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Big changes ahead in JCAHO's survey process, so start working now

'Shared Visions — New Pathways': Better quality but lower scores?

The Joint Commission's new approach to surveys promises benefits and improvements over the traditional methods, but don't let your guard down just yet. Those who have tried out the new process caution that you could see worse scores under the new system, and you need to start working right now to get ready for the change in 2004.

The Joint Commission on Accreditation of Healthcare Organizations recently announced a major overhaul of the survey process, one that it promises will make accreditation more relevant to actual patient care and eliminate some of the most troublesome parts of the current survey process. Called "Shared Visions — New Pathways," the new process will require hospitals and other providers to conduct their own self-assessments before surveyors show up, and then surveyors will focus on real patients instead of theoretical compliance with standards. The new plan will go into effect January 2004 for all Joint Commission-accredited organizations.

But don't wait until then to get ready for the new system. **Angie King**, BSN, CPHQ, is quality management director at Tift Regional Medical Center in Tifton, GA, one of two hospitals that conducted pilot tests of the new accreditation process, and she says you'll have plenty to do before 2004. King is wholeheartedly in favor of the new survey process and says it will be a more effective way of measuring compliance with Joint Commission standards, but her experience with testing the new process showed her how much work will be needed.

"I believe initially more work will be necessary by everyone," she says. "Not only is the survey process different, but they're reformatting the standards. In that reformatting, it's going to force the person responsible for the Joint Commission compliance to view things along a continuum, which takes more work than what you might be used to. You can't just go to a department and ask all those standard questions they've written books about, because now it's about a patient going through many departments

and whether each one of them did things right."

The new system includes streamlined standards and a reduced documentation burden, with more focus on critical patient care issues; a 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; and a system for focusing surveyors on specific areas that need attention during their visit. A new survey system with six basic components will replace the standard triennial survey format. Physicians also will be more involved in the new accreditation process.

A task force is continuing its efforts to review all Joint Commission standards and eliminate those that are redundant or unnecessary, says **Dennis O'Leary**, MD, president of the Joint Commission. O'Leary promises that the new survey process will eliminate much of the feverish preparation that comes before every Joint Commission survey under the current method and that the new process will relate much more closely to patient care.

King says the revisions will result in "a whole new language, and we have to teach everyone that new language."

The self-assessment will be the biggest change from the current survey method, says **John Noble**, MD, chairman of the Joint Commission's Board of Commissioners. Instead of surveyors coming to a facility once every three years to look it over closely, an accredited organization will complete the self-assessment at the 18-month point in its three-year accreditation cycle. Then that facility will submit its own self-assessment ratings by a secure Internet site.

For any areas in which the organization is not compliant, it must detail the corrective actions that it has taken or will take to comply. Then a Joint Commission representative will review the report, approve it or make further recommendations, and possibly provide advice on how to correct the deficiencies that were found. 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.

Providers that are at the midpoint of their accreditation cycles or beyond 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 facilities receive the self-assessment tool, they will have three to six months to complete it and plan any corrective actions.

Change will take a lot of hard work

When the Joint Commission surveyors show up, the visit should be quite different from anything you've been through before. Instead of focusing on documentation and other administrative proof that you're complying with standards, the surveyors will use "tracer methodology."

Russell Massaro, MD, executive vice president for accreditation operations with the Joint Commission, explains that this approach will have surveyors following the experience of actual patients, using their real experiences to investigate how your organization complied with appropriate standards.

"You're going to find that it focuses more on

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actual delivery of health care, and the Joint Commission is going to provide more of a continuing evaluation of health care quality, particularly with the evaluation of ORYX data," Massaro says.

From King's experience in the "Shared Visions — New Pathways" trial, she says the survey process will encourage providers to focus more on the big picture and the spirit of Joint Commission standards rather than just proving technical compliance. Organizations will have to scrap the whole idea of "departmentalization" of Joint Commission compliance, in which departments work separately to comply and document compliance, King says. Compliance will be measured more broadly, she says, and that takes away some of the crutches quality managers have used in the past.

