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Competition no obstacle in a new cancer project created by consortium

A new era of cooperation begins with oncology

Cancer hospitals always are quick to explain that they are different, often pointing to their special commitment to their patients and ability to deal with end-of-life issues. But those differences are rarely accounted for in the benchmarking data they use. The facilities have a keen sense of competition and have, until recently, been unwilling to come together for benchmarking purposes.

But all that changed in 1997 when the Joint Commission on Accreditation of Healthcare Organizations started talking about ORYX. Cancer hospital executives knew from experience that comparing data with noncancer hospitals wouldn't be useful, so a group of them came together and created a National Cancer Database initiative that would allow for subcomparisons within the ORYX system.

Four years later, they are beginning to see the results of their efforts, says **Colleen Allen**, RN, MBA, CPHQ, director of Clinical Quality and Resource Management at the James Cancer Hospital in Columbus, OH.

"Until we started this, it was a real struggle to find appropriate comparisons," she says. "There were few indicators from vendors that measured oncology care."

Representatives from 11 cancer hospitals attended the initial meeting, including MD Anderson in Houston, Fred Hutchinson Cancer Center in Seattle, and Memorial Sloan Kettering Cancer Center in New York City, which hosted the gathering.

Continued from cover page

Guest Column

Simple Solutions

Also in this issue

COMING IN FUTURE ISSUES

- Best practices in breast cancer care
- Service line indicator reporting
- Outcomes analysis and provider profiling
- Joint AMA/JCAHO/NCQA diabetes project

The group reviewed several benchmarking and data vendors before settling on the Medstat Group of Ann Arbor, MI — and the Comprehensive Cancer Center Consortium for Quality Improvement (C4QI) was born.

By March 1998, eight institutions were discussing what indicators to look at first. Their consensus: surgical hemorrhage for all acute care discharges; length of stay (LOS) for myeloproliferative disease; LOS for respiratory disorders; LOS for skin disorders; and LOS for digestive disorders.

Data submissions began in July of that year, and the data were returned from ORYX in 1999. The group had conferences over the course of the next year and produced its first report late in 2000.

The group was committed to comparing clinical quality, sharing best practices, and expanding its network. Now, says Allen, there are 14 cancer centers involved in the process, sharing information in monthly conference calls on issues such as wait time, appointment management techniques, and patient safety initiatives. It has decided upon 12 outcomes measures to focus on, including LOS; mortality; complications for myeloproliferative disease; and respiratory, skin, and digestive disorders.

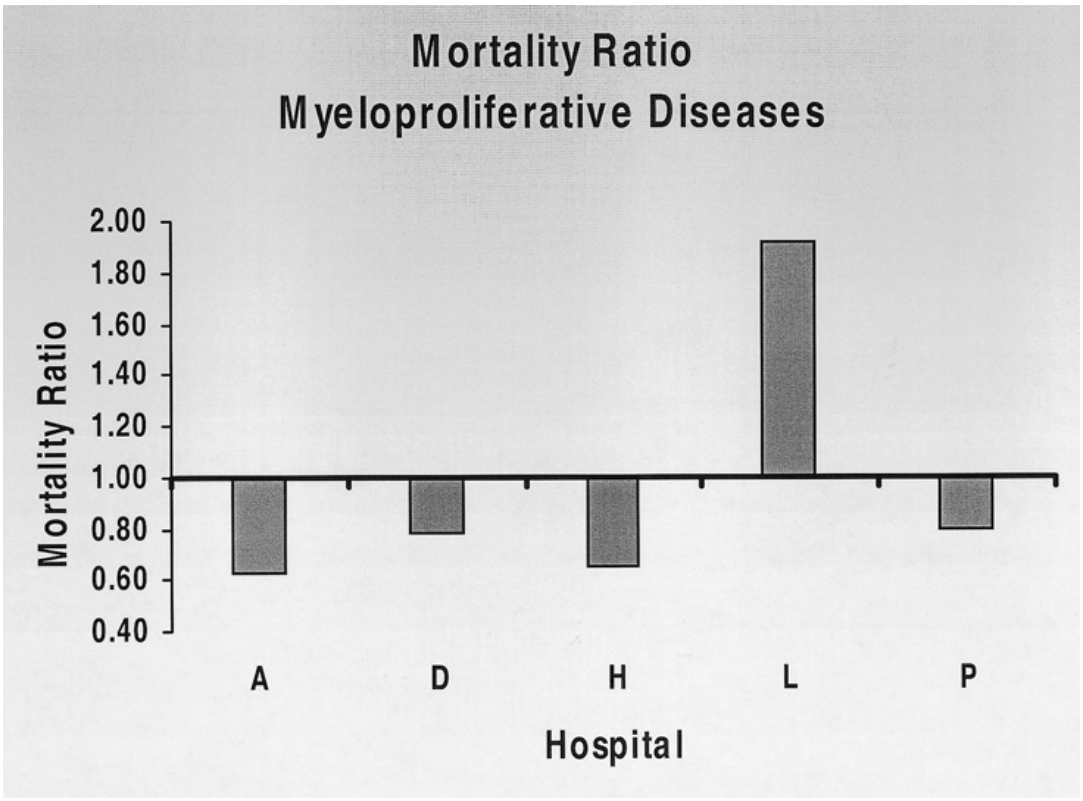
"The big breakthrough for use [came] as we grew and discussed how we would share information and work with Medstat on ORYX indicators," explains **David Snow**, RPh, MBA CPHQ, the quality management facilitator at MD Anderson Cancer Center in Houston.

