AMERICAN HEALTH CONSULTANTS
HOSPITAL PEER REVIEW®
YOUR BEST SOURCE FOR JCAHO, CREDENTIALING, AND QUALITY INFORMATION
27

IN THIS ISSUE

NOVEMBER 2002

VOL. 27, NO. 11 (pages 149-160)

Radical revision of survey process may ease compliance burden

Self-assessment, other changes designed to make surveys more relevant

Responding to years of criticism and pleas from health care providers, the Joint Commission on Accreditation of Healthcare Organizations has announced a major overhaul of the survey process that it says will make accreditation more relevant to actual patient care and less onerous for organizations being surveyed. Under the new plans, hospitals and other providers will conduct self-assessments long before surveyors show up, and the surveyors will focus on actual patient care experiences instead of more theoretical compliance with standards.

John Noble, MD, chairman of the Joint Commission's Board of Commissioners, says the board agreed that "now is the time for the Joint Commission to take bold action," and so it "radically revamped the accreditation process." The new plan will go into effect January 2004 for all Joint Commission-accredited organizations. Called "Shared Visions — New Pathways," the new process is very different from the system that now takes up so much of a quality manager's time. These are the major components of the new process:

- Streamlined standards and a reduced documentation burden, with more focus on critical patient care issues.
- Self-assessment process intended to support an organization's continuous standards compliance while freeing up survey time to focus on the most critical patient care issues.
- System for focusing surveyors on specific areas that need attention during their visit. Organization-specific data are used to highlight these areas.
- New survey system with six basic components that will replace the standard triennial survey format. The system starts with an opening conference between surveyors and hospital leaders, which is followed by a leadership interview, validation of self-assessment results, a focus on actual patients as the framework for assessing compliance with selected

standards, discussion and education on key issues, and a closing conference.

• More training, requirements, certification, and an enhanced role for surveyors. Surveyors will have to be certified and then recertified every five years.

• Revised decision and performance reports providing more meaningful and relevant information.

• The use of ORYX core measure data to identify critical processes and help organizations improve throughout the accreditation cycle.

• Better engagement of physicians in the new accreditation process.

• New approach to surveying complex organizations.

The new survey process will be more continuous and eliminate much of the "ramp-up" before a scheduled survey, says **Dennis O'Leary**, MD, president of the Joint Commission. A task force is continuing its efforts to review all Joint Commission standards and eliminate those that are redundant or unnecessary, he says.

"We're consolidating, saying things in a lot fewer words, and moving standards to the most appropriate sections," O'Leary says. "We have reduced the number of scorable elements, and that has a significant impact in terms of the burden on accredited organizations."

Perhaps the biggest component of this change is the self-assessment, in which the organization looks for much of what the surveyors would have looked for in the triennial survey. An accredited organization will complete the self-assessment at the 18-month point in its three-year accreditation cycle, rating its level of compliance with all standards that are applicable. There will be no surveyor visit at this point; the organization will submit its own self-assessment ratings by a secure Internet site.

If an organization finds it is not compliant in any standards area, it must detail the corrective actions it has taken or will take to comply. This information will not result in any change in accreditation status, O'Leary says. Once the information is submitted, a Joint Commission representative will contact the organization to review the findings, approve the corrective actions, and provide advice on taking those actions. At the 36-month point, the time for the triennial survey, surveyors will visit the site to verify that the corrective actions have been taken. The surveyors also will validate the self-assessment by reviewing specific critical areas.

Providers that are at or beyond the midpoint of their accreditation cycles as of January 2004 (meaning they are due for a survey in July 2005 or after) will receive the self-assessment tool in July 2003 or thereafter. Once you receive the self-assessment tool, you will have three to six months to complete it and plan any corrective actions.

That process is supposed to help organizations identify most problems long before the surveyors show up at the door, O'Leary says. And once the surveyors arrive, the experience should be quite different from any survey they've had in the past. The biggest change during the on-site survey involves what the Joint Commission calls "tracer methodology." In short, that means that surveyors will trace the experience of actual patients through the organization's system to determine

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10 to 20 additional copies, $257 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

American Health Consultants® is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours.

Editor: **Greg Freeman**, (770) 645-0702.
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).
Senior Production Editor: **Ann Duncan**.

Editorial Questions

For questions or comments, call **Greg Freeman** at (770) 645-0702.

compliance with Joint Commission standards, instead of quizzing staffers and studying representative documents.

That system will focus the survey process more on actual patient care than on theoretical compliance with standards, says **Russell Massaro**, MD, executive vice president for accreditation operations with the Joint Commission.

"In the past, surveyors might have asked what steps you take to prevent wrong-site surgery, and the organization would talk about procedures, education, and other steps," he says.

"In the future, we'll get at the same information but in a different way. We will choose at random from open records a patient who has just had surgery, and we'll trace that patient through the process, Massaro explains. The surveyor will go to the [emergency department] and ask how they X-rayed the patient, how they obtained consent, and so on. Then if the patient went to a unit, the surveyor will go there and talk about preoperative preparation. Then they'll go to the [operating room] and ask 'When this patient came up, was the site marked? Did you have a timeout before you began surgery to discuss whether this was the right patient and what procedure you were doing?'"

All of the questions pertain to the actual patient being traced, derived from the chart.

That kind of focus on actual patient care, as opposed to formal standards that supposedly affect patient care, draws more physicians into the accreditation process, says **William Richardson**, CEO of Tift Regional Medical Center in Tifton, GA, one of two hospitals that conducted pilot tests of the new accreditation process.

The changes make the overall accreditation more meaningful and less like an academic exercise, he says.

"For the first time as a CEO, I see the pertinence of the methodology," Richardson says. "I understand the standards better and see the relevance to patient care."

The same reaction comes from **Chuck Young**, administrator at Shriners Hospitals for Children in Spokane, WA, the other hospital testing the pilot program. Physicians at his hospital reacted most strongly to the difference in the accreditation process, he says. They responded favorably when they saw that the accreditation process was focusing on actual patient care and real patient experiences.

"In many cases, our physicians were not so involved in past surveys," Young says. "They're responsible for so much of what goes on in a hospital, but it was those of us who are hands-off who were being surveyed. Now the surveyors will be actually out on the floor seeing what happens to patients, and physicians see that as a sign that they're focusing on what really matters. You have a hard time getting physicians to care about something just because it's in a standard, but they'll care if you're looking at what actually happens to patients."

Costs and effort should be reduced

The Joint Commission promises that the new and improved survey system will be less expensive and less burdensome on providers. The average triennial survey fee for a hospital is $20,000, but O'Leary says accredited organizations usually don't complain about that. They complain about the cost of "ramping up" for a survey — all the improvements, consulting fees, and other preparation that goes into a triennial survey.

"Ideally, they should be ready for a survey all the time, but the fact is they do incur costs for the ramp-up," he says. "I've heard figures of a quarter million, half a million, numbers with lots of zeroes after them. We can get rid of that terrible expense if we have a survey process that inherently ensures the hospital is in compliance all the time."

Under the new system, you should be able to make smaller, more incremental changes over time and ultimately be more in compliance than when you were scrambling to get things in order for a triennial survey, O'Leary says.

Young says that was the experience at Shriners Hospitals when they were testing the pilot program for the new plan.

"We prepared for the mock survey under this new program as if someone were coming for dinner, and we did very well," he says.

"When surveyors are coming for real after 2004, we will prepare as if the in-laws are coming to stay for a week. Sure, we'll get some things in order and put our best foot forward, but we won't have to spend all this money on the ramp-up that you see now. It will be more a matter of cleaning up the house before guests come," Young adds.