"Now they submit a schedule for going from one department to another at a certain time. You can expect them in obstetrics at 10:15 a.m. on Tuesday, so you make sure that obstetrics is looking sharp and has everything in order at 10:15 on Tuesday," she says. "But under the new system, you don't know when they'll show up or if they'll show up. That means you have to make sure everything is ready all the time, which is the whole goal."

King says she is optimistic the system will improve patient care and get more staff involved in compliance, but says quality professionals like herself will be busy, at least in the transition to the new system.

"I have to be more organized, more prioritized, and a better teacher in teaching the continuum, all the parties involved in caring for a patient," she says. "The quality management coordinator has been too compartmentalized. It's going to be painful to make this transition if you have a hard time with change. If you can embrace change and see the value in the new system, you can enjoy it, but I do think it's going to be more work."

Elements may show up sooner than expected

King has another reason to spur quality managers on to the new system: She says you might see parts of the new "Shared Visions — New Pathways" system cropping up in your survey experiences before 2004.

The tracer methodology, for instance, has received enough publicity that she expects the Joint Commission to start using it right away in random, unannounced surveys. The methodology is so effective in showing whether standards are truly met throughout the hospital, rather than just in particular departments, that the Joint Commission would be foolish to avoid using it until 2004, she says.

Her hospital is adopting the tracer methodology immediately, partly in anticipation of the Joint Commission using it soon and partly because it helps King break through some departmental barriers, she explains.

"I think doing the tracer system will help the quality management person tear down the silos

6 months for self-assessments, few resources will be needed

Pilot hospitals did assessments in eight weeks

The self-assessment requirement in the "Shared Visions — New Pathways" survey process may not be a shock to anyone who has used self-assessment tools already in preparing for a survey. The Joint Commission on Accreditation of Healthcare Organizations' version should be familiar and not much more trouble, says **Russell Massaro**, MD, executive vice president for accreditation operations with the Joint Commission.

In the pilot programs, the participating hospitals reported that they didn't need any new resources to complete the assessment, and most already were completing self-assessments as part of their survey preparation. The pilot hospitals completed their self-assessments in only eight weeks, though they said they would rather have three to six months. To address that concern, the new system calls for the Joint Commission to contact organizations three to six months in advance of their accreditation midpoint with information about the on-line self-assessment tool. While doing the self-assessment, organizations can click on a "references" tool to read the standard's elements of performance and examples of implementation.

As long as an organization plans appropriate corrective action, the self-assessment will not change its accreditation status, Massaro says. The Joint Commission staff also will work with organizations to develop appropriate corrective actions, again with no penalties. When it is time for the triennial survey, the surveyors will validate the organization's compliance by looking at a minimum 12-month period in which all the corrective actions were in place. The corrective actions developed with the self-assessment will be used to develop the approach used by the surveyors. ■

that develop in a hospital," King says. "Even if you only use the tracer system in a mock survey, it will help staff understand that silos are not going to help us."

For instance, King says she would use tracer methodology during a mock survey to trace a particular patient through the emergency department (ED) to a floor unit. Or perhaps, she would track a patient from ambulatory surgery, through surgery, and then admission.

"I'd go to that patient's current position, talk to the patient, then start an open record review and back your way out," she says. "You do the survey components in each one, all the way back to the [ED] where they came in. You can see the different routes that patients take, whereas current surveys could just look at a couple of areas and never see most of the areas a patient goes through."

The tracer methodology has a real impact on clinical staff, King says. A patient's chart or other care notes start to have more meaning when the hospital emphasizes continuum of care and the tracer methodology, she says.

Overall, the clinical staff start to see that Joint Commission standards are more than just academic exercises. "This methodology forces the ICU [intensive care unit] nurse to really look at what the [ED] nurse is sending up with the patient," she says. "It's not just a verbal report coming up that you can forget once the patient is in your unit. And likewise, the ED nurse has to think this isn't a patient that I'm done with because he's gone to the ICU. The continuum of care is everything."

More consistent surveyors and lower scores?

