnaire to help direct the survey process. **Denise A. Dach**, RHIA, BMA, director of quality management at McLaren Regional Medical Center in Flint, MI, says, "My guess is that they would take the data proxies and try to correlate them in some fashion to the outcomes of the entire Joint Commission survey. . . . This information is something that the surveyors would come armed with and use to focus in on various processes."

The Joint Commission may eventually require

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Continuous Survey Readiness

facilities to perform routine self-assessments in order to supply surveyors with more information before going into a survey, according to **Joseph L. Cappiello**, MA, BSN, a Joint Commission official who spoke on this topic recently at the National Association for Healthcare Quality conference in Dallas.

But whether the Joint Commission ends up requiring such assessments, it's crucial for your facility to perform internal self-assessments that allow you to know where you stand and what you need to work on, says **Kathryn Wharton Ross**, MS, RN, CNAA, a health care consultant in Durango, CO.

"With the changes the Joint Commission has made just within the last year and some of the future changes it's discussing, it really is going to put a strain on hospitals to always be survey-ready," she says. "We used to be able to do a survey assessment to see where we were and fix some of the problems right before a survey. [Now] survey assessment's going to be almost like a QI tool, where it's an ongoing process in hospitals to make sure that those systems we have in place are working for us so that we are compliant with the standards all the time."

Dach agrees that internal self-assessment tools are critical for success. "We've changed our focus here from just Joint Commission accreditation to complete accreditation readiness. We undergo a number of different surveys by various organizations, not just the Joint Commission, so we fold all of those pieces into our self-assessment."

One approach McLaren took was to establish teams based on each of the functional chapters in the Joint Commission's standards manual, Dach says. "Each of the teams took a set of standards, went through them and, using the scoring guidelines, evaluated where they felt [our facility was] and where it needed to be. Then they identified various tasks and objectives. [Administrators] used that for the self-assessment tool, to identify where we needed to work, and then set up various tasks to ensure that polices and procedures were updated, re-educate staff, and change processes, to make sure that we were meeting the intent of the standards and achieving significant compliance."

McLaren also established regular measurements for several high-profile standards and provided feedback to various departments and units.

One example is McLaren's environment-of-care surveys. "We have a self-assessment tool covering all of the different environment-of-care areas and key questions for each of those areas," Dach says. "The tool is sent to a department director a week or two ahead of their designated rounding date. Once a month, we conduct our surveys and go around to each department on a schedule. Members of our environment-of-care committee will randomly ask questions of staff while doing their walk-around survey, and then they calculate scores. So it's a measurement tool that helps us understand on a department level how well our staff understand."

It can also serve as a teaching tool in department meetings, she notes. In addition, it allows the environment-of-care committee to identify common issues across the organization. "[The committee] sends out housewide briefings, which help educate or remind staff throughout the organization about a particular standard or a particular procedure or process that needs to be followed."

At McLaren, functional assessment teams usually include a number of staff, as well as a general department director or manager — someone from outside the area in question who can provide a different perspective.

The functional assessment teams report to the accreditation readiness team, which is charged with facilitating organizationwide compliance. "Members of the oversight team should have a significant leadership role [in the organization], as well as knowledge of Joint Commission standards and hospital processes," Dach says. "And certainly they should have some facilitation and process improvement skills because they end up being the liaisons and cheerleaders, if you will, for some of the functional teams."

How functional assessment teams report to the accreditation readiness team largely depends on the organization and what the specific issues are. "Typically, we start off with quarterly reporting. As you get a little closer to survey accreditation time, that may need to intensify, unless you're in really good shape," Dach says. Meetings usually become more frequent in the last six months before a survey in order to work out last-minute details, such as putting together all the required documentation.

Mock surveys continue to be a significant part of survey preparation, but before your facility hires an expensive consulting firm to perform one, it's important to know what the options are. For example, should you even hire an outside consultant, or would you be better off performing a mock survey internally or in partnership with another hospital?

"With cost constraints, it's becoming more important for hospitals to evaluate where they put their resources," Dach says. McLaren typically uses consultants, but Dach says other facilities might choose not to. "I believe hospitals will find themselves trying to develop those kinds of competencies within their own staff and doing more internal mock surveys or sharing with other organizations," she says. "It really depends on how much time, energy, and money you want to use in the process."

Mock surveys cost thousands

She notes that, depending on the consultant, costs can run from $10,000 for a two-day mock survey, to $30,000 to $40,000, depending on the size of the organization and what it wants the consultants to do.

"There are various components that increase the expense," she says. For example, how many consultants do you want to come? Do you want a physician, an administrative surveyor, and a nurse surveyor, or do you want just one person to examine key components? "That's how you decide what your need is: How much do you have in resources to spend on it? What are you trying to get out of it? How much external information do you think you need?"

Dach says McLaren plans to perform internal self-assessments annually and do shared surveys with sister hospitals perhaps every other year. "We probably will also have an external review at about the 18-month mark. But it will probably be a single independent person who will look at key policies, procedures, and processes so that we can be sure that we're doing what we need to do."

Dach points out that McLaren's plans might change if and when the Joint Commission begins sending surveyors out midcycle. "At that point, we'll probably need to reevaluate whether . . . there's any benefit to continuing with a consultant, or if we should move that up earlier in the cycle period," she says.

However you choose to go about measuring

Spotlight on standards: What's important for 2001

If you want to know what standards the Joint Commission on Accreditation of Healthcare Organizations is likely to focus on in the coming months, pay attention to which ones are references in multiple functional chapters, says **Kathryn Wharton Ross**, MS, RN, CNAA, a health care consultant in Durango, CO.