(In next month's Hospital Peer Review*, look for much more information about how the changes in the survey process will affect you and how you can prepare.)* ■

Changes make integration of services a priority

Complex organization survey process begins 2004

Before long, the Joint Commission on Accreditation of Healthcare Organizations will change the way surveyors judge your worthiness for accreditation. Some of the changes will make the accreditation process easier, but they also bring their own additional risks.

Questions remain about how the new survey process will work, but two facets of the revised process were announced earlier than the rest, and some observers say they merit a good dose of caution. The first involves the introduction of a new complex organization survey process that will replace the Joint Commission's current process for conducting tailored surveys. Tailored surveys are conducted at organizations that provide services covered by standards in more than one of the Joint Commission's nine accreditation programs.

Introduced in 1982, the tailored survey has become "substantially fragmented and inefficient, resulting in duplicative surveys of certain organizationwide functions, such as leadership," the Joint Commission now says. The new complex organization survey process is meant to remedy that problem, and it will begin in 2004. It includes these factors:

- survey profile that includes information about the applicant organization's specific settings and services;
- customized sets of standards matched to the organization's survey profile;
- surveyors who have skills and expertise most appropriate to the organization to be surveyed;
- use of interrelated evaluation techniques such as self-assessment to assess standards compliance;
- concurrent evaluation of the various organization components.

While the survey process will change, complex organizations will continue to receive a comprehensive accreditation decision that reflects the performance of the entire organization. Performance information at both the organization and component levels will continue to be publicly disclosed.

Those changes will be welcomed by many large providers, but beware of the hidden risks, says **Susan Mellott**, PhD, RN, CPHQ, FNAHQ, a consultant in Houston. The change for "complex organizations" really applies to just about any hospital or health care system that has more than one patient care unit, she says. That could be a hospital with a long-term care facility, an ambulatory surgery center, or a home care service, for instance.

"It means the entire organization and all of its components will be surveyed at the same time with a group of surveyors who will be there all at once to speak with the hospital leadership and to see all the information at the same time," she says. "They're trying to get the whole group of services provided by the hospital to go through the process at once. That should cut down on the duplication and the extra effort by the surveyors."

The new system will offer benefits to accredited providers, she says. For starters, you will have fewer surveys to prepare for and less disruption from repeated visits by Joint Commission surveyors. A single, comprehensive survey also will reduce much of the confusion that hospitals can be left with when different health services are surveyed separately. Too often, Mellott says, hospitals are left with inconsistent and sometimes contradictory survey results when the surveyors work independently.

Most providers will welcome that change, but it may come with an increased risk, she adds. With the entire hospital system under scrutiny at once, there will be more pressure than ever to have everything in order at the same time. There will be no opportunity to focus all your preparation efforts on one area facing an upcoming survey and then move on to the next. Everything will have to be ready at once, and that actually is one goal of the Joint Commission's change, Mellott says. Many of the process improvements at the Joint Commission are intended to encourage providers to be survey-ready all the time, rather than just when the surveyors are due.

"I've talked to hospital leaders who are worried about what's going to be included in this new process that was never included before. I don't think we know yet," she says. "And they're worried that the survey team will spend more time at the hospital and have more time to find problems. With the focus on integrating the survey process for different service areas, I'm sure they will look more closely at whether you have all those areas integrated well into your operations."

That leads to Mellott's recommendation about how to prepare for the 2004 survey changes: If you have associated health care services such as long-term care, make sure they are clearly and

effectively integrated into the hospital's overall quality program. And make sure you will be able to show that integration to the surveyors.

In addition to that major change, another more immediate change addresses the concerns of long-term care providers. Effective Jan. 1, 2003, the Joint Commission is offering hospital-based and freestanding long-term care services two new accreditation alternatives that are intended to be responsive to concerns about the costly duplication of federal Medicare surveys. These new options include the exclusion of long-term care services from the organization's tailored survey or selecting a new accreditation option that is substantially based on Medicare / Medicaid certification at a lower cost. The new alternatives are in addition to the current long-term care accreditation program offered by the Joint Commission.

These are the new alternatives:

- **No review of long-term care services.** For hospitals and other complex organizations that provide long-term care services, this alternative allows for the exclusion of these services from the organization's tailored accreditation survey as long as they are able to provide evidence of Medicare / Medicaid certification of these services at the time of survey. The organization's accreditation certificate will explicitly exclude the organization's long-term care services from the JCAHO accreditation award.
- **Medicare/Medicaid-based accreditation.** Accreditation will be based substantially on the most recent Medicare / Medicaid certification survey. These surveys cover approximately 70% of the Joint Commission's long-term care standards. The Joint Commission's accreditation survey will address areas of deficiency identified through the Medicare / Medicaid certification survey, as well as selected Joint Commission standards not addressed by the Medicare / Medicaid certification survey. For complex organizations, the accreditation survey findings will be incorporated into the accreditation decision for the organization. For freestanding long-term care organizations, the accreditation survey findings will constitute the sole basis of the decision. In both organizations, the accreditation certificate will indicate that accreditation is substantially based on the organization's most recent Medicare / Medicaid certification evaluation of its long-term care services.

So why continue the Long-Term Care Accreditation Program at all? According to a statement from the Joint Commission, the program is being retained "to support the more than 2,200 long-term care organizations currently accredited under this program as well as for new long-term care organizations desiring this comprehensive evaluation." The accrediting body says it developed the new alternatives to decrease the survey burden on long-term care organizations that already receive an annual, unannounced Medicare / Medicaid certification survey. In the future, the Joint Commission says it will be examining whether health care organizations accredited in any of its other accreditation programs undergo a similar annual Medicare / Medicaid survey.

"Long-term care groups were dropping out of the Joint Commission's accreditation program faster than any other group, so I think these changes are being offered to try to keep them, to get them back in the fold," Mellott says. "The Joint Commission is giving them more options to make it more attractive and keep them from leaving."

Two initiatives being tested

The Joint Commission also reports that it is in its third year of working on accreditation process improvement (API) initiatives to make the accreditation process more consistent, relevant, and focused on important issues specific to each health care organization.

During 2002, two critical initiatives — the priority focus process and organizational self-assessment — are being pilot tested and the technological infrastructure to support them is being built. The priority focus process will use pre-survey data to identify critical processes to be addressed, appropriate agenda activities, and relevant standards.

Findings from pilot testing will be integrated into a new on-site survey process.

The model for this new process, now being pilot tested, includes:

- time for surveyors to review pre-survey data from the priority focus tool output and the organization's corrective actions identified in their self-assessment;
- more time for evaluation at the sites of care guided by use of a systems analysis approach that the Joint Commission calls the tracer methodology and for educational activity on key issues, such as emergency management and patient safety;
- physician involvement in survey process, particularly as part of tracer methodology;
- time for surveyor team interaction in order to create a dynamic, flexible survey that meets

the needs of the specific organization being surveyed.

Pilot testing has been completed in eight hospitals with positive results, including support for increased surveyor time spent "out on the floor" using the tracer methodology and positive feedback about the elimination of many of the interviews and much of the document review time from the current survey agenda — indications that the survey team is better able to link findings at the patient level to systems issues using tracer methodology.

Refinement of the new survey model, additional pilot testing, and intensive surveyor training are planned during 2003.

[For more information, contact:

• ***Susan Mellott**, 5322 W. Bellfort, Suite 208, Houston, TX 77035. Telephone: (713) 726-9919.]* ■

Long-term focus pays off with perfect score

Hospital wasn't shooting for 100

Every health care provider undergoing a survey by the Joint Commission on Accreditation of Healthcare Organizations wants the best score possible; but in reality, most just are hoping they don't get any Type I recommendations and walk away with their accreditation intact. What if you want to do better than that? Can you really shoot for a perfect 100 on your survey?