Massaro says the new system includes more stringent requirements for certifying Joint Commission surveyors. Surveyors who fail the certification exam must undergo remedial studies before they are allowed to be the surveyor of record, and they only get three tries at passing the certification exam. All surveyors must be recertified every five years.

King suspects that the new training promised for surveyors under the "Shared Visions — New

Process will direct surveyors to areas needing attention

Process aims to reduce unconscious surveyor bias

A primary goal of the "Shared Visions — New Pathways" survey process is to make the system meaningful instead of concentrating on rote recitations of standards or paperwork that seems to indicate compliance but may not.

To that end, the Joint Commission on Accreditation of Healthcare Organizations plans to use a priority focus process (PFP) that directs surveyors to the organization-specific, critical patient care processes and systems most useful for assessing compliance and quality of care.

The PFP guides the entire survey process by providing surveyors and Joint Commission central office staff with insight and information about your organization long before the survey. According to information provided by the Joint Commission, the PFP will be driven by an automated tool called the priority focus tool (PFT) that gathers pre-survey data from internal and external sources.

Those sources include the Joint Commission's quality monitoring system, ORYX data, self-assessment information, accreditation history, and an organization's own demographic and statistical information. The tool uses automated sets of rules to sort the data and turn them into valuable information that focuses the on-site survey on critical areas of focus.

In addition to making the survey process more relevant to each organization, the PFP also promises to virtually eliminate any unconscious surveyor bias or habit in the survey's focus. Organizations with the same profile should have a consistent, predictable set of priority focus areas.

The Joint Commission offers the example of an organization with a large geriatric population and a high volume of medical admissions. The number of prescribed and dispensed medications is expected to be higher than that of an organization with mainly elective surgery populations, so medication-use issues would be critical. For the same facility, another focus area might be do-not-resuscitate orders and end-of-life care.

Critical focus areas are defined as processes or systems in a health care organization known to significantly affect patient safety and quality of care. If these processes fail, the Joint Commission says, there is a higher probability of negative outcomes.

These are the 14 areas of critical focus that the Joint Commission has identified and which the PFP can direct surveyors to investigate closely: patient assessment, communication, credentialing, equipment use, infection control, information management, medication use, organizational structure, staff orientation and training, rights and ethics, physical environment, quality improvement expertise and activity, safety engineering, and staffing. ■

Pathways" program will reduce surveyor variability, a frequent complaint from accredited organizations. But she also thinks the new system could be tougher and result in lower survey scores. Lower scores could result in part from the way the new system will rely on a review of fewer medical records than the current system.

Instead of surveyors sampling a number of records to look for specific points of compliance, the tracer methodology will have the surveyors looking at numerically fewer records as they follow actual patients through the system.

"The impact on records reviews will mean a smaller denominator, which makes keeping records correct even more important," she says. "You're not going to have a large number of records reviewed, so if you have a problem with a few, you can't say they're just a small percentage. The smaller size record review means there's a good chance for a lower score."

King says quality managers should get to work right away in preparing for the new survey system, first by keeping close track of the information released by the Joint Commission. New details will be released in the coming months about how to do the self-assessment and what standards are being changed.

She also says every hospital or health care organization should make sure that someone "knows the format and standards better than the surveyors when they come rolling in. Know it inside and out."

Though the hospital's experience with "Shared Visions — New Pathways" was only a test run, King says Tift Regional Medical Center has improved as a result. The hospital tested the new system in June, with Joint Commission surveyors using tracer methodology to check compliance, and then the hospital's *real* triennial survey came two months later.

The real survey was conducted under the current, traditional method, but King says the pilot project had lasting benefits. Tift Regional scored 97 on its triennial survey, and the hospice scored a perfect 100. King attributes part of that success to the staff's trial experience with the upcoming survey process.

"The pilot project helped the staff become comfortable," she says. "Their ease in conversation in August was so much better because they understood it more. They saw how the standards really applied to patient care, that it was more than just whether the record shows a notation for a nutritional consult."

[For more information, contact:

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Accreditation decision will be handled differently

Details still are being worked out

The Joint Commission on Accreditation of Healthcare Organizations still is working out the details of how it will render an accreditation decision and how it will communicate that decision.