"[The Joint Commission is] thinking in terms of systems now," she says. "And [it's] looking at the various functions and where a certain standard would be placed in a system."

Here are some of the standards Ross suggests Joint Commission surveyors will pay particular attention to in 2001:

• **Staffing and human resource standards.** "I think these are going to get a lot of focus in the coming year," she says. "The Joint Commission is proposing to look at some systems in order to survey staffing. So I think all the human resource standards are going to be a major focus, but primarily staffing and competency."

• **Medical staff standards.** The areas of credentialing and peer review are also likely to draw a lot of attention, Ross says, as are any other standards that concern patient safety issues. "There's still going to be significant emphasis on peer review and the use of aggregate data, particularly on reappointment," she adds. "That's reaffirmed with one of the new changes for 2001, where we're looking at a practitioner-specific date and comparing it to the aggregate, either by department or for the hospital. I think that's moving one step beyond what some organizations have been doing."

She adds that the telemedicine standards "certainly open up a new arena for us in medical staff," but they aren't likely to prove very problematic for hospitals.

• **Pain management.** Pain management is a theme that runs through several functional chapters in the standards manual, and even has implications for leadership planning, human resources competency, and medical record documentation. "There are education and orientation issues in terms of making staff familiar with new practices in pain management and using some of the guidelines," Ross says. "It's also important to know that people are competent when it comes to pieces of equipment that may be involved. In information management, it's important to make sure that we have documentation of how we're doing and the results of our pain management processes."

• **Anesthesia and sedation.** In the past, some hospitals have had difficulty understanding how to apply the Joint Commission's anesthesia standards, Ross notes. "It seems to me the Joint Commission was a little concerned," she says. "There have been some sentinel events that have occurred with conscious sedation, and I think there was a feeling that it had to tighten up those standards a little bit. For a while, hospitals were in a kind of never-never land, where the anesthesia standards were not being surveyed in the area of conscious sedation. But after January 2001, they will be, and they'll be enforced."

Also, in the preface to standard TX.2, the Joint Commission "basically told hospitals that they had to do protocols that addressed things like staffing, competencies, equipment, and monitoring the patient. They've actually incorporated that into the TX.2 standard now. So there are probably going to be some rewrites and rethinking of how we're doing conscious sedation and what that's going to mean in terms of our practitioners and what we're looking at. It's certainly going to require organizations to clearly define what kinds of outcomes they're going to monitor in those areas."

• **Restraints.** In January, the Joint Commission will shift its focus regarding the survey of restraint standards to conform to the Health Care Financing Administration's (HCFA) Condition of Participation on restraints. "HCFA looks at the standards in terms of the behavior of the patient, instead of the site of care," Ross says. "In January, the Joint Commission will be surveying the standards based on the behavior of the patient as well, not necessarily the site where the patient is. That's going to be a major change for hospitals." ■

your survey readiness, it's important to make sure that what you have on paper matches what practitioners at your facility are actually doing, Ross stresses. "I find that people get so ingrained in trying to prepare for a survey that they think there are these magic right answers," she says. "Often, for example, I see a documented policy or procedure that deals with an ethics committee. And yet, when you go around and talk to people in the hospital, you find that in actual practice they have various systems to deal with those ethical dilemmas."

What's important, Ross adds, is to build systems that assure you can maintain compliance with accreditation standards on an ongoing basis. "Survey readiness right now is going to have to

be ongoing, and it has to make sense to clinicians. You're always going to have to be prepared for a survey. If there is a magic answer, it's that you have to figure out what systems you have in place, how they meet the standards, and let people talk about them." ■

Information management central to JCAHO surveys

Management is about more than record keeping

Hospitals preparing for surveys by the Joint Commission on Accreditation of Healthcare Organizations should pay close attention to improving organizational performance, says **Eric Silfen**, the former chief medical officer at Reston (VA) Hospital Center who now oversees the hospital's outcomes research division. "That carries the bulk of the quality of care improvement initiatives and establishes the guidelines for that process," he says.

Nancy Cuccaro, quality management coordinator at Huntington Hospital in Long Island, NY, takes a similar view. She says her staff are establishing a new structure for Joint Commission surveys. "We are not calling it Joint Commission preparation. We are calling it continuous survey readiness." In part, that's because of the Joint Commission's plan to potentially perform surveys every 18 months instead of every three years. She says that prompted Huntington to establish the continuous survey readiness program.

But she also points out that Huntington deals not only with the Joint Commission but with the New York State Department of Health and an assortment of other licensing and accrediting bodies that visit the facility. "This incorporates many more people than it would if we were only talking about the Joint Commission," she explains. For example, the preparation includes ambulatory care sites, clinics, physician office sites, as well as labs and radiology, which sometimes are surveyed separately by other agencies.

Cuccaro says Huntington is also establishing a reporting structure with smaller groups reporting directly to a senior administrator who functions essentially as an adviser. The advisors, in turn, report to the board of directors in order to promote a constant flow of information, including any survey results. The hospital also plans to include a board member and a senior medical staff officer in the preparation process.

"Another increasingly important area right now is the area of information management," says Silfen. With the expanded ability to record, store, and broadcast clinical information and all of the attendant problems surrounding privacy and confidentiality, that has turned into an area that is impacted by all of the other Joint Commission required standards, he says.