It's a high goal to set, but it can be done. And if your organization gets that perfect 100, it will be able to crow about it for quite a while, showing it off in your community as proof that you are among the very best when it comes to health care quality. When Olympic Memorial Hospital in Port Angeles, WA, recently scored a perfect 100 on its survey, leaders there were shocked, albeit quite pleasantly, because they had not made a perfect score the goal of their quality programs. But what they found out was that focus and hard work can make the difference between mere accreditation and a perfect score.

The process began in 1999 after the hospital's last triennial survey, says **Maureen Guzman**, RN, director of quality and strategic value at the hospital. At that time, the hospital scored an 89 on its survey and received four Type I recommendations — two related to human resources, one in information management, and one concerning medication security. The hospital received its accreditation, and the 89 score is exactly the national average, nothing to be ashamed of at all. Even the Type Is could be addressed, but that wasn't enough for Guzman and others at the 126-bed acute care facility with outpatient services and a 125-bed skilled nursing facility.

"We were organizationally not very happy with the score we received and felt like we were a better organization than the score indicated," she says. "At that time, we vowed to do things differently and prepare for the next survey. We wanted to do a lot better."

Guzman joined the hospital soon after the 1999 Joint Commission visit, so one of her first tasks was to address the problems found in the survey. But she and the other hospital leaders took on much more.

Three years later, the hospital joined an elite group of facilities that have scored a perfect 100. Less than 1% of the 4,765 hospitals accredited by the Joint Commission score a 100 on their surveys, according to **Charlene Hill**, spokeswoman for the accrediting body. She says the Joint Commission actually discourages focusing too much on the numerical score, but she acknowledges that a 100 score is a mark of excellence.

Olympic Memorial trumpets the perfect score in marketing materials, showing it off as a point of pride and a guarantee of quality for patients. **Mike Glenn**, CEO, says the perfect 100 score is something that patients can understand easily, even if they don't know much about the Joint Commission. "Too often, the public reads about hospitals that are not performing up to patients' expectations," he says. "With our 100% score, patients know how serious we are about the quality of our care."

As of June, 67 hospitals in Washington had been surveyed by the Joint Commission, according to information supplied by the accrediting body. The average score in that state was 90, with a range of scores from 76 to Olympic Memorial's 100. **Leo Greenawalt**, CEO of the Washington State Hospital Association in Seattle, says the score is worth crowing about.

"Frankly, in my 21 years of hospital association work, I've never known of a hospital to get 100%," he says. "This is an incredible accomplishment."

Nationally, the average score for all surveyed

(Continued on page 156)

Take time to prepare, include others in survey preparation

Don't cram for survey; make meaningful changes

As the triennial Joint Commission on Accreditation of Healthcare Organizations survey continued for three days at Olympic Memorial Hospital in Port Angeles, WA, **Maureen Guzman**, RN, director of quality and strategic value at the hospital, realized that the two years of preparation was paying off.

She now suggests that is one of the biggest lessons from Olympic Memorial: You can't cram for a survey and expect to actually improve quality at your facility. Meaningful changes often take time, and Olympic Memorial took two years to achieve some of the changes that landed them a perfect 100.

"It's like studying for a test in college," she says. "If you cram at the last minute, you might get the questions right until the professor asks you something slightly different, something that digs deeper into what you really know. Then you're lost."

These are some other lessons from Olympic Memorial:

✔ **Be willing and prepared to showcase your strengths.**

The survey process can be nerve-wracking, so some providers just grit their teeth and wait for it to be over. Big mistake, Guzman says.

"If you've done something really good in a department, talk about it — show it to the surveyors," she says. "That's OK, more than OK. The surveyors want to see what you're doing right, even if they don't know to ask you about it. It's good to show your enthusiasm."

✔ **There is strength in numbers.**

Having a large circle of hospital leaders and staff directly involved in the survey process broadens the pool of knowledge available to the surveyors. The surveyors may not ask for input from everyone who is available, but their presence shows support from a wide range of experts. And in some cases, the assembled brains might rescue a struggling staffer.

"We had one instance in which the nurse surveyor couldn't find the order for the last time a patient had been in restraints," Guzman says. "But we had some knowledgeable people hovering who explained that the patient had expired recently and so there was more time allowed to get the record together."

✔ **Do whatever is required to get your medical staff and board of commissioners on the team.**

Guzman says the surveyors were pleased with the way the physicians and board members participated fully in the survey process and obviously had been instrumental in the quality improvement process. Showing that kind of involvement, rather than having them marginally and begrudgingly involved, makes a big difference to the surveyors.

That may not be easy, but you must strive to show consensus, that you're all part of the same team.

"We asked the CEO to help us determine who would be good representatives from the board," Guzman says. "Then we set up individual meetings to get them on board. Some of them were not fond of the Joint Commission, so it took a lot of talking."

When it came time to educate the board members about the survey process, Guzman was careful to avoid lecturing or any presentation that sounded like a PhD dissertation.

"It was more like just talking about how these surveys work, getting them to a real comfort level by the time they would actually talk to a surveyor," she says. "We spent about 12 hours with the board members doing that."

For the medical staff, Guzman and others asked to be put on the agenda for physicians' meetings. They spent about 9 hours educating the physicians about the survey process, with the same emphasis on not lecturing and making everyone comfortable with terminology and goals.

✔ **Consider your policies and procedures to be "living documents."**

It's easy to think of policies and procedures as something you get in shape for the Joint Commission survey and then forget for a while. But Guzman says you must think of them as living documents that must be updated and improved whenever necessary. That change in attitude will result in more meaningful documents that improve quality of care and show substantive improvement to Joint Commission surveyors.

✔ **Never utter the phrase: "Because the Joint Commission says so."**

Strike that phrase from your vocabulary and replace it with: "Because it's the right thing to do."

✔ **Focus on how you can improve your organization, not how you can prepare for the survey or respond to the last one.**

That's more than just an ideal way to look at things. It actually pays off in the long run, Guzman says, because you improve the organization in more significant ways. Joint Commission surveyors will see the difference.

"They're going to look at how you judge yourself, how much you hold yourself to high standards, rather than just how much you can follow instructions written in the standards," she says. "Waiting for the survey to show you what's wrong so you can fix it is not the best way. Surveyors won't be impressed by that attitude." ■

facilities is 89, Hill says. So that additional 11 points is the tough part, and Guzman says she and her staff had to work hard to cover that ground. The first step, as it always is with quality improvement projects, was to get buy-in from the hospital leadership. Thirteen top-ranking hospital leaders committed to improving quality and improving the score in the next Joint Commission survey. Their main goal was to create a constant state of readiness in the hospital, with all areas in compliance all the time, so the team was named the "Continuous Accreditation Readiness" team, or CAR. The CAR members took responsibility for 15 different areas in the hospital, such as pharmacology and radiology, setting up subcommittees to continuously monitor and improve compliance.

"In previous years, we had hired a consultant to come in and do a mock survey; then we addressed the deficiencies," Guzman says. "In the new way, we looked at every standard from beginning to end and showed compliance with each one. That made sure we were in compliance, but it also ensured a better knowledge base and helped us be more prepared for the survey."

In addition to hospital leaders, Olympic Memorial was able to bring the hospital's board of commissioners into the plan. Three members of the board attended leadership and strategic planning meetings, and Guzman helped educate them about the Joint Commission survey process so they could be present and contribute during the survey.

"I spent a lot of time addressing what the surveyor would be asking and how they would ask," she says. "It's not that the board members wouldn't know the information, but sometimes the surveyors' questions are, shall I say, a little bit esoteric. It helped them to know how the questions would be phrased and what the surveyor is looking for."