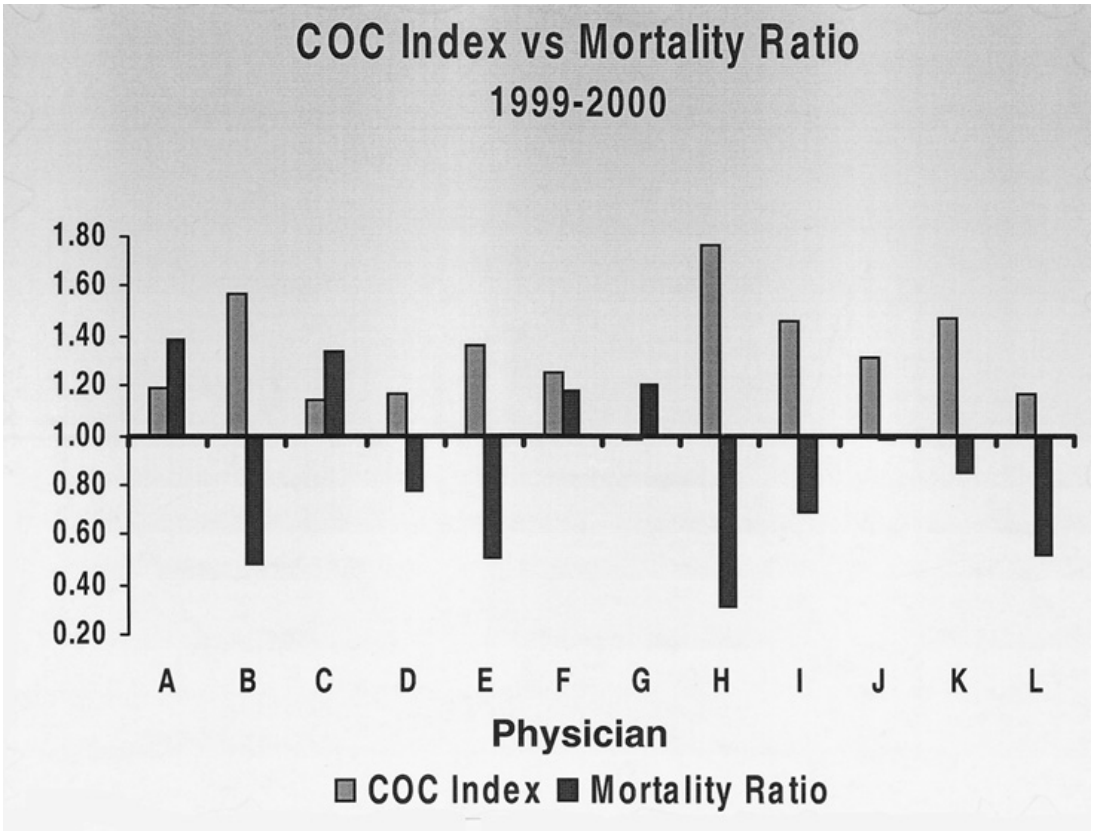
Looking for critical mass of participants

Thus far, five of the 14 members are reporting data, and the rest are on the way, says Snow. But already the group is finding the data useful. "I think it's because the data aren't volume driven, but rate driven," says Allen. "We don't have to rely on the number of patients exhibiting a certain complication, but on the rate of patients as compared to like institutions."

Snow cites data related to mortality in myeloproliferative diseases. **(See chart on myeloproliferative diseases, p. 63, top.)** "Why is hospital L so different?" he asks. "We look at end-of-life decisions, and we find that this is for inpatient data — for patients who died in the hospital. But in some facilities, hospice is in-house, so their mortality rate is going to be higher. That was part of the answer in this case."

(Continued on page 64)


Mortality Ratio
Myeloproliferative Diseases
Mortality Ratio
2.00
1.80
1.60
1.40
1.20
1.00
0.80
0.60
0.40
A
D
H
L
P
Hospital


COC Index vs Mortality Ratio
1999-2000
1.80
1.60
1.40
1.20
1.00
0.80
0.60
0.40
0.20
A
B
C
D
E
F
G
H
I
J
K
L
Physician
COC Index
Mortality Ratio

Looking at complications of care (COC) vs. mortality, Snow continues, "You wonder what makes complications of care go up and mortality go down. **(See chart on COC index, p. 63, bottom.)** When we investigate, we find it is that one group may use hospice and home care, and another group would rather leave them in the hospital. What we have been able to do is identify practice patterns between similar physicians."