But information provided by **Russell Massaro**, MD, executive vice president for accreditation operations with the Joint Commission, indicates that some changes are in store in this area as well.

The new format, still being developed, should result in an accreditation decision and performance report that are more meaningful both to the organization and the general public, he says.

If the Joint Commission's Board of Commissioners approves, the accreditation decision categories should be changed for January 2004.

"Accredited with Full Standards Compliance" will be changed to simply "Accredited." Also, "Accreditation with Requirements for Improvement" will be deleted altogether.

Those changes are intended to reflect the new survey process in which needed improvements are carried out before the Joint Commission's final report and eliminate any distinction among accredited organizations. Organizations that receive Type I recommendations will have 30 days to submit a corrective action plan, and their accreditation status would not be changed during that 30 days, Massaro explains. At the end of that period, successful fulfillment of the recommendations will result in "Accredited" status.

If the organization still has recommendations outstanding at that point, it will be assigned the new category of "Accreditation Pending." The requirements for improvement would be subject to disclosure on performance reports. Other decision categories would not be changed. ■

Quality reports and ratings may not impress patients

Evaluations not growing in influence, either

One strategy for improving the quality of health care is to evaluate providers and plans, and to publish the results to help consumers make more informed choices.

Unfortunately, according to data from Rochester, NY-based Harris Interactive, the publication of ratings and rankings of health plans, hospitals and physicians has had almost no impact on the choices that consumers make.

While millions of people have seen these lists, hardly anyone (1% or less of adults) has changed providers or health plans as a result.

Furthermore, a comparison of 2001 and 2002 data finds no evidence that these evaluations are growing in influence.

These findings make important, but depressing, reading at a time when there is much talk of health care consumerism, the importance of consumer choice, the emergence of "consumer-directed" health plans, and a more market-driven health care system.

To evaluate the influence of published ratings, Harris Interactive asked a nationwide sample of 1,013 adults, via telephone in June 2002, whether they could remember seeing any ratings of hospitals, health plans, and physicians; whether they had considered making a change based on these ratings; and if so, if they actually had made a change.

The results unequivocally show that many millions of people have seen such ratings but that only 1% or less of all adults have made a decision (to change plans, physicians, or hospitals) based on these listings.

In other words, these published lists of ratings, which rank different plans and providers, have had virtually no impact on consumer choice. This is the second survey that asked these questions. A virtually identical survey of 1,008 adults surveyed in June 2001, suggests that the influence of published ratings is not increasing over time. The results are disappointing for those who believe in the dissemination of objective quality ratings.

Insofar as there were any changes from 2001 to 2002, they show modest increases in those who remember seeing ratings of hospitals and plans (but a small decrease for physicians) and no increase in influence. All of the changes are relatively insignificant statistically.

[For more information, contact:

*• **Harris Interactive**, Corporate Headquarters, 135 Corporate Woods, Rochester, NY 14623-1457. Telephone: (800) 866-7655.]* ■

Detroit hospitals put their disaster plans to the test

11 area hospitals participated in smallpox drill

Hospitals are paying much more attention to their Joint Commission on Accreditation of Healthcare Organizations-mandated emergency preparedness plans now that terrorist threats could call them into action at any time. Hospitals in the Detroit area recently tested their plans with a regional disaster preparation drill.

The drill was a collaboration among 11 hospitals in Detroit, including Children's Hospital of Michigan; Detroit Receiving Hospital; Harper University Hospital; Henry Ford Hospital; Huron Valley-Sinai Hospital; St. John Detroit Riverview Hospital; Specialized Complex Care Inc.; Sinai-Grace Hospital; St. John Hospital; St. John Northeast Community Hospital; and the Veterans Affairs Medical Center, as well as Bon Secours Hospital in Grosse Pointe. Volunteers taking part in the drill acted as patients and were dressed with the early physical symptoms of smallpox.