Every member of the medical staff credentialing unit also participated. The chief of medicine and chief of surgery both were present during the survey. Having those heavy hitters present and ready to participate demonstrates a cohesive structure for the surveyors, Guzman says.

The most recent survey began with a 15-minute meeting with the two surveyors, Guzman, and a few more hospital leaders. Then they began the two-hour document review.

"One thing that was very helpful is that our staff was experienced in previous surveys, so they knew how to put the materials together in a

JCAHO surveyors' questions show areas of focus

These are some of the questions posed to staff at Olympic Memorial Hospital in Port Angeles, WA, by Joint Commission on Accreditation of Healthcare Organizations surveyors during its recent survey:

- ❑ How do medical staff react when told you don't have enough staff to take care of a patient? How do charge nurses react?
- ❑ What kind of patients are admitted to the critical care unit?
- ❑ What arrangements ensure there is adequate medical staff coverage for the critical care unit?
- ❑ What determines which caregiver will take care of which patient?
- ❑ When using the Pyxis dispensing system, how do you monitor the medications?
- ❑ How do you make sure that surgeons don't bring in unapproved equipment from vendors?
- ❑ Do personnel from all shifts participate in fire drills? How do you make sure?
- ❑ Are you working to reduce mercury contamination?
- ❑ How would you respond if your water supply was contaminated?
- ❑ How do you monitor sharps injuries?
- ❑ How are you addressing the hazards posed by medication abbreviations?
- ❑ Since you imposed a moratorium on vaginal birth after cesareans, how do you handle those patients?
- ❑ If you have no patients in the obstetrics unit, what do you do with the staff assigned there?
- ❑ How do you document patient education? How?
- ❑ What determines a "short stay" in your hospital? How do you decide whether a patient is a short stay or full admit?
- ❑ Do you use preprinted medication orders? In what units?
- ❑ How do you provide effective pain management? How have you improved your pain management program?
- ❑ What process do you have in place for emergency physicians to access patient records?
- ❑ When have you conducted a hazard vulnerability analysis? What did you learn? How did you respond?
- ❑ When and how did you get consent for this patient's surgery? Has the anesthesiologist seen him? ■

way that was very user-friendly for the surveyor," she says. "The surveyor said this was one of the best document reviews she had ever seen. One said he had never before been able to see everything he wanted to see in the two hours."

To put together such a good presentation, Guzman says you first should go to the Joint Commission web site (www.jcaho.org) and check the information about the survey process. Everything the surveyors want to see is listed there.

"It's important to put together exactly what they've asked for — no more and no less," she says. "Then we put together everything in separate binders by topic and made it easy for the surveyor to find cross-referenced material. Anytime there was a cross-reference to the medical staff bylaws, for instance, the bylaws were right there in the binder for the surveyor to see. We were really trying to make it easy for the surveyor to see, and that's much appreciated."

After the document review, the surveyor moved on to the performance improvement review. This is the part where the hospital has an opportunity to present a summary of its quality improvement programs and highlight performance measures for the surveyor, but Guzman and her team weren't sure how long a presentation to prepare. They had heard conflicting accounts in the previous year about how much surveyors wanted to hear, so they played it safe by preparing three different presentations of different lengths.

The 15-minute presentation covered only the most basic information such as ORYX data, and a 30-minute version covered more about quality improvement efforts such as Olympic's pain management program. The full-hour version covered all of that and more, such as what indicators the hospital chose for measuring its staffing effectiveness and how it chose them.

It turned out that the surveyors wanted the full-hour presentation. The only glitch in the presentation was that the ORYX data in the presentation didn't jibe with the data that had been transmitted to the Joint Commission already. The cause was a problem with the electronic transmission of the data.

"We ended up having to write a formal letter afterward explaining the variation, but they accepted that," Guzman says. "Pretty much the only question they had at the end of the hour was how well the physicians had accepted the clinical practice guidelines. They didn't have much to ask about the content of the presentation."

The next step was the leadership and strategic planning meeting with the CEO, other senior leaders, Guzman, three members of the board of commissioners, and the chief of the medical staff. They presented another overview of the hospital's quality and compliance efforts and fielded the surveyors' questions.

"We showed our emphasis on patient safety and quality improvement throughout all the entities, and they asked a lot about patient safety," she says. "They also wanted to know a lot about how we're changing the culture to look more at the process rather than blaming individuals."

After lunch, the surveyors split up and went to different units. They started working their way through the hospital, talking to staff at every opportunity.

"We found that there is a new emphasis by surveyors to talk with line staff," Guzman says. "And it was almost enjoyable to hear them ask and then listen to the responses. In the past, we cringed and hoped the staff knew the answers. But this time, we found that everyone responded with great enthusiasm and with great confidence."

'Porcelain Pearls' in bathroom educated staff

Education efforts in the previous years were paying off for the staff. As part of the overall compliance and quality improvement plan, the hospital took every opportunity to educate staff about Joint Commission compliance. There were the typical meetings and seminars, but one of the most successful efforts was called "Porcelain Pearls." These were "pearls" of wisdom about patient safety, quality, and Joint Commission compliance posted in the bathrooms for staff to see.

"The surveyors said they were never greeted with that 'deer in the headlights' look that they're used to seeing from staff," Guzman says. "The staff had a comfort level with the information and could talk about it easily. That comes from all the education efforts."

Guzman got nervous that evening when she heard that the surveyors had returned after hours to talk to the staff without the leadership team hovering nearby.

"They're all doing middle-of-the-night surprise visits now," she says. "They'll ask questions about staffing and competency. I was nervous about how the staff would do, but I was happy with what I heard. They did fine."

Patrice Spath, RHIT, a health care quality and accreditation consultant in Forest Grove, OR, says Joint Commission surveyors now rely on staff

input to decide if an organization is in compliance, unlike previous years when formal interviews with selected leaders determined your score. That change makes it very important to educate your staff well before a survey, she says.

"You not only have to educate them on what is going on in the organization, but you also have to educate them in Joint Commission-ese, the language of the standards," she says.

"What you're doing might be in perfect compliance, but if the staff member doesn't understand what he's being asked, he might hesitate or stumble in his answer and give the surveyor the wrong idea," Spath adds. **(See box, p. 155, for advice on how to prepare, and list of common questions asked by surveyors, p. 156.)**

When the survey was completed, Guzman expected the surveyors to meet only with the CEO to explain the results. She was surprised when they invited her to join the meeting and hear the score.

"The first thing the surveyor said was 'You're accredited.' Then he said there were no Type Is. Then he said there were no supplemental recommendations," she says. "The CEO and I looked at each other like we couldn't believe it. Then he said we got a 100, and I couldn't breathe."

The hospital already had received a deficiency-free report from the state department of health earlier in the year, but the hospital's quality leaders never dreamed they could get a perfect 100 from the Joint Commission. It felt odd to be left without a list of recommendations to work on after the survey, but Guzman says the hospital intends to continue its quality improvement efforts.

"The score was an incredible, pleasant shock," she says. "It was definitely an experience where you look at your career and realize that was a pivotal moment."

[For more information, contact:

- ***Olympic Memorial Hospital**, 939 Caroline St., Port Angeles, WA 98362. Telephone: (360) 417-7000.*
- ***Patrice Spath**, Brown-Spath Associates, 2314 19th Ave., Forest Grove, OR 97116. Telephone: (503) 357-9185.]* ■

THE QUALITY - CO$T CONNECTION

Part 3 of 3

Develop a patient safety management system

Focus on gaining widespread support

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

The establishment of a patient safety program, will not, in itself, necessarily result in "perfect" compliance with all critical human actions or an immediate reduction of adverse patient incidents. Care must be taken to ensure that the mere establishment of a patient safety program does not lull the organization into a false sense of safety. Effectively used, patient safety management (PSM) should enable a health care organization to improve its safety performance and avoid or reduce adverse events over time.