All of the data will have an impact in the way care is provided at MD Anderson, he says. "We suddenly have a new way of comparing our data. We have a way to look at why and how we are different."

Allen agrees that having the data is a giant step forward for cancer centers, with implications for administration as well as clinical care. "One thing we are looking at is how we code complications."

In viewing surgical hematoma and hemorrhage, two organizations have higher numbers than the rest. "We are looking together to see how our coding affects this." **(See chart on surgical hemorrhage and hematoma, below.)**

There are 37 cancer centers in the country, and membership in the C4QI group is growing. "I don't know if we will get around to all of them," says Snow. "It would be nice, but what we really want is critical mass. That way anyone who wants to compare themselves to our data can, knowing that it is a statistically valid database of cancer patients only."

Allen thinks the group is near that critical mass. "We have made real progress in the last two or three months, and the word is out. We were just a budding initiative with four or five of us talking to each other. But now we have gained support from CEOs and nurse executives of the [prospective payment system]-exempt cancer hospitals. They recognize that this is something of great value to them."

A web site is under development for the group, and there are discussions pending about what data to examine next. Also on the agenda: standardizing definitions and methodologies and incorporating patient satisfaction data. "We are all competitors," says Snow. "But we have learned that we can share data, allow for confidentiality, define best practices, and still remain competitive."

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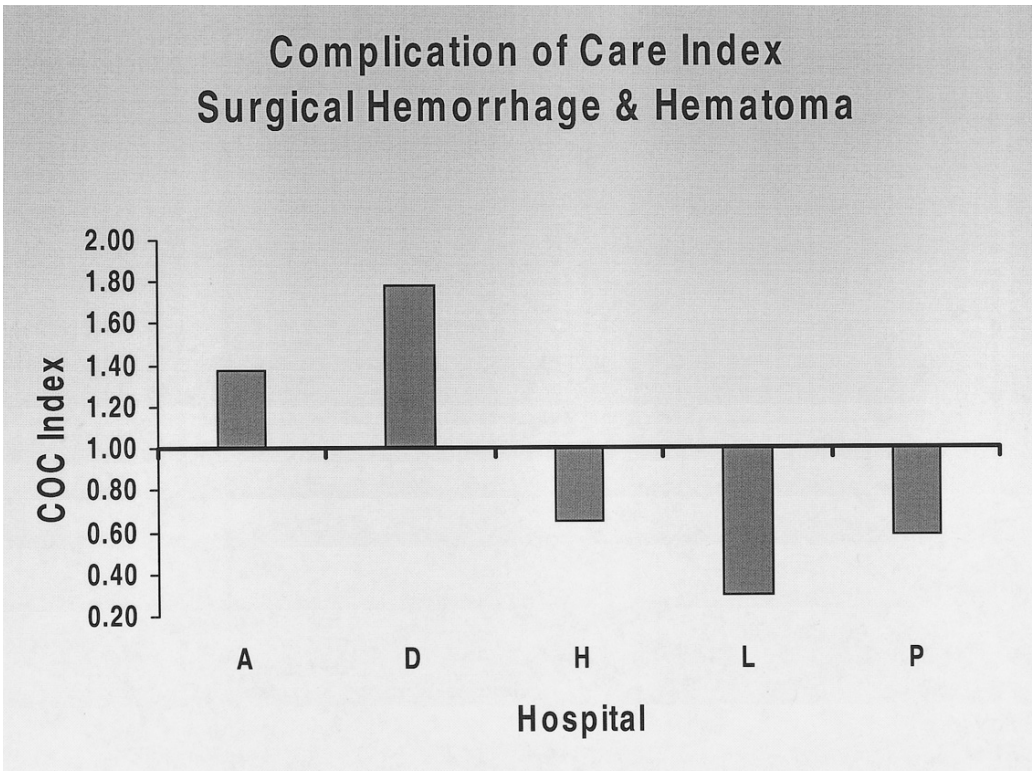

Source for all charts in this story: Comprehensive Cancer Center Consortium for Quality Improvement.

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UHC records project is attention grabber

Keen interest in revenue cycle benchmarking

Talk about benchmarking in general and most hospitals will probably think of clinical quality indicators or financial comparisons.

But for the University HealthSystem Consortium (UHC) of Oak Brook, IL, a recently completed project has benchmarked medical records practices at 37 member facilities. For 26 of them, it was the second time in two years they had looked at the topic.

Danielle Carrier, program director for operations improvement at UHC, says there is plenty of interest among members in all revenue cycle areas, from admitting and registration to patient accounting and financial services.

"We usually have some project related to that area every year," she explains.

Even in a time of tight travel budgets, 35 people still attended the knowledge transfer meeting earlier this year when the project's results were unveiled.

How do the best performers do it?

Along with providing data on cost and cycle time issues from labor and outsourcing costs to record retrieval rates, UHC conducted more in-depth interviews with the four best performing hospitals **(for list of key indicators, see chart, p. 66)**:

• Brigham & Women's Hospital in Boston;

• New York University (NYU) Medical Center in New York City;

• Shands Medical Center at the University of Florida in Gainesville;

• Stanford (CA) Hospital and Clinics.