"It is more than just record keeping," Silfen explains. "It is how clinical information is transmitted, used, stored, and configured throughout the health care organization." For example, he says, hospitals must address how the Internet will be used as they link physician offices as well as ambulatory surgical centers and outpatient clinics to the hospital. In short, he says, the challenge for hospitals is how to transfer information and keep it confidential and secure and still leverage the opportunity for clinical information that is outside "the four walls of the hospital" to improve overall patient care.

"That is a tremendous area that still is uncharted," Silfen adds. Not only does it involve the Health Insurance Portability and Accountability Act, but the double encryption of information that is required when it is being transferred electronically. "The potential for improvements in processes is very significant, but we have to struggle with the standards the Joint Commission has for specific indicators and metrics for measurement," he explains.

"This is an area that is becoming even more encompassing," adds Silfen. In the past, the focus was mainly on completeness of the medical record and whether all the data elements were there. But now it is starting to spread over a number of areas it had never touched before because patients' clinical records can be updated and carried forward almost as quickly as they move through the health care system, he explains.

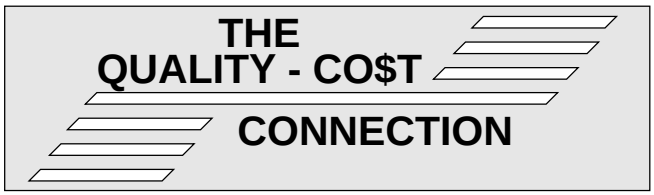
Cuccaro says it is also critical to find ways to educate staff at all levels about common Joint Commission issues. She says that includes disseminating information and involving key staff members in seminars and information sessions. **Kristine Hegman**, quality improvement coordinator at St.

Mark's Hospital in Salt Like City, adds that hospitals must begin this process by getting buy-in from physicians.

"Simply telling physicians that their surgical wound infection rate is going to be reviewed will not do much good if they do not understand the importance of it," she argues. "You must get physicians to appreciate the significance of the issue without making it look punitive."

Instead, Hegman says hospitals must help physicians understand exactly how these measures will improve patient care. Often the best way to do that is to let the physicians help select the areas that require improvement, she says.

"On the other hand, you don't just let them pick whatever they want," she adds. "The areas selected must require improvement and experience enough volume to make them representative of a large group of physicians." ■



Surveyors looking for well-designed processes

How to prioritize process improvement projects

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

The Joint Commission on Accreditation of Healthcare Organization's performance improvement standard requires that organizations do an effective job of designing new processes. New processes may be those that have been revamped in a way that makes the process dramatically different or new services/activities that never existed before in your organization. According to the standards, process design activities should include consideration of:

- your organization's mission, vision, and plans;
- the needs and expectations of patients, staff, and others;
- up-to-date sources of information;
- process performance and outcomes in other organizations.

Joint Commission surveyors will want to see that your organization has followed a systematic process development approach. For example, the activity of redesigning the medication administration process should proceed as follows:

1. The quality council (or other oversight group) confirms that redesign of the medication administration process is consistent with the organization's mission, vision, and business plan. If patient safety improvement is a goal of the organization, then reducing medication errors through process redesign will definitely be a worthwhile endeavor.

2. A team of people who are involved in or affected by the medication administration process is formed. The team is charged with achieving specific process improvement goals based on an understanding of what's not working well in the current process as reported by patients, staff, and others.

3. Team members identify important medication administration tasks that need improving. At this point, team members review outside sources of information about methods known to improve the process. Team members may visit other facilities to learn about their process and identify "best practices." Books and journal articles on the subject of medication administration are reviewed. Vendors of software designed to improve the safety and efficiency of the medication administration process might be invited to speak at team meetings.

4. Finally, the medication administration process is redesigned to meet the goals of the organization. Timing, location, specialization, technology assistance, sequencing of the work, and current literature recommendations are considered when designing the ideal process.

5. The proposed new process is shared with others in the organization to obtain their input into factors such as safety, environment, process reliability, measurements, and documentation standards.

(Continued on page 167)

PATIENT SATISFACTION PLANNER™

New satisfaction survey offers lessons to hospital

Response rate for patient surveys almost 100%

Perhaps you think that patient satisfaction data are the lightweights among your benchmarking data. Not so, according to a Chicago-area behavioral health hospital.

The information that can be gleaned from patient perceptions is so important at Alexian Brothers Behavioral Health Hospital that last year the facility opted to change its surveys. The result has been a nearly 100% return of both in- and outpatient surveys. And more than just being a good way to gauge customer satisfaction, **Francine McGouey**, chief operating officer at Alexian Brothers, thinks surveys offer her facility an opportunity to improve patient care and thus improve outcomes.

Until last year, the facility used an internal survey instrument developed by its staff psychiatrists and social workers. "We liked it because it was customized to our needs and could probe patients about their perceptions of our services," says McGouey. But it didn't allow the facility to benchmark against other hospitals. "We had looked at an external survey several years ago, but we couldn't find one that satisfied our needs as a psychiatric facility."

Hospital administrators looked at three different instruments, considering issues of cost and service as well as the issues investigated by the survey. They opted for one developed by Parkside Associates of Chicago, in part, because its survey most closely mirrored what Alexian Brothers had already been asking, and also because it offered training and quick responses to questions.

Finding something specific to psychiatric facilities was important, says McGouey, because patients often come in with a different mindset than patients going to a standard medical hospital. "They may not be coming to you voluntarily, and the circumstances may be very trying," she says. "The questions you have to ask must be geared specifically to their experience here, not to their general satisfaction with their health care."

Patrick McDowell, a research consultant at Parkside Associates, admits that there is a tougher methodology in creating surveys that work for behavioral health.