A heavy emphasis on formal procedures, excessive documentation, and record keeping may cause priorities to become misplaced.

The focus should be on gaining widespread support, planning effectively, defining roles and responsibilities, providing valuable training, and improving communications. This should involve reasonably frequent feedback loops to physicians and staff. This last in a series of three articles addresses the final phase of PSM: measuring, checking, and corrective action and leadership review. Checking and corrective action include monitoring and measuring critical patient care activities to assess performance and conducting audits and assessments. Corrective action is taken in the event that specified practices are not followed or in response to incidents. Administrative and medical staff leaders must periodically review the results of monitoring and corrective action procedures to ensure the suitability, adequacy, and effectiveness of the patient safety program. The PSM framework should allow the organization to achieve and systematically control performance that affects patient safety.

The questions in the Patient Safety Management

Self-Assessment Tool **(see tool, inserted in this issue)** are to be used to rate the last PSM phase in your organization.

The questions can be used to identify to what extent your measuring, checking, and corrective action activities conform to the generally agreed upon fundamentals of an effective program.

Consider the examples provided for each score in ranking your organization. A space is provided beneath each element to record your score.

Next steps

When you have completed the checklists found in this series of three articles, there are many different actions you can take depending on the results.

Don't focus too much on the scores themselves; the numbers are intended mostly as a guide to help you do the following:

1. gauge your relative position;
2. focus on discrete program elements;
3. facilitate discussion and support learning throughout the organization;
4. prioritize patient safety program improvements.

First, take a careful look at your organization's results and consider these types of questions:

- Are there specific PSM elements with a low score that need attention?
- Do you need to work on several elements or perhaps even all the elements?
- Is there a logical starting point? Are there certain elements or sub-elements that present a high risk and need immediate attention?
- Should you prepare a written "action plan" with specific tasks, assignments, and a schedule based on available resources and priorities?

Build upon existing systems whenever possible. For example, if you have an old environmental safety policy, consider updating and expanding that policy. Likewise, use existing safety or quality-related committees, manuals, or procedures as a starting point, if possible. Don't reinvent the wheel.

Although each health care organization is unique, other facilities may have addressed many of the same issues you are now facing. See what other organizations are doing by speak directly with those responsible for patient safety in other health care facilities. Effectively used, a PSM system should enable a health care organization to improve patient safety and reduce adverse events over time. ■

CE *questions*

17. Which of the following is not a component of the Joint Commission's "Shared Visions — New Pathways" initiative?
    A. revised decision and performance reports providing more meaningful and relevant information
    B. better engagement of physicians in the new accreditation process
    C. surveys conducted annually rather than triennially
    D. a new approach to surveying complex organizations

18. The Joint Commission introduced tailored surveys in what year?
    A. 1978
    B. 1982
    C. 1994
    D. 1998

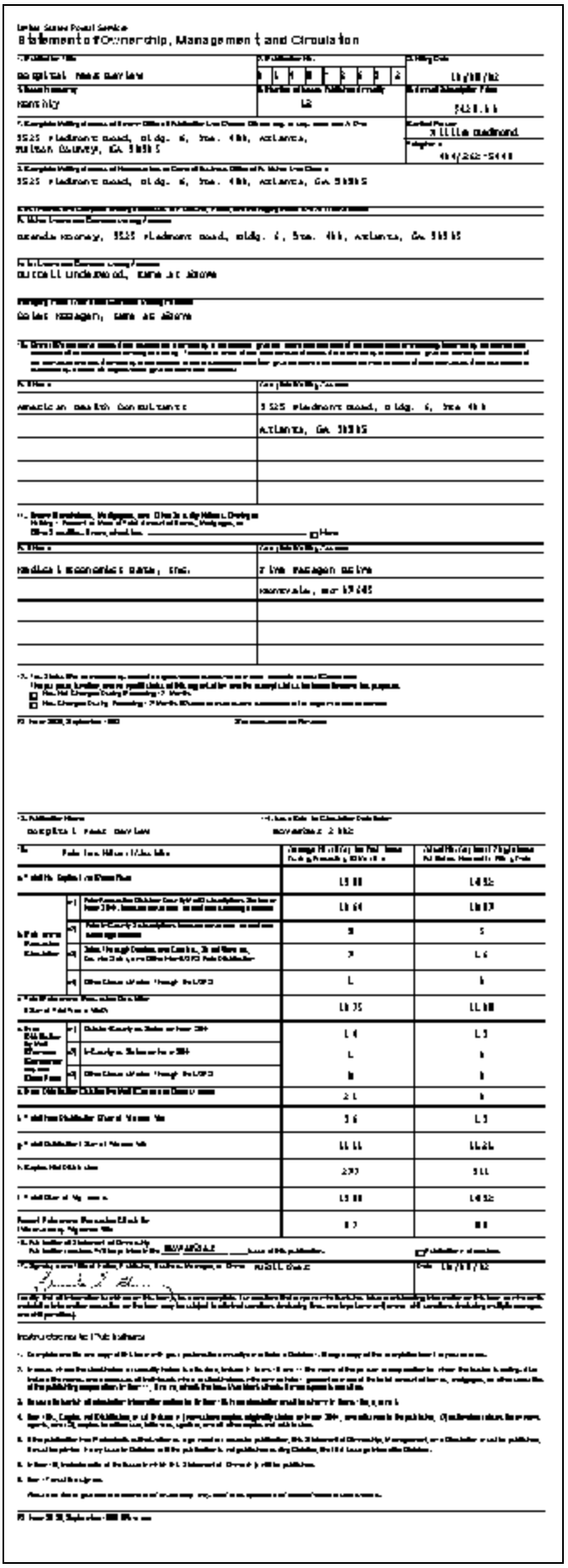
19. The perfect 100 score that Olympic Memorial Hospital in Port Angeles, WA, received on its most recent Joint Commission survey represents an increase of how many points over its 1999 score?
    A. 11
    B. 9
    C. 7
    D. 5

20. What percent of the 4,765 hospitals accredited by the Joint Commission score a 100 on their surveys?
    A. 10%
    B. 6%
    C. 3%
    D. less than 1%

Answers: 17. C; 18. B; 19. A; 20. D

COMING IN FUTURE MONTHS

- Physician profile comes in handy for recredentialing
- Implementing Joint Commission's patient safety goals
- Top mistakes made during triennial surveys
- Standards to focus on if survey is near
- Quality program reduces nosocomial infections



Statement of Ownership, Management and Circulation

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Peer Review*, CE participants should be able to meet the following objectives after reading each issue:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

If you're not an *HPR* CE subscriber and would like to sign up, call customer service at (800) 688-2421. ■

HOSPITAL PEER REVIEW®

Accreditation
Credentialing
Discharge Planning
Medicare Compliance
Patient Satisfaction
QI/UR/PRO
Reimbursement

Improve your income with better data skills, leadership

Survey shows median income of $55,000

Incomes are holding steady for health care quality managers, according to the latest *Hospital Peer Review* Salary Survey, but leaders in the field say you should improve data management and analysis skills if you want to preserve your role as a significant player in your organization.