Their input resulted in an extensive list of actions that other hospitals could take to emulate their success. **For more on the data collected, see road map, inserted in this issue.)**

D'Arcy Myjer, PhD, director of health information management at Stanford Hospital, says running a medical records department "is a service business. If that's your business, you want to know how good a service you provide and how your service compares to others." In addition, he says, doing this kind of project gives him a chance to see some of the good points of his department.

"When you sit at your desk in the director's office you often only hear about people's problems and where you have let the system down. It can be a lopsided view of the world," Myjer adds.

Myjer has much to be proud of: Stanford was singled out in the study as outstanding in record completion, unbilled records rates, loose filing rates, and release of information turnaround times.

The four better performers all had traits in common that led to their superior performance, the study states. Among their strengths is a culture that embraces continuous quality improvement by:

• **Designing processes from a customer perspective.** At Shands, that means having physicians come in weekly to the department for records completion.

• **Leveraging technology.** At Brigham & Women's Hospital, physicians are automatically notified when there are missing dictations.

• **Letting staff lead improvement initiatives.**

• **Looking at the bigger picture and evaluating how processes impact and are impacted by other disciplines and departments.**

The better performers also regularly monitor and report performance, integrating them into bonus programs and staff goals. Delinquency rates are reported at NYU and Stanford by service and physician, and Shands incorporates performance targets into its vendor contracts. Those vendors are penalized if they don't meet the targets.

Accessing medical records

Better access to medical records is another shared characteristic of the four hospitals. NYU and Brigham use on-line documentation, while Stanford uses optical imaging. The cost per record when optical imaging is used is $36, compared to $41 for those who don't use it. Their retrieval rate is 97%, compared to 90% among the facilities that don't use such systems.

But even without using those systems, there

Key Performer Indicators

	Mean	90th Percentile	75th Percentile	50th Percentile	n
Labor & Outsourcing Cost per Adjusted Record (Total)	$40.74	$25.10	$26.66	$36.91	32
Average # Days Unbilled Inpatient Records	11.5	1.4	3.1	5.9	27
Unbilled Dollars as % of Total Inpatient A/R	15	1	2	7	20
Average # of Days Incomplete Inpatient Records	24	4.6	12.2	18.2	30
% Inpatient Records > 30 Days Incomplete	35	1	9	23	28
Average # Days of Loose Filing (Total)	2	0	0	1	35
# Inches of Loose Filing per 100 Records	4	1	2	3	35
Inpatient Record Completion Time (in days)	23	11	16	19	30
STAT Record Retrieval Time to ED in Minutes	21	5	10	15	37
Record Retrieval Rate for Scheduled Clinic Visits	10	4	5	7	36
Release of Information Turnaround Time in Days	8	2	4	6	35

Source: University HealthSystem Consortium, Oak Brook, IL.

are strategies that the better performers use to make access to records easier. For instance, they restrict when paper records can leave the department or stop delivering paper records to physicians' offices for completion.

Myjer knows that the technological edge that Stanford has by scanning is a key to its success. "The downside is that makes us less comparable to the others," he says. "But there is still value in sharing what we do so others can learn from us. In being an early adopter of scanning, we made a lot of mistakes, which four years later seem obvious. Part of why you do this is so that you can share those mistakes and keep others from making them."

Gail Hines, RHIA, MPA, director of medical information at NYU Medical Center, agrees that one of the great benefits is learning from others. "Other people have gone the electronic record retrieval and imaging route," she says. "We haven't done that yet, but when we do, we can learn from their mistakes and do it better."

NYU was a strong performer in record completion, incomplete record rates, loose filing rates, retrieval time, and release of information turnaround times. With its three counterparts, the 850-bed facility shared a habit of expediting the coding process.

Among the practices that the four facilities use to do this are:

- They use aggressive discharge control to receive records within a day of discharge. Stanford also scans those records within four to eight hours of receipt.
- The facilities make coding the first priority when a record enters the department.
- They code from electronic documents.

Making sure physicians know what is expected of them regarding record completion is another key to success. At NYU, there are sanctions for

physicians who don't meet their expectations, and facilities that have sanctions cut record completion time from 29 to 22 days. Add incentives to the mix, and completion time can go down to 19 days.

Others have implemented on-line editing or shortened the definition of "delinquency." When the latter action is taken, record completion time is cut from 25 days for those with between 21 and 30 days in their delinquency definition, to 16 days for those who call greater than 14 days delinquent.

Learning from peers

Some of the discussions that were held during the knowledge transfer were as enlightening as the survey data. "The way UHC designed this was inpatient-oriented," Myjer says.

"But almost half of our records are outpatient services. The statistics are still about inpatient admissions, but that's not how hospitals run themselves anymore. We spend our time, energy, and money on our clinics. So now we are saying, 'Gee, maybe we aren't measuring the right things.' We need to engage the financial managers in a discussion, and we need to create solutions that are both outpatient- and inpatient-oriented. How you provide information is different for an admitted patient than for an outpatient who has three clinic appointments on the same day," he explains.