Starting at about 7 a.m., volunteers began arriving at the participating hospitals, where emergency department personnel were unaware of the drill. The "no-notice" drill was planned for nearly a year, says **Jenny Atas**, MD, chair of the regional planning committee for the City of Detroit's Local Emergency Planning Committee. The drill continued until 1 p.m. "We wanted to test the internal emergency processes and responses of our area hospitals. Keeping the time, date, and details of the drill a secret was key to its effectiveness."

Atas also is the chair of the Emergency Preparedness Committee for the Detroit Medical Center.

In addition to personnel from the participating hospitals, the nearly 50-person drill-planning committee consisted of representatives from the Detroit Health Department; the Michigan

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Decision-aid tool helps patient communication

Outcome measurement leads to patient education

Outcome measurement at University of Washington Medical Center in Seattle typically is tied in some way with quality improvement office initiatives. Therefore, to improve patient education, staff recently looked at the quarterly patient satisfaction reports the medical center receives from a vendor.

Several questions on the survey pertain to communication- and education-related aspects of the patient's care experience. "We homed in on one of our lower-performing areas, and that was 'getting answers to your questions in a way you could understand,'" says **Cezanne Garcia**, MPH, CHES, manager of patient and family services.

To help patients get the information they need, a committee developed a decision-aid tool titled "About Your Visit." The pamphlet cues patients and/or family members through questions they might ask when they come for their visit with their health care provider, she reports.

It covers all medical areas, prompting questions on everything from medications to equipment, and it has space for patients to write answers. "We really wanted a tool that would be useful across the continuum," Garcia says. Patients are encouraged to select two or three questions from the list that reflect their main concern. This method for using the tool is suggested because clinicians were concerned about patients coming in for an appointment armed with 20 questions, she explains.

To determine if the new pamphlet would be effective, it first was reviewed by 20 patients for readability, and to determine if the questions gleaned from similar tools found in the literature and at other institutions represented the main concerns of patients at the University of Washington Medical Center.

Once the pamphlet was perfected, it was pilot tested in two waves during the course of a month. About 150 patients during each test period were given the pamphlet when they came in for their appointment and asked to fill out a survey before they left. They were given the option to mail the survey back, but most completed it before leaving the clinic.

The questions on the survey were modeled after those the vendor asked patients on its quarterly patient satisfaction survey. In addition, a few questions about the pamphlet's usefulness were added. The questions were designed to determine if the patients' main concerns were addressed during their visits and their questions answered in a way that they understood.

The front-desk staff distributed the pamphlet at the time that patients checked in for their appointments. They handed the pamphlet to the patients and said: "Your questions are important to us. At this visit, be sure to write them down. Here is a tool to help you with that."

Also, at a clinical staff meeting, clinicians were encouraged to ask patients during the pilot test if they had written down questions they wanted answered. Extra copies of the pamphlet were placed in the room so the clinician could point to it and ask the patients if they had any questions from the handout they were given that they wanted addressed, Garcia says.

The rapid-process, quality-improvement initiative provided enough data to launch the pamphlet systemwide. Small margins of change were revealed during the pilot test that were significant enough for the methodology used, she says.

However, the real test came when results from the next quarterly patient satisfaction survey were released from the vendor. "We have seen significant changes. In all areas, we hit the median; and some areas, we went beyond that," she adds.

While many other factors could have impacted the results, there clearly was a change during the first quarter after releasing the tool to all clinical areas, Garcia says. Regardless of how many patients come into the exam room with the tool completed, it helps staff remember to ask at the beginning of the visit what the patient's main concerns are. "It's currently a way to trigger communication," she says.

The brochures are distributed in clear plastic holders in all areas of the clinic. Many outpatient areas also send the brochure with patient appointment notices.

During the pilot, many patients said it would be helpful to receive the brochure before their visit. While inpatient areas can use the brochure, its greatest impact has been in the outpatient area, says Garcia.

The brochures were created with the aid of a Microsoft Word-based template patient and family services uses to produce patient education materials. It costs the medical center 18 cents to create each brochure.

Similar decision-aid tools can be purchased, but the last two pages of the brochure created for use at the University of Washington Medical Center lists resources such as education kiosks in waiting room areas and small resource centers on some floors and clinics. It also encourages people to look at a few select web sites.