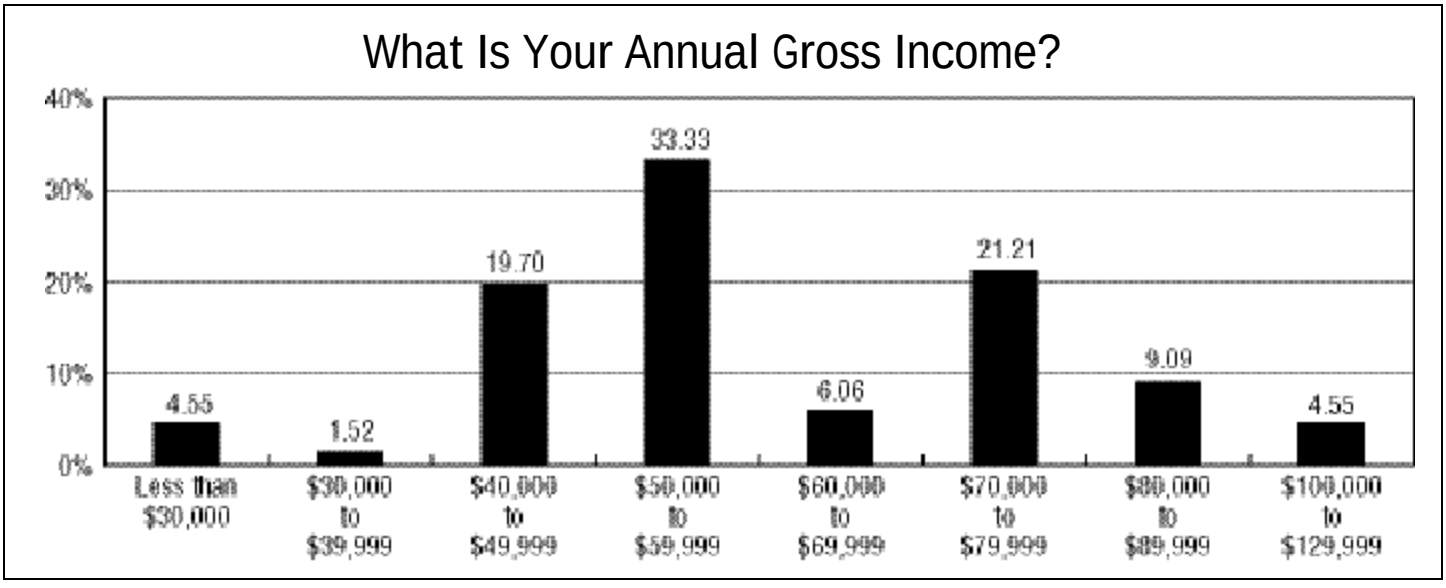
The exclusive 2002 *Hospital Peer Review* Salary Survey was mailed to readers in the June 2002 issue.

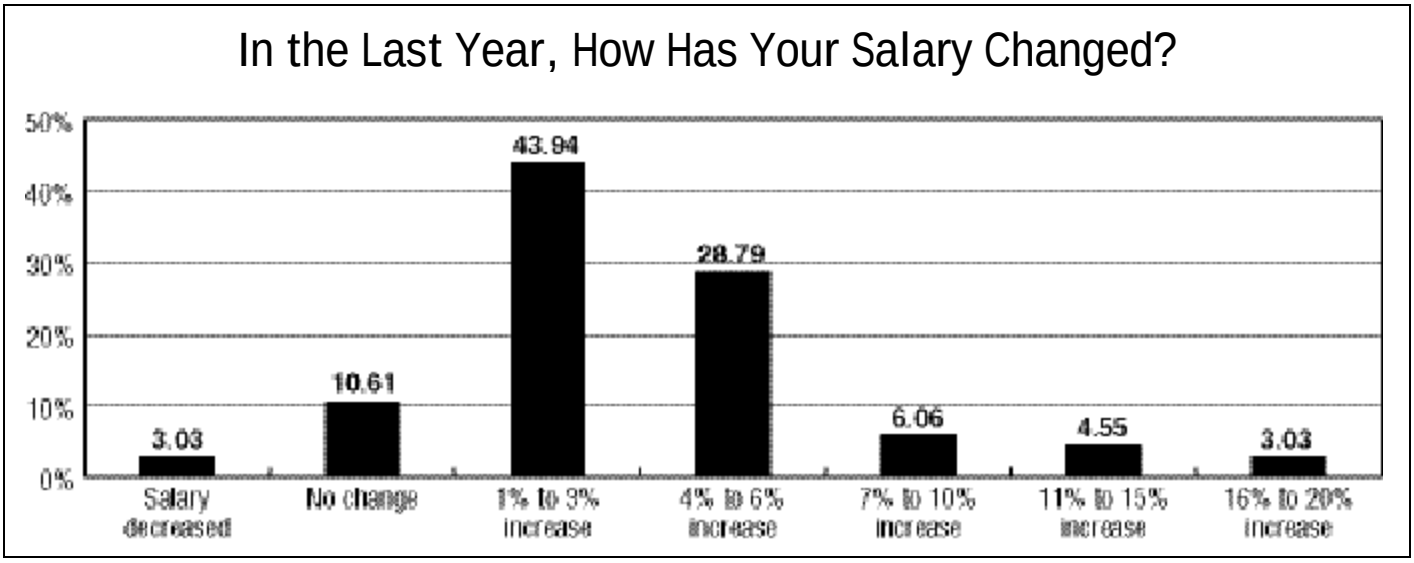
Previous years have shown a slight upward trend in income, but this year's results suggest that quality managers are making about the same as last year. This year's survey shows a median income of $55,000, about the same as last year. **(See chart, below.)** In previous years, the median income for quality professionals has been in the $50,000 to $55,000 range.

The survey shows that almost half of the respondents, 44%, reported an increase of 1% to 3% in their income from the past year. Another 29% reported a 4% to 6% increase. About 11% reported no change, and 3% reported a decrease. A lucky few reported increases of between 7% and 20%. **(See top chart, p. 2.)**

Long hours are still the norm for *HPR* readers. Thirty-five percent report that they work 41-45 hours per week, and 24% report that they work 46-50 hours per week. Another 18% report working 51-55 hours per week. **(See bottom chart, p. 2.)**

The job description of a quality manager is changing in many health care organizations, and that makes salary comparisons more difficult, says





Patrice Spath, RHIT, a consultant in Forest Grove, OR. Some quality managers are taking on more responsibility for patient safety, she says, and that is likely to elevate your role in the organization and increase your income. But regardless of what other duties you take on, Spath says the biggest challenge facing quality managers this year is the increased focus on data and statistical analysis.

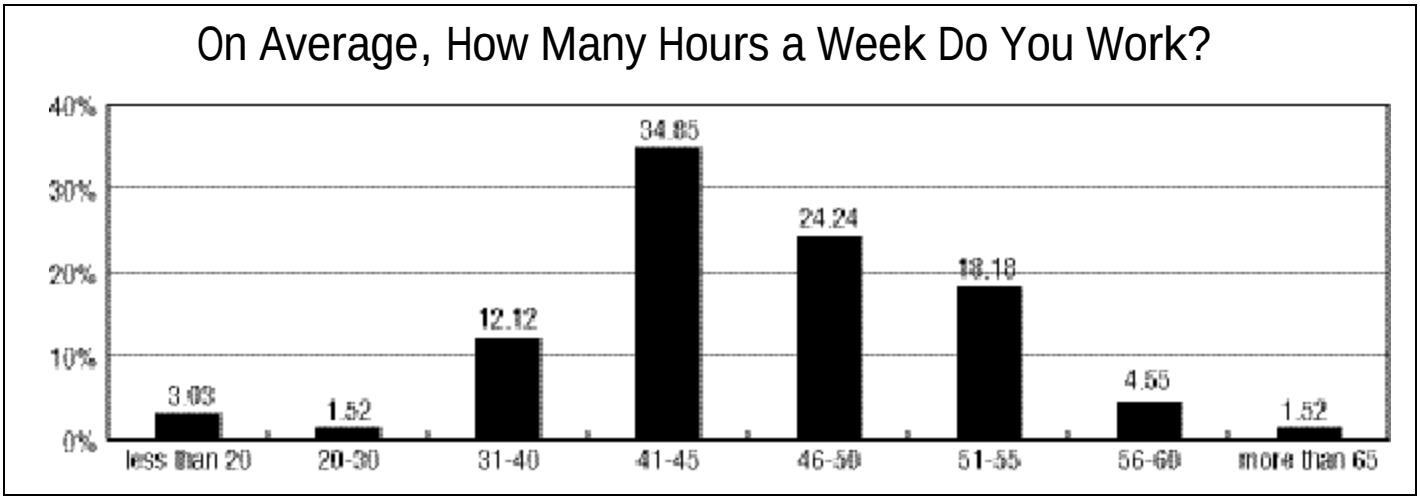
"The health care industry is focusing much more on process management techniques like Six Sigma," she says. "Having good skills in statistical analysis and with techniques such as designing experiments is essential for quality managers who want to excel at their jobs. Getting involved in projects like Six Sigma is usually necessary if you're going to become a leader, and Six Sigma is all about data."