Hines says her facility had just finished a re-engineering project that covered medical records when the benchmarking study got started. "For us, it was a way to see if we left any weak areas as well as a way to share information with others."

Having already completed the navel gazing, there was nothing amazing in the data. "We'd had our eureka moments before," Hines says. For instance, two departments were at odds: one saying it collected information on the patient's place of employment, and the other saying that it wasn't in the record, so it must not have been collected.

"It was a black hole. But they were both right, because there was never a computer interface written that included that information on the patient record. It was input but had nowhere to go," she adds. Some of the more informal discussions between participants could be as helpful to Hines as the formal presentations. For instance, how to solve staffing problems was a common topic of conversation.

"If you have a heavy discharge day Wednesday, how do you get the staff on Thursday without having them work over the weekend? People don't like to work 24/seven, but that's when hospitals run. There were ideas on that, like the increased use of casual staff you can call as needed or part-time workers who are more flexible," she explains.

Talking with her peers also gave Hines insight into how many institutions were using electronic signatures for signing transcribed documents. "We hadn't assigned a high priority to that, but in listening to some of the others talk about its convenience, we decided to move it to the front burner." NYU is doing a pilot project now.

Looking for the choke points

Myjer says hospitals that want to look at these kinds of functions would do better to identify choke points than to focus on inputs and outputs as places to improve.

"For instance, when you look at when patients are discharged, you want to put the record into ICD-9 codes. That is the foundation for the bill and for the statistical data in hospital studies. The input is patients, by type, that were discharged yesterday. The output is what is the coding backlog. But if there is a process of getting the chart from the nursing unit into the department, that can be the choke point," he adds.

Looking at the backlog won't tell you anything except that you have a problem. Solving it is completely dependent on recognizing the choke point and finding a way to fix it, Myjer says. "Maybe they are forgetting to send it or the residents haven't finished their documentation, or there is an interesting case and they want to present it. You may discharge 90 patients, but miss out on 10 charts. Why you miss those 10 charts is the key bit of information."

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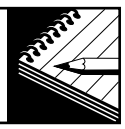
GUEST COLUMN



Pain management: The fifth vital sign

Press, Ganey assesses how well you do

By **Peter Lanser**, MS, CHE, CPHQ
Director of Information Integration
and HIPAA Compliance
Sabina Gesell, PhD
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The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) had a marketing blitz in December to announce new pain standards.

They were developed over two years in conjunction with the University of Wisconsin, Madison School of Medicine. The measures were designed to ensure all patients the right to appropriate assessment and management of their pain and underline that organizations have a responsibility to develop processes within their settings to help support improvements in pain management.

The new standards make pain an issue for patient rights, staff competence, leadership support, and quality improvement.

Controlling pain in three settings

The commission's accreditation manuals have 11 chapters organized by functions or activities that their accreditation process requires of ambulatory care, behavioral health care, home care, hospice, hospital, long-term care organizations, and networks. The new pain standards are contained within six of the 11 functional chapters.

We decided to examine national results of the Press, Ganey survey question: "How well was your pain controlled for the inpatient, ambulatory, and ED [emergency department] settings?"

The study shows that pain is controlled better during ambulatory care than inpatient and ED situations. "Very good" ratings were given by 70% of ambulatory respondents.

In contrast, "very good" ratings were given by only 44% of patients receiving emergency care and 53% of inpatient respondents.

The January 2001 inpatient response frequencies — 53% very good, 36% good, 8% fair, 2% poor, and 1% very poor — have remained constant since January 2000. Because the database is so stable, it should be sensitive to future changes in patient ratings.

The question becomes: Will patient satisfaction increase with this new attention being paid to pain control or will satisfaction drop as patients recognize that they have the right to have their pain treated?

Our recent look at national responses to the pain control question identified other noteworthy results, as well. Cancer patients treated in an ambulatory setting — when evaluating the support they received in managing the various physical and psychological side effects of chemotherapy and radiation therapy — expressed the highest satisfaction with the support they received in managing their pain.

The national inpatient study shows that other variables impact patients' satisfaction with pain management. In general, patients from our sample are less satisfied with pain control in teaching hospitals vs. nonteaching hospitals. Our data also show differences in patient satisfaction with pain control depending on American Hospital Association (AHA) region.

Patients in AHA Region 1 are significantly more satisfied with pain control than patients in other AHA regions. We found no difference, however, in satisfaction with pain control by nursing model (team, functional, primary, patient focus units) on noncritical care units.

Additionally, inpatients are less satisfied with pain control in big cities compared to rural communities. However, one big-city teaching hospital that has had stellar ratings over the past two years is the Evanston (IL) Hospital.

Barbara Hocking, senior clinical director for medical, surgical, and outpatient services at Evanston Northwestern Hospital, stated that "the most crucial key to success has been the basic education program for all nurses, pharmacists, and residents/interns as it provided an excellent foundation for the pain management initiative. This grass-roots effort continues to be driven by committed clinicians who provide the education and the role modeling."