"It was a way to encourage the concept that we welcome and encourage their self-directed learning," says Garcia. However, the first resource for patients listed on the brochures is the clinicians, and the brochure copy emphasizes the importance of partnering with the health care team.

"We continue to score well in this area [communication and education], and we know from our stocks and materials management that the brochures are being used," she adds.

[For more about creating a decision-aid tool to improve communication and education, contact:

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Make a good thing better: One hospital's rallying call

Satisfied staff equal satisfied patients

How does a hospital get a No. 1 ranking and score in the 99th percentile on the South Bend, IN-based Press Ganey Associates patient satisfaction survey? It might have something to do with taking a good situation and continually trying to improve it.

A new customer service initiative in the admissions department at Wake Forest University Baptist Medical Center in Winston-Salem, NC, started because, while the customer service numbers always were good, "we knew we could make them better," says **Ponetta Barber**, admissions manager. "We asked our staff members, 'What are things we could do that would specifically improve our area?'"

Admitting staff came up with ideas such as giving patients and their families complimentary meal tickets or valet parking passes when they have to wait for a room or are inconvenienced in some other way, she says.

Admissions also works closely with the patient relations staff in such situations, Barber adds, contacting that department when patients have waited for an extended length of time. "They send gift baskets, flowers, or something else they think is appropriate to the patient's room."

It also is admissions department policy for an employee to check in every 15 minutes with patients who are waiting for a room, she says. When patients have been waiting an hour, the employee notifies Barber or admissions supervisor Regina King, "and we go out and talk to the patient as well," Barber adds. "It's just a conscious effort to make us all more aware that patients are waiting."

For each of the two quarters, the hospital achieved the No. 1 rating and scored in the 99th percentile on the Press Ganey survey, she says, and the extra customer service push began shortly before that period.

Keith Weatherman, CAM, associate director of patient finance, says he believes the high employee morale and extremely low turnover rate in the admissions department are major components in the customer service achievement.

"It probably boils down to just recognizing that they are more than employees, they're people, and treating them with respect all the time," he adds, crediting the "family-type atmosphere" that Barber fosters.

Many of the admitting staff have been with the department 10 years or more, Barber notes. Most employees are cross-trained, she says, and are flexible about switching areas and doing "whatever it takes to get the job done."

That might involve working in any of the areas under her supervision, which include admissions, bed control, patient escort, ancillary clinics, and scheduling, and if necessary, she says, helping out in the emergency department, which is under another manager.

On an employee climate survey conducted last spring, Weatherman points out, the admissions

department exceeded its score on the previous survey and did better than the rest of the hospital. "They don't wait for that [measurement], though," he adds. "They're constantly doing a sort of internal climate survey, making themselves available and listening to staff."

"We held meetings with staff and asked them about the barriers they encounter in their everyday jobs," King says. "It's important that we give them feedback on that."

Complaints aired at the meeting were taken care of quickly and, if that wasn't possible, employees were kept apprised of the situation, Weatherman adds. "We didn't just leave them hanging."

Employees were concerned, for example, that the department didn't have enough wheelchairs and carts for transporting patients and their belongings to the nursing units and that a lounge chair was needed for patients who had to wait for awhile, he says. "Nothing was outrageous. They asked, for example, if housekeeping could do a better job of cleaning a particular area."

The department's extensive training program is another contributor to employee and patient satisfaction, Weatherman suggests.

New admitting employees receive a week of initial training with the hospital's verification and quality services staff, Barber says, and continue to get on-the-job instruction within the admissions department.

"[Training] goes on for several months," King adds. "There is a training checklist at least four pages long. New employees sit with more experienced employees and get hands-on training."

The verification and quality services department, meanwhile, reviews demographic and financial information for accuracy, Weatherman notes, and admitting supervisors distribute the results to employees.

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Bedside registration: Wireless system's a hit

Technology, focus on efficiency produce results

Bedside registration in the emergency department (ED) and a new transfer center are the latest innovations helping to define the department of patient access and business operations at Philadelphia's Presbyterian Medical Center.