The more you can become involved in leadership projects, the more you can improve your standing in the organization, and Spath says that inevitably will lead to higher incomes. Quality managers are a good fit with projects such as Six Sigma, which is data driven, using data to test different process improvement choices. But Six Sigma and other top-tier leadership projects in a health care organization usually involve senior managers and executives. That may not include quality managers, Spath says, because the average quality manager doesn't have the necessary skills in data analysis.

Two types of people typically go into quality management, she says. One is more interested in the team-building aspects of the career and the other is more interested in the statistical analysis.

"I see people from the team-building aspect going back to school to get a master's in statistical process control or information management," she says. "You pretty much have to if you want to keep up with what people are going to expect of you."

But not everyone is pursuing that kind of career advancement. Spath refers to "the graying of the quality manager" and notes that many currently in the field are nearing retirement, getting close enough that they aren't very motivated to pursue

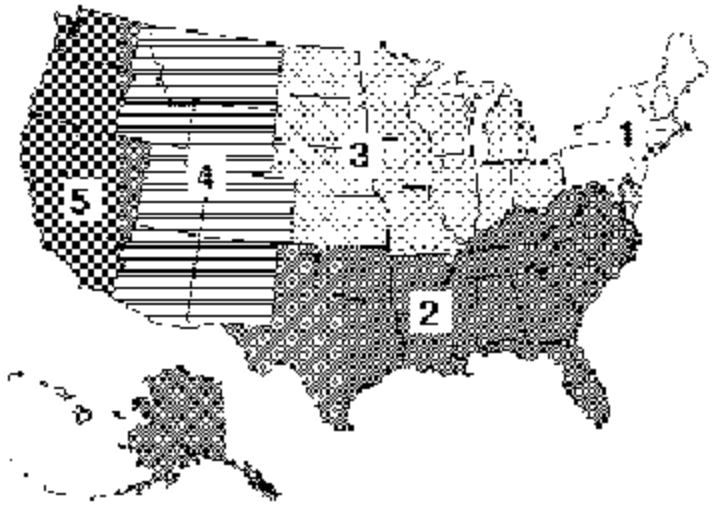


additional training. That theory is borne out by *HPR*'s survey results showing that 47% have worked in health care for 25 years or more. This trend can work to the advantage of other quality managers who decide they have enough time left in their careers to justify improving their skills. Spath says those are the quality managers the health care providers will turn to when better positions and higher salaries are available.

"Who's going to step in when those other people retire? The administration will be looking for people with statistical analysis skills and data management skills," she says. "Hone those skills now to be ready. We as quality managers need to have better skills in analyzing data, uncovering the story behind that information, and helping our employers react to unfavorable trends in that information. The key to a better salary is having the ability to turn data into useful information."

Salary by Region

Income	Region 1	Region 2	Region 3	Region 4	Region 5
Less than $30,000	0.0%	0.0%	13.64%	0.0%	0.0%
$30,000 to $39,999	0.0%	4.55%	0.0%	0.0%	0.0%
$40,000 to $49,999	23.08%	4.55%	27.27%	25%	40%
$50,000 to $59,999	7.69%	36.36%	50%	50%	0.0%
$60,000 to $69,999	15.38%	9.09%	0.0%	0.0%	0.0%
$70,000 to $79,999	23.08%	36.36%	0.0%	25%	40%
$80,000 to $89,999	15.38%	9.09%	4.55%	0.0%	20%
$90,000 to $99,999	0.0%	0.0%	0.0%	0.0%	0.0%
$100,000 to $129,999	15.38%	0.0%	4.55%	0.0%	0.0%



Many quality professionals already are improving their skills, says **Janet Brown**, RN, CPHQ, head of JB Quality Solutions in Pasadena, CA. She teaches classes for those seeking CPHQ certification, and she says she sees a trend toward younger people in the profession. There also is reason to be optimistic about hiring opportunities.

"At the last workshop, I was amazed that 25% in attendance were new to the field, in quality for less than two years," she says. "I was very much impressed with the fact that not only did that seem to indicate hiring, but most were there at the cost of their employers. That means to me that the field is intact, that people are hiring."

Brown says the push for patient safety in health care can only improve the career opportunities for quality professionals. "There isn't any way to have patient safety without reengineering processes of care, and that's a job for quality professionals," she says.

While Brown is optimistic about career opportunities, she agrees with Spath that quality professionals must improve their skills if they are to take advantage of those opportunities.

She advises staying current with accreditation requirements, legislative and regulatory requirements, core performance measures, and patient safety methodologies. Brown also says that recent corporate scandals could lead to a bigger role for quality professionals.

"The whole concept of corporate character has come to the forefront, and corporate character has to be taught by the quality professional," she says. "Quality is an issue that can't be compromised, and there has to be someone in the organization who can stand up and say that, and be respected when they do."

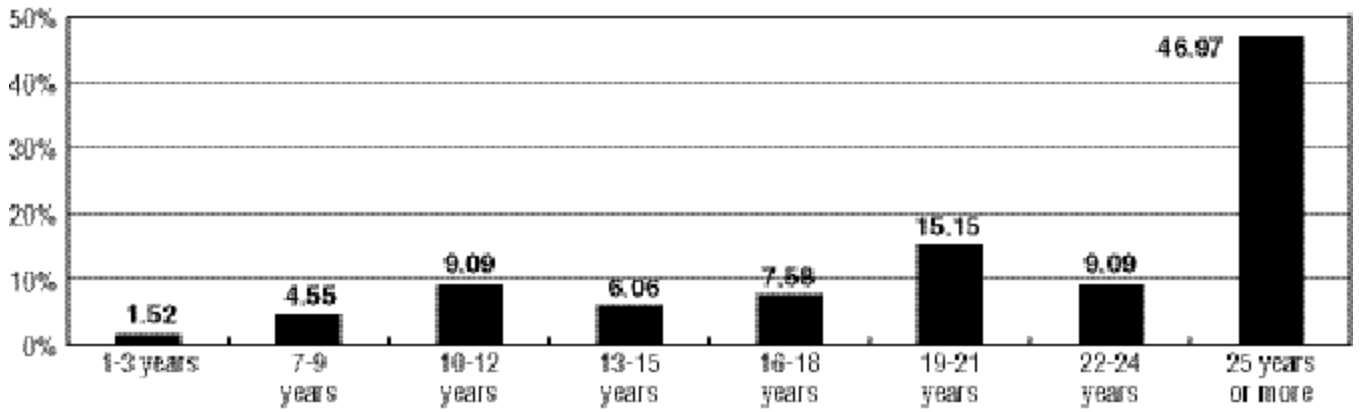
Positioning yourself as a respected leader in the organization is one of the best ways to ensure a good career and improved salary, Brown says. That means you must be seen as a key resource for your superiors, especially top leaders like the CEO.