Press, Ganey has found that in addition to focusing on pain control for humane and accreditation purposes, pain control may be a competitive advantage. Looking at the inpatient setting in

2000, we have found that satisfaction with pain control is highly correlated with overall satisfaction with care ($r = 0.7$, $p < .001$, $n = 770,405$) and with patients' likelihood to recommend the hospital to others ($r = 0.56$, $p < .001$, $n = 770,405$). These relationships are even stronger in the emergency department ($r = 0.81$, $p < 0.001$, and $r = 0.75$, $p < 0.001$, respectively).

Not only is pain control extremely important to emergency department patients, they also report the lowest levels of satisfaction with pain control compared to inpatient and ambulatory surgery patients. This combination of low scores and high relevance puts pain control in emergency departments (along with wait time) at the top of the national priority index for improvements.

Many organizations consider pain control directly related to their mission. The free data-linking services available from Press, Ganey allow organizations to look at issues such as pain control by DRG (diagnosis-related group) and MDC (major diagnostic category). The ability to stratify important issues such as patient satisfaction with pain management by clinical variables has enabled many of our clients to provide bedside caregivers with meaningful and actionable data.

Since JCAHO released its new pain standards, Press, Ganey has noticed a marked increase in the number of clients who have added custom survey questions in order to:

- assess how much pain the patient experienced;
- assess how well staff responded to expressions of pain;
- assess how well the patient's pain was controlled throughout the hospital visit;
- assess the extent to which the patient was involved in deciding how their pain would be relieved.

One facility that has improved pain management by focusing on the issue and changing processes is Beebe Medical Center in Lewes, DE. According to **Sue Howell**, RN, Beebe's director of inpatient care, "Control of pain afforded us many opportunities at Beebe Medical Center. As patients are well-educated in their rights and disease processes, it became apparent that we could improve in pain management," she says.

"To change the process of pain control, we reviewed charts, analyzed our Press, Ganey scores and comments regarding pain, researched literature, talked with staff, and brought in an outside resource to discuss pain control with physicians and nurses."

She calls the research "an eye-opener for our medical center." An interdisciplinary team was formed to revamp the tools used for assessment and documentation and reevaluate the types of medication and methods of administration.

Process changes included:

1. **Ordering new patient-controlled analgesia (PCA) pumps.**

2. **Increasing the number of available PCA pumps.**

3. **Using a new flowsheet for anesthesia and nursing.**

4. **Initiating PCA pumps in PACU.**

5. **Including only IV analgesia on the revised pain order.**

6. **Including alternative methods of pain control on the revised orders.**

7. **Increasing patient-controlled epidural analgesia usage has for abdominal as well as orthopedic surgery.**

"The attention to detail and patient comfort is a focus for all the inpatient units," Howell continues. "Physicians, nurses, and nursing assistants take pain control as a serious matter and our Press, Ganey results are most encouraging. We are now in the 99% percentile as of the last quarter, increasing from 87% for the April-June 2000 quarter regarding the survey question on pain control."

Pain management: Greater satisfaction

The lowest-scoring issues in the ED are waiting time and pain management. One emergency department that has high ratings on the questions regarding pain control and staff sensitivity to pain is at Duncan (OK) Regional Hospital (DRH). The facility is extremely proud of the work being done by the staff to educate their peers, patients, and family members on patient pain control.

A great deal of work, planning, and "creative" education has been put into place with an emphasis on making sure Duncan's patients do not suffer with pain.

Gina Flesher, RN, education instructor and

Cindy Rauh, RN, director of acute care services, state that, "Pain is the No. 1 symptom of the majority of all patients we see at DRH. It is the goal of the staff to ask 100% of our patients on admission to the ED if they are in pain.

"If the answer is a 'yes,' the next goal is to treat that pain within 30 minutes and reassess the intervention to bring that pain down below the level of 5 (on a scale of 1-10) within two hours, " she says.

"We are aggressive in our pain management, recognizing that the patient's self-report of pain is considered the single most important indicator of pain," Rauh adds. There is also a monthly column in the hospital's monthly newsletter, *Viewbox*, to educate not only the nursing staff, but the entire staff, on the hospital's commitment to making sure our patients are comfortable.

In response to the increasing amount of interest in additional pain control questions, the Press, Ganey research and development team has developed a new selection of optional pain control questions. At this time, clients will not be required to add any pain control questions to their surveys. However, as new surveys are developed or as existing surveys are revised, the requirement of pain control questions will be assessed.

For example, during the revision of the ED survey it became clear that a standard pain control question was indeed necessary. All clients involved in the revision agreed upon this matter and numerous clients who were not directly involved in the development process called and wrote to us requesting that a pain control question be added.