The creation of the new department began in July 2001 with the hiring of **Anthony M. Bruno**, MPA, MEd, as director of patient access and business operations.

"When we spoke before," he adds, "[the admissions department] was only open five days a week. As of July 1, we're open seven days a week, and the hours are 6 a.m. to midnight. It's all part of developing a department that didn't exist a little over a year ago."

Although a wireless system for bedside ED registration has been approved recently, the ED process has greatly benefited from the paper bedside registration already in place, Bruno reports. "We've moved the registration process from the front-desk triage window to the bedside. We're working with the clinicians to get the patients back to the exam rooms more quickly and to not have people languishing in the ED waiting area."

In addition to enhancing patient satisfaction, bedside registration has reduced the left-without-being-seen number that every ED tracks, he notes.

Another advantage of wireless bedside registration will be its ability to coordinate with the EMTRAC (emergency medicine tracking and charting) system, a product that allows clinicians to enter orders and chart information for ED patients directly into the computer, he says.

In effect, the ED will be paperless, he says, "with everything entered [directly] into the system. By having wireless [registration], we'll be able to put in that information more quickly, which will allow [clinicians] to do their EMTRAC more quickly. It will help expedite charges for the billing system as well."

One of the biggest accomplishments of the fledgling patient access and business operations department has been the establishment of the transfer center, Bruno says. Helping to oversee that effort, he notes, has been admissions manager **Karen Randall**, one of several members of the management team Bruno assembled soon after taking his position. "Karen and her staff have worked to set up a much tighter screening process for patients who arrive uninsured and candidates to be transferred," Bruno reports. "We have the ability to screen patients and make decisions as to whether we can accept patients who are uninsured from other facilities. We have a very strong insurance pre-certification process

that wasn't in place in the past."

Immediately after a physician from another hospital calls a physician at Presbyterian Medical Center to ask about transferring a patient, Randall explains, "we turn around and call the other hospital and ask for an admission sheet."

"When we find out the patient is uninsured," she continues, "we ask why the patient needs to come here. Then we contact the financial counselor, and she calls the referring hospital to find out if a Medicaid application has been started for the patient. If so, we continue where they left off. If not, we start one. Once we find out there are no hitches, we approve the transfer. It usually takes about three hours."

"This is another example of admissions and the business office working together as a team," Bruno adds.

A physician is brought into the process to decide whether there is a medical need for the patient to be transferred to Presbyterian, Randall says. "[The physician from the other hospital] has to plead the case, and it has to be clinically approved." Before a formal admission process was established for transfers in January 2002, "patients were just called in and transferred with no questions asked," she notes. "It was just like an open-door policy."

In the case of a patient who is insured, Randall says, an access employee calls the insurance company to confirm that the coverage is in place and that the hospital participates in that insurance plan. "Then we go back to the bed board and confirm that a bed is available. It takes about half an hour." If there is a problem with the insurance, she notes, the hospital administration makes the decision on whether to accept the patient.

Efficiency decreases amount of free care

As a result of the new transfer process, the amount of free care provided by the hospital has declined, Bruno points out. "It's not that we don't want to give free care," he explains, "but we want it to be something we control."

Broadening its scope in another direction, the admissions center recently began performing all the insurance pre-certification and verification for the 35 physicians in the hospital's cardiology groups, Bruno says. "We made the commitment because cardiology is one of the major product lines, and [the physician groups] had difficulty trying to manage all of the pre-cert requirements. We felt we could help them do it very efficiently."

"We started the pilot in March, with four physicians and one practice, and as we were praised and given accolades, everyone wanted to jump in," notes Randall, who previously worked as the manager of admissions and outpatient services for a specialty heart and lung center. "By June, we took on all the cardiology practices."

Although no formal figures were available, the amount of collections has increased since admissions took over the pre-cert duties, Bruno says. "There are no more denials because insurance companies were not called. All authorizations are put into the [admission / discharge / transfer] system and go to the [case managers] so they have the information at their fingertips."