"Usually, we work with a mail-back methodology. But there are legal issues about that with psychiatric patients. So we have to have a method of handing the surveys out. That makes staff buy-in even more important," he explains.

Responses soar with new survey

Staff like the new survey, and that could be part of the reason for its success. The national average of inpatient satisfaction response rates is about 50%, and outpatient response rates normally are about 58%.

The new survey has exceeded those averages. Currently, **Lois Nicol**, case manager and team leader for customer satisfaction, says 100% of outpatient surveys are being returned, and inpatient responses are in the high 90s.

McDowell says one sure element of the new survey's success is the effort the hospital put into rolling it out to staff. "[Alexian Brothers] piloted it first to make sure that it was working correctly and make sure that [the survey] did what it [was supposed] to do," he says.

Simple things also helped, such as assuring patients don't have to hand the survey back to a person, but can drop it off in a box that is conveniently placed and well-labeled.

Alexian's staff understand the survey process is an important part of discharge, says McDowell. "It is a top-down initiative, and they understand it requires more than handing something to the patient and saying, 'fill this out if you want.' Instead, they let the patient know that they are interested in providing the best service and would greatly appreciate any feedback the patient can give."

"We did a lot of preparation for this," McGouey explains. "One of our primary goals was to have a good response rate, and all of the units brainstormed on ways to make it happen. We have to arrange circumstances so patients have an opportunity to participate and ensure that their confidentiality is being protected. We

have to assure them that we are doing this so we can improve services for future patients."

Nicol says another reason for the good response is that the same system for dissemination and collection is used throughout the hospital. Staff are trained and given scripts to help them know what to say. "That has been very helpful."

Staff also are motivated because each unit has chosen two or three questions for monthly feedback, Nicol says. Before the surveys are sent to Parkside, where results are tabulated quarterly, units have their specific questions tabulated. Those are presented monthly and discussed at unit meetings.

For example, on the geropsychiatric unit, delivering compassionate care at the last stages of life is important, says McGouey. So that unit tracks responses to questions about whether staff have explained treatment in a way that the patient can understand. On the adolescent unit, administrators track responses to questions about how available staff react when the patients want to talk. "It is important for [patients in] that age group to feel that we have time for them and listen to their responses," McGouey says.

Validating your program's effectiveness

There is a benefit to being able to compare satisfaction data at Alexian to other facilities that serve this field, says McGouey. "You always think you have a great program, but this allows you to verify that," she says.

In addition, it allows the facility to verify that it is fulfilling its mission and adhering to the values of respect that are at the core of the religious order with which the hospital is affiliated. "The survey helps us to ascertain if we are respectful of our patients, if they are participating in their treatment, and if they understand it. Listening to them, being accessible — those are all elements of respect," McGouey adds.

In addition, in behavioral health as in perhaps no other kind of health care, having patient buy-in with treatment plans and satisfaction with them is key to positive outcomes. "We have had a chemical dependency outpatient program for more than 25 years," McGouey says. "If our satisfaction rates are low, we know we have to change something because if they aren't satisfied, treatment is more likely to fail."

Compliance in any treatment regimen is important, she continues. In a med/surg ward, patients who don't finish their antibiotics or who don't learn how to care for incisions may end up back in the hospital after discharge. "If you don't get buy-in, you are less likely to succeed in treatment. If you ask the right questions, patient satisfaction can indicate if patients have enough confidence in the care you provide to follow through with their treatment."

That is a lesson that any facility can take from the Alexian experience with patient satisfaction surveys.

Nicol says that the increasing amount of research showing the link between spiritual, mental, and physical health makes it important to ensure patients are happy with their care. "The more they feel their caregivers are providing the best care, the more likely they are to follow through with treatment, and the more likely you are to have good outcomes." ■

Care managers help improve quality of care

Rehab patients benefit from seamless care

When a trauma patient first enters the 360-bed Gundersen Lutheran Medical Center of La Crosse, WI, and is admitted to the intensive care unit (ICU), the patient is assigned a care manager who stays with the patient until he or she is discharged from inpatient rehabilitation.

The care manager role, particularly having one care manager follow a patient through each medical setting, is crucial to the quality of care in the rehab facility, says **Linda Wieczorek**, BSN, CRRN, staff nurse on the hospital's 17-bed rehab unit.

"The care manager is serving patients to make sure all their needs are met," Wieczorek says. "Previously, we had a care manager in ICU, then when the patient transferred to the medical or surgical floors, there would be a brand new care manager, and then when the patient arrived on the rehab unit, there would be another care manager."

That resulted in communication problems and other issues because the patient and family continually had to explain their concerns and difficulties to staff, Wieczorek explains.

To solve those problems, Gundersen Lutheran Medical Center started the continuous care management program several years ago as a way to

provide continuity of care to ICU patients and their families. **Cathy Bly**, BSN, one of the two nurse care managers, works with patients who have suffered from a spinal cord injury, brain injury, or other type of trauma.

"Everybody is unique, and it's important for us to know what kept a patient comfortable at home and what strategies worked at home so that we can provide a less threatening environment for that patient," she says. That's Bly's job — to find out what a particular patient needs and to communicate those needs to the staff in ICU, acute care, and rehab.

The hospital hasn't measured outcomes since beginning the continuous care management program, but Wieczorek says the anecdotal evidence suggests it helped the rehab facility reduce lengths of stay and improve quality in patient care. "It has been real positive for patients to have a trusted person right with them through their recovery," she says. Also, rehab staff benefit from having one person they can contact if they need to give the patient's doctor or family some new information about the care plan.