Thus, how well your pain was controlled will become a standard question on the revised ED survey starting this spring. ■

SIMPLE SOLUTIONS

On-line FAQs help

Nurse designs web site for common questions

Mark Hammerschmidt, RN, has seen orientation programs come and go during his 21 years of nursing. But when his large, New England teaching hospital (it requested not to be named for this story) lost its clinical educator for the medical intensive care unit (MICU), Hammerschmidt was asked to help out.

"One of the senior staff had the idea of starting unofficial teaching classes for the new orientees in the interim, and I volunteered to produce handouts for her to use in classes," he says. The result is an on-line file of FAQs — frequently asked questions — that can be printed or accessed via computer by new hires or existing nurses who need to brush up on a particular topic.

His employer is happy to make use of his skills — although what he does isn't considered "official" — and the site (http://www.geocities.com/markhammerschmidt/) now contains 15 peer-reviewed files that contain an in-depth look at topics from intra-aortic balloon pumpings (IABP) to localizing infarcts.

"The idea sort of popped into my head," he says. "The problem seemed to be that the new nurses were very overwhelmed by the MICU, which only makes sense, since we are very much the high-tech, ultra-sick population kind of place. Breaking up the topics that needed covering into small chunks seemed helpful. You can hop around in a FAQ and pick out the parts you're looking for with ease if the question lists are formatted the right way."

In the year since Hammerschmidt — a senior staff nurse at the hospital — started the program, the hospital hired a new clinical nurse supervisor who has been very supportive. "I produce a file every month or so. I hand it first to my wife (who is also a nurse). Then it goes to other senior staff in the MICU for comments." **(See box, p. 71.)**

Specialists are consulted

Sometimes, it goes to specialists, such as the IABP staff who are most familiar with balloon pumping, he notes. "I figure the files are never really finished, which is only right, as the art of nursing continues to develop all the time," he says. "The pressors and vasoactives file got updated a while back to include vasopressin."

Hammerschmidt says his biggest goal was to help new hires understand that there is always help at hand. And it didn't hurt for the more seasoned staff to have ready access to help, either.

He adds that he enjoys sharing knowledge, and having the chance to focus on topics that are of interest to him specifically. "People have also started stumbling across the web site and sending in notes from places such as New Zealand, Australia, Texas, and Florida. It's astonishing."

The real lesson, though, isn't something that

Sample Contents of a FAQ File: Defibrillation

1. **What is fibrillation?**
   1-1: Atrial fibrillation
   1-2: Ventricular fibrillation
2. **What is defibrillation?**
3. **What is cardioversion?**
4. **What is a defibrillator?**
   4-1: monitor
   4-2: capacitor
   4-3: numbered buttons 1,2,3; output dials
   4-4: paddles
5. **How do defibrillators work?**
   5-1: What is depolarization?
   5-2: What does electricity have to do with it?
   5-3: What is a joule?
   5-4: What is monophasic defibrillation?
   5-5: What is biphasic defibrillation?
   5-6: What is "transthoracic impedance"?
6. **How do I cardiovert someone?**
   6-1: Cardioverting a-fib
   6-2: Cardioverting VT-with-a-pressure
7. **How do I defibrillate someone?**
   7-1: Defibrillating VT
   7-2: Defibrillating VF
8. **What bad things do I have to watch for during cardioversion or defibrillation?**
   8-1: Using synchronization correctly
   8-2: Keeping the process orderly
   8-3: Clearing the bed
   8-4: Using contact gel properly — contact burns
9. **What things should I do after the cardioversion defibrillation?**

Source: Mark Hammerschmidt, RN, Marlborough, MA.

Hammerschmidt wrote about already. It's that he took an interest and developed it. "Find something about your job that interests you and get to it," he says.

Next on the list, Hammerschmidt deadpans to his e-mail list of supporters: "maybe 'Acute Coronary Syndromes' — or 'Not-so-Cute Coronary Syndromes.' Then maybe 'What if my patient . . . ,' organized by system, starting with neuro, and working southward. Thanks for all the encouragement — this has really been, and continues to be, a lot of fun."

(For more information, contact:

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Joint Commission forms a task force

To review standards, compliance requirements

The Joint Commission on Accreditation of Healthcare Organizations is taking a hard look at the relevance of its hospital standards and compliance requirements.

An 18-member task force will pinpoint which

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Editorial Questions

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accreditation standards are most relevant to the safety and quality of patient care with a goal of eliminating or modifying those that don't contribute to good patient outcomes.

In addition, the task force will identify redundant and overly burdensome documentation requirements for potential streamlining, and identify areas needing additional focus.

Standards relating directly to Medicare Conditions of Participation (COPs) for hospitals will receive special consideration.

Assembling list of possible additions

While the task force will identify potential additions, deletions or modifications to this subset of standards, the Joint Commission recognizes that these standards are the "law of the land" and are required by the government. The task force's ideas, however, may serve as the basis for Joint Commission discussions with the Health Care Financing Administration when it considers changing the COPs.

Led by **Ken Shull** of the South Carolina Hospital Association in West Columbia, the task force will include quality directors, medical records directors, nurses, physicians, engineers, risk managers, and other hospital leaders who have first-hand experience with Joint Commission accreditation standards and surveys. Doctor groups will also be enlisted to specifically review medical staff standards.