One characteristic of a good leader is that he or she doesn't strive to know every last detail, but is surrounded by people who do. Brown says you should strive to be one of those people.

"You want to be the one people turn to when there is a quality concern, any sort of question related to quality statistics, or analysis, or performance improvement," she says. "The more you position yourself at the table as a key player, the more your salary will increase."

Brown says salary levels currently look good

How Long Have You Worked in Health Care?



for quality professionals, with the only downside being that employers seem less willing or able to pay for the education you need to stay current. Overall, she says this is a good time to be a health care quality professional.

"I'm amazed at how many people I see making $75,000 and up," she says. "But those are the organizational experts, the ones who have made themselves key players with the leadership. They've established that level of expertise, they're certified, and most either have a master's degree or are in the process of getting one." ■

Audio conference tackles HIPAA privacy concerns

The recently released final privacy rule under the Health Insurance Portability and Accountability Act (HIPAA) makes significant changes to the existing regulations. With the April 14, 2003, compliance deadline fast approaching, are your staff receiving the proper training?

Sweeping changes will be needed

The American Hospital Association says implementing HIPAA will require "sweeping operational changes" and will take "intense education of hospital workers and patients."

To help you and your staff prepare, American Health Consultants offers **HIPAA's Final Privacy Regulations: What You Must Know to Comply**, an hour-long audio conference Dec. 4, 2002, from 2:30-3:30 p.m., ET. You'll learn detailed information on changes to the privacy rule, as well as practical methods to implement new procedures within your facility.

Also learn how to successfully manage privacy issues with business associates, and how to spot and avoid costly HIPAA violations.

Do you know what your enforcement priorities are? Do you need real-world examples? Our expert speakers, **Debra Mikels** and **Chris Wierz**, BSN, MBA, will help you understand your responsibilities and identify potential liabilities. All this will allow you to develop a HIPAA-compliance strategy with a rationale behind it.

Mikels is corporate manager of confidentiality for Partners Healthcare in Boston. The Partners system includes some of the largest and most respected facilities in the country, including Massachusetts General Hospital, Brigham and Women's Hospital, and Harvard Medical School. She will provide the practical information and guidance you need to implement a comprehensive privacy policy in your organization.

Wierz is vice president of HIPAA and compliance initiatives for Houston-based Healthlink Inc., a health care consulting firm. She has worked with numerous facilities across the country to prepare them for HIPAA compliance, and now she shares many of her ideas with you.

The cost of the conference is $299, which includes free CE or CME for your entire staff, program handouts and additional reading, a convenient 48-hour replay, and a conference CD. Don't miss out. Educate your entire facility for one low price.

For more information or to register for the HIPAA audio conference, please call American Health Consultants' customer service department at (800) 688-2421. When ordering, please refer to effort code: **65151**. ■

Patient Safety Management Self-Assessment Tool

4.0 CORRECTIVE ACTION AND EVALUATION

4.1 Is information systematically collected that is pertinent to the evaluation of programmatic and functional aspects of the patient safety management system?

Score	Description
0	No formal process exists for the evaluation of programmatic or functional aspects of the patient safety management system.
1	A process exists which includes the identification of information types necessary for evaluation of the patient safety management system. Information is collected on an informal or random basis.
2	A formal system exists which includes: • identification and ongoing evaluation of important aspects of patient safety; • established frequencies for the collection of information; • collection of both programmatic and functional information; • Information covering relevant clinical operations and services.
3	A formal system exists which also includes: • collection of information from physicians and staff in all levels and functions of the organization; • collection of information by appropriate clinical units to self-evaluate performance; • processes for documenting and archiving information, which allows ease of access to trended performance data; • systems that allow for collection of patient safety concerns from patients, families, and the community.

Our Score: _____

4.2 Are processes in place that support the collection of information to determine compliance with applicable regulatory requirements and accreditation standards?

Score	Description
0	No formal process exists for determining compliance with regulatory requirements and accreditation standards, with the exception of inspections performed by external groups.
1	Internal compliance assessments are performed only as a reaction to significant adverse incidents. Compliance assessments are not performed by all departments and not for regulations/standards for which they are responsible.
2	A formal assessment program exists which includes: • a requirement that compliance assessments are performed in all direct patient care departments and for all regulations/standards for which they are responsible; • established frequencies for performing compliance assessments.
3	A formal assessment program exists which also includes: • a requirement for self-assessment by all direct and indirect patient care departments in order to evaluate their own performance; • collection of information, which verifies that the compliance assessment requirements of the department are being met; • information that is documented and archived to provide ease of access to all pertinent individuals.

Our Score: _____

4.3 Is collected information analyzed to identify deficiencies and areas of concern?

Score	Description
0	No processes are in place for analyzing collected information.
1	No written procedures exist for the analysis of information. Individual departments analyze information, but results are not shared throughout the organization.
2	A formal system exists which includes: • written procedures for analyzing information; • sharing results throughout the organization; • data analysis at functional and programmatic levels; • using subject matter experts to analyze data;

- evaluating performance indicators against performance objectives;
- assessing and tracking trended data to proactively identify areas of concern.

3 A formal system exists which also includes:
- Results are documented and reported to the board and administrative and physician leaders.
- Results are compared to internal performance objectives and external benchmarks or organizations.
- Root causes are identified and resolved.

Our Score: _____

4.4 Are corrective actions developed to prevent future adverse events, in addition to correcting the immediate problem?

Score	Description
0	No formal process exists for addressing outcomes or taking preventive actions from the collection and analysis of data.
1	Informal preventive actions are taken to address patient safety concerns. Actions are developed by people who generally will not be directly involved in the implementation.
2	A formal system exists which includes: • written action plans; • actions which address root causes; • lessons learned being developed and disseminated; • appropriate levels of clinical, management, and subject matter experts involved in action plan development; • those responsible for implementing actions being involved in their development.
3	A formal system exists which also includes: • all appropriate physicians, staff and levels of management are informed of necessary actions; • completion dates and responsibility for each corrective action are clearly defined and tracked; • development of improvement actions, which include preventive and corrective actions that support aspects that are effective and critical to success of patient safety management.

Our Score: _____

4.5 Are corrective actions verified for implementation?

Score	Description
0	No process exists for verifying the completion of corrective actions.
1	Completion of improvement actions is tracked only by those responsible for their implementation.
2	Completion of improvement actions is tracked by both the department responsible for implementation and at an appropriate management level.
3	Information is shared with both the “owning” department and administrative and medical staff leaders. Lessons learned are developed, as appropriate, and disseminated throughout the organization. Preventive and corrective actions are incorporated into appropriate procedures.

Our Score: _____

4.6 Are corrective actions evaluated for effectiveness?

Score	Description
0	No assessment process exists for checking the effectiveness of corrective actions.
1	The process owner may evaluate individual facets of the corrective actions on an irregular basis.
2	All aspects of the corrective actions evaluated. The evaluation occurs on an irregular basis. Evaluation of the corrective actions includes appropriate levels of administration and the medical staff, department managers and staff, and subject matter experts. The results of corrective action evaluations are fully documented.
3	Correction actions are evaluated on a regular basis. Results are shared with the Board and administrative and medical staff leaders. Required changes are implemented and evaluated for effectiveness.

Our Score: _____

Source: Patrice Spath, Brown-Spath Associates, Forest Grove, OR.