Here's how the program works:

1. **The care manager assesses patients after ICU admission.** Bly completes a tool called the Functional Health Patterns Assessment based on what she learns from the family of new patients. When a patient is able to answer questions, she will confirm the family's answers with the patient.

That tool, which takes about 10 minutes to complete, gives Bly an overview of the person's life, including questions about how the patient eats and sleeps, elimination issues, who the patient's supports are, how the patient copes with problems, overall health issues, and spiritual aspects of the patient's life. "This gives us a pretty good picture of the patient," Bly says.

Improving the patient's hospital stay

She uses the information to create a more comfortable environment for the patient. For example, if a patient enjoys a certain television show, Bly will write this into the care plan, so hospital and rehab staff can remind the patient when that show is on. The same strategy is used to find music and other activities the patient enjoys.

During the most traumatic and intensive part of a patient's hospital stay, Bly meets with patients and their families about twice a day. She typically checks in with the family and patient during the mornings and then again in the afternoons.

"Sometimes, the families are so overwhelmed with the big words and complexities of the medical equipment that they want someone to decipher what is happening," Bly says. "So I sort of become a communication link."

Likewise, if a physician has told the patient and family something they don't understand, Bly checks with the physician to get a clear answer for them. She also meets daily with dietitians, social workers, chaplains, and other disciplines to discuss the patient's care.

2. **The care manager develops relationships with the patient, family, and staff.** Soon, patients and their families begin to trust Bly and see her as their advocate and liaison. "They begin to trust my judgment, and things move smoother for them," she says.

She is, in effect, a buoy in an ocean of uncertainty for parents of young people with brain injuries. "I've shared a period with them when we don't know if their son or daughter is going to live or die, and consequently, we often become buddies in this tragedy," Bly explains. "I know what the families are going through, and I can give them some encouragement."

Giving patients, families continuity

Another stressful time is when the patient leaves the ICU and is moved into another area of the hospital. The family and patient sometimes are frustrated because they suddenly have to start all over meeting a new staff of nurses. Bly provides some continuity in their experience, because she will be with them whether they have moved to acute care or directly to the rehab unit.

Since Bly became a care manager for traumatic injury patients, she's often convinced the rehab team that certain patients do not need to be transferred from the ICU to acute care before entering rehab. "We can transfer a patient directly from ICU to rehab so the patient and family don't have an intermediate stop. For the cases where that has happened, it has worked out very well."

She convinces the rehab team that some patients will not have medical problems too complex for the rehab unit to handle. The team has grown to trust Bly's judgment, and it usually follows her suggestions.

"I've had 100% success with the ones I've sent over to rehab," she says. "I know the work that's

involved, and I don't want to see someone fail." She also paves the way emotionally for rehabilitation patients. "Within a day or two, if we have a patient who is going into rehab, I start to get the staff psyched. I commit to my patients, and I want the staff to like them as much as I do."

3. **The care manager provides unique services to patients.** Care managers work closely with patients and their families and therefore have some opportunities to provide services that are out of the ordinary. "I try to see each patient as being unique and try to get the things that person specifically needs," Bly says.

For example, one of her patients was a grandfather, so she made sure he received some photos of his new grandchild. Another patient was a from a foreign country and needed to return home after his injury.

Bly made phone calls to airlines to check their weight limits on baggage and packages and then, along with volunteer help, assisted the man in packing his belongings in boxes that were under the 70 pound limit. The hospital even sent someone with him on the plane trip because he needed assistance with his wheelchair.

"There aren't any specific boundaries to what you can do with this job," Bly says.

She also prepares patients and their families for rehabilitation and the subsequent changes to their lives. "I educate the family of what to expect, like if they need ramps or 24-hour supervision. This way, it's less overwhelming for the family to deal with the patient's disability because we've been talking about the changes from the start."

Early on, she provides families with manuals on head injury and spinal cord injury. The families have plenty of time to read them and ask her questions as the patient progresses.

4. **Care manager provides follow-up care.** When patients are discharged, Bly calls their homes to see how things are going. She also sees them when they come in for appointments. "This is a plus with the families because, if you've been with them for an extended period of time, they like to see you again," she says.

If a patient is readmitted to the hospital or rehab unit for any reason, Bly is automatically identified as the care manager. That, again, provides the family with reassurance and gives the patient an added dimension to the continuity of care. ■

Care managers support therapists, nurses

Care managers serve as partners in rehab

Rehab facilities and hospitals that have a care manager providing continuity of care to patients also will benefit from the care manager's support to rehab staff.

For example, at Gundersen Lutheran Medical Center in La Crosse, WI, care managers attend staffing meetings and provide support to all areas, including neuropsychology, occupational therapy, physical therapy, speech therapy, and dietary.

Care manager **Cathy Bly**, BSN, works closely with the rehab team to answer questions they may have about patients or serves as a liaison between the family and staff. Bly says she has become identified as the nurse who understands rehab issues and provides support to rehab staff and patients.

The care manager also serves as a partner with rehab nurses, says **Linda Wieczorek**, BSN, CRRN, staff nurse on Gundersen's rehab unit. "We work together and fill in those blanks that are specific to the rehab nursing needs of the patient," she says. "We talk nearly every day."

Bly explains to Wieczorek and other rehab staff about patients' specific needs and histories.

"This saves families from having to retell their story," Wieczorek adds. The care manager also is a liaison between rehab team members and the physician. "Cathy grabs doctors if need be and gets all my questions answered, and then she comes to me with all the information that she's gathered, and she gives that to me," Wieczorek explains.