Shull and his colleagues will consider the following when reviewing standards and regulations:

- Continuing relevance in promoting patient safety or high quality care.
- Redundancy with other external quality requirements.
- Applicability of standards to hospital care.
- Likelihood that compliance will be consistently evaluated.
- Extent to which compliance can actually be measured.
- Linkage to patient outcomes.

The Joint Commission also will ask the task force to identify common misconceptions and misinformation regarding requirements for demonstrating standards compliance. These fallacies often result in unnecessary costs for hospitals in both staff time and resources. The standard review is part of a continuing effort by the Joint Commission to change the accreditation process into something that is more continuous, consultative, and focused on performance improvement. ■

Performance Improvement Road Map

COST

Performance Measure	Why Measure Is Relevant	How to Direct Future Efforts
Labor & Outsourcing cost per adjusted medical record	Indicates staff productivity and operational efficiency	1. Have staff lead improvement initiatives 2. Develop interrelated staff goals to promote collaboration 3. Institute a staff pay-for-performance program 4. Provide daily measures with targets to help staff manage work 5. Schedule staff to facilitate completion of work 6. Rotate and/or cross-train staff to enhance flexibility 7. Develop short-term strategies to eliminate backlogs 8. Include penalties in vendor contracts for unmet targets 9. Determine what information is needed by end user 10. Maximize on-line documentation and/or optical imaging 11. Hold multidisciplinary meetings with all revenue cycle areas 12. Stop delivering paper records to physicians' offices for completion 13. Develop on-line physician profiles for when to send medical records for ED and clinic patients 14. Cease printing on-line documents unless requested
Average number of days of untilled records Unbilled dollars as a percentage of A/R	Promotes prompt billing for reimbursement	1. Use aggressive discharge control to receive records within 24 hours of discharge 2. Scan records within four to eight hours of receipt 3. Code from electronic documents 4. Begin coding when record first arrives in department 5. Automatically place record in coding queue when necessary documents become available 6. Use daily reports to help set priorities 7. Assign more record completion staff and coders to heavy discharge days 8. Develop short-term strategies to eliminate backlogs 9. Use computerized discharge summary for short stays to eliminate delays for dictated discharge summaries 10. Automatically provide documentation required for billing purposes
Average number of days of unfiled loose documents Average number of inches of of loose filing per 100 medical records	Indicates the availability of current patient information for the delivery of patient care Minimizing loose documents decreases rework of record assembly	1. Develop short-term strategies to eliminate backlogs 2. Have staff lead improvement initiatives 3. Drop file loose filing to eliminate filing backlogs 4. File loose documents on the evening shift 5. Maximize on-line documentation and/or optical imaging 6. Cease printing on-line documents unless requested 7. Eliminate unnecessary documents sent as loose filing

CYCLE TIME

Performance Measure	Why Measure is Relevant	How to Direct Future Efforts
Inpatient record completion time Transcription turnaround time	Makes patient information available for the delivery of patient care	1. Maximize on-line documentation and/or optical imaging 2. Develop short-term strategies to eliminate backlogs 3. Redesign process from customer perspective 4. Use aggressive discharge control to receive records within 24 hours of discharge 5. Scan records within four to eight hours of receipt 6. Code from electronic documents 7. Begin coding when record first arrives in department 8. Automatically place record in coding queue when necessary documents become available 9. Use daily reports to help set coding priorities 10. Assign more record completion staff and coders to heavy discharge days 11. Have on-line editing available 12. Automatically notify physicians of missing documentation 13. Use physician folders for documents with pending signatures 14. Have physicians report to department weekly to review records 15. Develop medical and administrative leadership support to enforce sanctions and promote physician record completion 16. Decrease delinquent record definition to two weeks 17. Keep medical staff informed of delinquency rates by service and physician 18. Use a computerized discharge summary for short stays to eliminate delays for dictated discharge summary 19. Include penalties in transcription vendor contracts for unmet targets 20. Hold multidisciplinary meetings with all revenue cycle areas
STAT record retrieval time Record retrieval rate for scheduled clinic visits	Makes patient information available for the delivery of patient care	1. Maximize on-line documentation 2. Promote the use of on-line documentation vs. paper record by end users 3. Develop on-line physician profiles for when to send medical records for ED and clinic patients 4. Set rule stating when paper record can leave the department 5. Fax needed documents from off-site storage to expedite record retrieval 6. Stop delivering paper records to physician offices for completion 7. Include penalties in storage vendor contracts for unmet targets
Release of information (ROI) turnaround time	Makes patient information available for customer needs	1. Maximize on-line documentation 2. Develop short-term strategies to eliminate backlogs 3. Have staff lead improvement initiatives 4. Include penalties in ROI vendor contracts for unmet targets 5. Make copies for ROI requests in early morning and evening 6. Automatically provide documentation required for billing purposes

Source: University HealthSystem Consortium, Oak Brook, IL.