That allows her to focus on the patient's care needs rather than spend time tracking down information from the doctor and other staff. Wieczorek doesn't need to be the patient's sole emotional support in rehab because the care manager has time to provide emotional sustenance. "There are times when a patient is telling you things, and you're thinking, 'Oh my goodness, I wish I had the time to spend with you and meet your emotional needs, but I have four more people I have to get to.' But Cathy has more flexibility and has established a relationship with the family through their tragedy, so there's a special bond there." ■

(Continued from page 162)

6. Before implementing the new medication administration process, the team selects measures of success. The team also determines how often progress toward the goals will be measured and when they will meet again to assess performance.

Survey 'hot spots'

Surveyors are interested in how the organization prioritizes process improvement projects and how effective the activities have been. While your organization has the leeway to select any process for improvement activities, it is likely that surveyors will be looking for projects that focus on issues that are currently receiving national attention, such as patient safety improvement, reduction of restraint use, protection of patient rights and confidentiality, and improved pain management practices. Of course, if your organization's comparative ORYX measurement data reveal significance variation from other facilities, surveyors will expect that a project was undertaken to examine the cause of the variation and necessary actions initiated.

Surveyors may not ask, "Have processes been designed well?" but they will look for evidence that clinical practice guidelines were used in the design of new patient care processes. For example, if your medical staff have undertaken a project to improve care for patients who have had heart attacks, process redesign activities should include an emphasis on timely administration of anti-thrombolytic therapy and appropriate use of beta-blockers. Surveyors will expect to see that information published by groups such as the Institute for Safe Medication Practices and the Food and Drug Administration was used in redesigning the medication administration process. Where appropriate, you should able to show how patient satisfaction data and input from staff and community members helped guide process design activities.

Be sure that your organizationwide quality management (QM) plan defines the process improvement steps used by people in your facility. These steps should include a statement that the design of new processes is based on several factors, including the needs and expectations of customers, professional standards and practice guidelines, and best practices identified in the literature. Your QM plan also should identify who has responsibility for ensuring that new processes are well-designed. This may be the quality council for processes that cross departmental boundaries and the department director for intradepartmental processes. **The checklist shown below** can be used to determine if processes are being well designed. A similar checklist could be added as appendix to your QM plan. ■

Process Design Checklist

When people in our organization design new processes or significantly change existing processes, do they:

- ☐ Select processes for redesign that are important in achieving our organization's mission, values, and goals?
- ☐ Select processes for improvements that have been identified in the literature, by the Joint Commission on Accreditation of Healthcare Organizations, or by other national groups, as being high-risk, problem-prone, or important to evaluate?
- ☐ Clearly identify process improvement goals based on known problem areas and input from patients, staff, and other customers of the process?
- ☐ Include on the improvement team representatives from all departments involved or affected by the process?
- ☐ Consider process improvement suggestions found in current literature?
- ☐ Use benchmarking techniques to identify best practices from other organizations that can be incorporated into the process?
- ☐ Use clinical practice guidelines to identify important evidenced-based patient care recommendations that should be incorporated into the process?
- ☐ Identify the difference in performance between the current process and the processes suggested by current literature, practice guidelines, and benchmarking partners?
- ☐ Understand as much as possible about the details of the current process before making significant changes?
- ☐ Identify appropriate measures of success?
- ☐ Review the results of success measures in a timely manner to ensure that the process design/redesign has achieved desired goals?

Aid survey preparation with management principles

Use disclosure strategy to change behavior

By **Paula Swain**, RN, MSN, CPHQ
Swain & Associates
St. Petersburg, FL

It is amazing that well into the 20th year of the Joint Commission on Accreditation of Healthcare Organization's (JCAHO) requirements for a "systematic process to improve care," staff and administrators alike are baffled at what it takes to pass a survey.

Looking at what has happened over those 20 years, one can see that since "quality" has been in vogue we have gone from four studies annually to continuously improving our organizations. The mystique of "survey readiness" disappears when the principles of management prevail, rather than reaction to JCAHO's notice of survey. Some steps to consider:

1. **All standards come into being somewhat gradually.** Using the tools of today — the Internet and newsletters that raise awareness — it is easy to test the organization's status on the new or revised topic and measure it as the topic comes into compliance. New topics such as pain management, patient safety, CPR effectiveness, restraints management, and sedation and anesthesia standards are going to be a focus of the surveyors, and they should be a focus of health care organizations as well.

For example: Pain management issues have evolved from best practices to monographs, from multiple associations to field testing of standards, and finally to standards with a year of lead time. Because the surveyors had been educated on how to score them, many sites had advanced practice in how to structure programs.

In turn, those facilities have been sharing this information in journals, survey findings that are posted on listservs, and on assorted Internet sites.

So, to keep an organization ready, use the management strategy of disclosure to examine and change behavior.

✔ Ask a few burning questions of patients, such as "What didn't we tell you that we should have about pain?"

✔ Examine medication practices that are considered the standard in pain management. For example, does the organization use Demerol or morphine?

✔ Test the staff's perception of pain by using vignettes and reliability-tested surveys from the Web site www.cityofhope.com.

✔ Examine a few medical records to see if pain management is anticipated through a protocol or plan of care or reacted to by a patient complaint.

Armed with the organization's own information, compare how it measures up against the standards. Ask senior management to initiate a new indicator organizationally about the topic under review so it can track the organization's compliance to the topic. In this case, the baseline for pain management methods could be any of the data listed above, or the answer to the question asked throughout the organization, "Are patients comfortable?" All subsequent data collection and analysis will be dedicated to answering that question.

Going through the management steps of awareness raising, examination of the organization, and creation of an action plan and a measure that can be seen monthly, is the best and only effective method of dealing with JCAHO's new or revised standards.

2. **Communication vertically, laterally, and across disciplines is essential.** The entire survey process links together the organization's ideas, solutions, and care practices. The initial hour of the survey tests this concept. Set the stage using examples that the staff have reported as "important changes." An organization can have projects compete for "best communicated" by testing what staff perceive as the biggest change, not the board of directors' idea of change. If the first hour of the PI interview does not line up with what the surveyors will hear in later interviews, a disconnect will be identified.

For example: If a policy about patient rights, which is under scrutiny from both JCAHO and HCFA, is not discussed the same way throughout the organization, the surveyors can easily see that not everyone is involved in that process. To be sure that everyone is in sync regarding the organization's stand on topics, there

needs to be a planned method for that to occur.

Policy distribution is an area where standardization of thinking occurs. If policies are just cast throughout the organization, it is likely the manager filter will determine what is essential for the staff to know. For example, in nutritional screening, this particular situation occurred. There were screening criteria set up in the organization to refer patients for nutritional needs "when appropriate." Because the inpatient was thought to be the focus, no one thought about the outpatient, lactating mother in the clinic setting or emergency room when she was given antibiotics for her infection.

The "manager filter" did not pose anything beyond the policies that were presented, yet nutritional screening was appropriate in these settings. That is true with abuse screening for violence against elders and children, and domestic violence in either sex.

"How can this policy apply to my staff?" is a good question to ask before dismissing a policy as "not for me." When considering that, think beyond assessment and consider the reassessment standards as well. A patient's condition can change throughout the stay and between visits.

Because everyone in the organization is asked questions about policies that relate to JCAHO standards, communication through a team or staff meetings with designated departments sharing information is critical.

Have all policy-makers define on a cover sheet, "who the policy is intended to affect." Also include how the policy-makers will know when the change has been institutionalized and what measures will be used to determine if those departments got the message as designed.

Now when the staff throughout the organization are polled as to the biggest change, management will see the effectiveness of their methods to diffuse information.

3. **Integration in all communication processes is vital.** Besides the leadership (LD) standards that demand integration in LD.3, the surveyors see integration expressed most prominently in the unit interviews, chart reviews, and time spent in dialogue with staff. It's a good attempt at integration to write many departmental names on policies and protocols, but it is all fluff if the unit meetings that discuss patient care don't see evidence of group management of the patient.

Some situations show how little integration there is when an amputation patient who shows evidence of a heart attack is put in a critical care area and physical therapy is never visible in the record. Or when a dietitian makes recommendations because a patient's lab values are out of whack, her calorie counts are too low, and a diet change is needed, but the physician never takes note of the findings, and there are no comments why or follow-up from nursing to pursue this nutritional situation.

These situations can be avoided by using a few key words that are problem-oriented and negative, such as or "severe iron deficiency" or "lack of mobility." In this case, the whole team could rally around the patient's "poor nutrition," and the amputee could have a focus in his care of "lack of mobility." Then all the interventions staff are doing would dovetail, and upon querying each service, they could tell what their contributions are for each problem or issue.

In the past, this concept has been known as a "care plan," but usually there is emotion and disregard associated with this concept. However, patients get better in a shorter period of time if there is a way to center care. Look at the effectiveness of care paths and standardization on protocols and guidelines. These are all tools that lend to integration. Surveyors expect this.

It is sad to get a group of care providers together and see them hoard their notes in notebooks that go to the basement with them at day's end, while the unit housing the patient has no idea what the plan is. Also, as a surveyor prepares to query the team, a singular question is asked: "Can you tell me about this patient from your perspective."

In those sessions, the disclosure may be that the staff member had no idea the patient came from a higher intensity of service, or had a pacemaker, or was on a complex, high side effects type of drug. If the organization has no way to centralize care, a simple question such as, "what is the patient's favorite food?" will be a nail in the coffin of integration.

Check to assure there is a problem to manage. The management features of health care are done from the patient bedside to the board room. That's the point of getting everyone involved; if a high census should take a key player away, someone else should know how to step in.

Examples of management are found in the interdisciplinary documents that meet JCAHO standards like patient education and assessment. You will have arrived in the eyes of the surveyors if a "control panel" document such as a patient education form is present in the record that:

✔ shows education from preadmission through discharge;

✔ has an entry at least daily;

✔ demonstrates many types of providers contributing to the patient's education.

Plus, the organization can defend its practice of interdisciplinary communication and its grasp of the standards when this form is filled in and provides guidance to the group caring for the patient. The true gold medal documentation test would be to see a service such as respiratory therapy reinforcing a prior entry on the education document by dietary regarding calories required in the food prescribed to sustain the exertion required for the patient to increase his respiratory tolerance. ■

AHQA report highlights shifting role of PROs

PROs well-positioned to partner with hospitals

Physicians and hospitals increasingly have the opportunity to use Medicare peer review organizations (PRO) to measurably improve health care for seniors, according to a report recently issued by the Washington, DC-based American Health Quality Association (AHQA), a not-for-profit association of independent, community-based quality improvement organizations holding Medicare PRO contracts. However, the association contends that while Medicare PROs are well-situated to partner with physicians and hospitals to identify and correct systemic problems in a timely fashion, not all hospitals are fully aware of these opportunities.

To date, many hospitals are more familiar with PROs in the context of the payment error prevention programs they already are required to participate in, according to AHQA's director of communications **Alwyn Cassil**. The model for the quality improvement projects is a voluntary nonpunitive collaborative educational model. "What is remarkable is that more than 4,000 hospitals have worked with PROs on quality improvement projects and they do it because they recognize that the PROs are a valuable resource," says Cassil.

About a year ago, the Health Care Financing Administration (HCFA) established a national campaign designed to harness the collective capability of the PROs and the country's hospitals and physicians to improve care in six critical disease areas: heart attack, breast cancer, diabetes, heart failure, pneumonia, and stroke. To guide quality improvement efforts, HCFA collected information about the care Medicare beneficiaries received in 1997-99 based on 24 clinical indicators in the six targeted disease areas.

Based on the results, which were recently published in the *Journal of the American Medical Association*, AHQA argues that tremendous opportunities remain to improve care for older Americans. *A Measure of Quality: Improving Performance in American Health Care* documents the results of more than 300 community-based projects conducted in 1996-99 by Medicare's PROs. The pilot projects involved almost 10,000 hospitals and caregivers and fostered improved care for an estimated 16 million Medicare beneficiaries.

AHQA executive vice president **David Shulke** says many hospitals don't recognize that 70% of the work performed by the PROs in Medicare is in the area of clinical quality improvement. "Most institutions, or at least the upper echelon at these institutions, don't know that PROs offer all these services," he contends. In short, Shulke argues that PROs are essentially acting as free consultants to hospitals to help them improve the quality of the care they provide through the use of suggested clinical pathways and analyses of data. He notes that PRO services also include free abstraction of records and a variety of other suggestions and services paid for by Medicare.

Shulke maintains that hospital administrators responsible for the operation of the entire institution are the ones who most frequently are unaware of collaborative efforts already under way, as well as the opportunity for collaboration presented by PROs.

He says that's because the issues that rise to their level are typically regulatory and financial matters, even though presently those account for only about 20% of the work currently performed

by PROs. "That sometimes creates challenges when we are trying to work with the hospital industry on quality issues," Shulke asserts. He adds that many in Congress continue to believe the way to improve the quality of care is to require hospitals to submit incident reports to the Joint Commission.

"We think the most valuable thing that could be done is for there to be more confidential, on-sight real-time review of care and sharing information about best practices," he argues.

Shulke also notes that PROs increasingly are adapting their quality improvement approach with hospitals and physician group practices to the more sophisticated quality improvement tools established by the Institute for Health Care Improvement and other quality improvement organizations.

For example, he says PROs are now abstracting medical records for individual institutions in addition to providing state-level data received from HCFA contractors. "They are actually extracting information for the individual hospitals and sometimes even for the physician group practices." Those practices are then feeding the data back to hospitals and group practices on almost a real-time basis, he adds.

According to Shulke, that means the data might be only two or three months old when they are received.

"The most important development in the near term is more real-time specific feedback on the care that is being provided by the doctors and the nurses and pharmacists," he asserts. "That means there is a greater likelihood that doctors and others will remember the systems they were or were not using, and they are in better positions to work with the PROs to change those systems and improve the care they provide."

Shulke adds that while national data are very useful for hospitals, state-specific data are often even more valuable. Now, he adds, many hospitals and doctors are demanding their own data. "The data that are being fed back by the PROs increasingly are very close to where the care was provided itself," he reports.

Phil Dunn, CEO of the Texas Medical Foundation, takes a similar view. He points out that what might be an effective method of improving the delivery of care in one state may not be as effective in another. For example, he notes that New York does not have the same rural health care delivery system as Texas. As a result, patients who suffer from a heart attack in New York may go straight to a tertiary-level hospital, while in Texas they sometimes have to receive care at an intermediary facility first.

Likewise, he says, variations in personal behavior can require different preventive measures among states. For example, the incidence of smoking may be significantly greater in one state compared to another. "There has to be recognition that different processes must be improved in different states because of personal behavior and the way health care is structured in different parts of the country," he argues.

Dunn also agrees that the evolving role of PROs is consistent with HCFA's shift in emphasis from enforcement to quality improvement. He says that when PROs were focused primarily on

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Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Production Editor: **Ann Duncan**.

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For questions or comments, call **Russ Underwood** at (404) 262-5521.

performing case review in a retrospective fashion, they were limited to showing that care was not afforded in a timely fashion. With the emphasis on quality improvement, he says, processes can be improved much more rapidly and on a broader scale.

Finally, Dunn says the shift toward improving the quality of care rather than retrospective review is consistent with the shift toward prospective payment throughout the Medicare program.

"In 1984, prospective payment for inpatient care was a radical change," he explains. "Now that we have prospective payment for skilled nursing care and home health agencies as well as hospital outpatient services, I think it is very appropriate that we are trying to address and improve the processes of care that will change the quality of care rather than chase outlier cases." ■

JCAHO grants ORYX grace period to some providers

In late October, the board of commissioners at the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, slightly modified the ORYX requirements in the accreditation programs for home care, behavioral health, and long-term care.

Under the modified requirements, which were implemented to help reduce the expense of accreditation, newly accredited organizations will be allowed to postpone contracting with an ORYX performance measurement vendor for up to two years, or until core measures for those areas have been implemented. ■

SourceKit

Denise A. Dach, RHIA, MBA, Director of Quality Management, McLaren Regional Medical Center, Flint, MI. Telephone: (810) 342-2248.

Kathryn Wharton Ross, MS, RN, CNAA, Health Care Consultant, Durango, CO. Telephone: (970) 247-1130. ■

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