In the past, he adds, insurance companies often were called two or three days after patients arrived, resulting in reimbursement "carve-outs" for the days that weren't preapproved. "We are now looking to expand to the department of surgery and perhaps orthopedics."

To handle the increased duties, the admissions center recently hired a second pre-certification coordinator, Bruno notes. "On the outpatient side, we've taken on the responsibility for registering the cardiology patients as well."

As part of what Presbyterian Medical Center's practice partnership program, he has put together a hospital services directory describing the different services offered at Presbyterian Medical Center. The directory was designed to be a guide for physician offices, allowing them to more easily contact various departments within the hospital, Bruno adds.

"If you want to contact medical imaging services, for example, the directory will tell you the location, the phone and fax numbers, the hours of operation for inpatients and outpatients, and lastly, will describe who the management is," he explains.

Although there is a telephone book for the University of Pennsylvania system, it has about 300 pages, he points out, making it difficult to pinpoint the right number for the specific service needed. The book also gets out of date pretty quickly, Bruno notes.

"We've gotten a lot of feedback [from physician offices], and they love it," he says. "They've asked for multiple copies to give to the staff."

[For more information, contact:

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(Continued from page 166)

Community Health Department, the Detroit Fire Department Divisions of Emergency Management and Emergency Medical Services, and the Wayne County Public Health Department. The proposed drill was approved by the Detroit mayor's office.

"This is the first time this many Detroit area hospitals have come together, collaborating with the area health departments and other agencies, on an emergency preparedness drill," Atas says. "Not only was the drill very successful in testing our medical personnel, but we've established a connection within the core group of individuals that can be quickly activated in the event of a true large-scale emergency."

In accordance with major communicable disease policy and planning established by the state of Michigan and implemented by the hospitals, the Detroit Health Department and the Michigan Community Health Department were appropriately notified of the diagnoses of the "patients," which is a critical step in limiting exposure to the general population.

"Our hope was that the medical teams at the participating hospitals recognized the symptoms of smallpox and implemented the proper emergency and notification procedures," Atas says. "We're very pleased with the outcome of the drill."

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Nursing shortage can affect patient survival

The continuing shortage of nurses in the United States has a direct effect on patients' survival after surgery, according to a new study.

Linda H. Aiken, MD, and colleagues at the University of Pennsylvania in Philadelphia surveyed more than 10,000 staff nurses and reviewed medical data on more than 230,000 general, orthopedic, and vascular surgery patients discharged from one of 168 Pennsylvania hospitals over nearly two years. They found that the patient-to-nurse ratio ranged from less than 4-to-1 to more than 8-to-1. (*JAMA* 2002; 288:1,987-1,993.)

Aiken says the research revealed a correlation between a higher patient-to-nurse ratio and an increased risk of patient death. For each additional patient per nurse, the risk of dying within 30 days of surgery increased 7%.

The research also revealed high levels of emotional exhaustion and job dissatisfaction among nurses, especially those with the heaviest workloads. Those in hospitals with the highest number of patients per nurse were more than twice as likely to report burnout and were nearly twice as likely to report dissatisfaction with their jobs than the nurses with fewer patients to care for. The authors suggest that improving staffing and reducing nurse turnover ultimately could lower hospital costs in addition to saving lives.

The authors say their findings also support a California law that will go into effect next year mandating that one nurse can care for no more than six patients at once. That law ultimately would require that nurses have no more than five patients under their care.

[For more information, contact:

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NCQA: Quality measures up for third year in a row

Improvements seen in more than 12 key measures

For the third year in a row, health care quality in the United States improved substantially, despite broad public concerns over cost, the uninsured, patient safety, and other systemwide ills, according to a new report from the Washington, DC-based National Committee for Quality Assurance (NCQA).

The group's "State of Health Care Quality" report documented significant improvements in clinical performance on more than a dozen key measures among selected health plans serving the Medicare, Medicaid, and commercially insured populations.

The report also found that, despite these improvements, more than 6,000 deaths and 22 million sick days could be avoided annually if

the "best practice" care found at the nation's top organizations were adopted universally, says **Margaret E. O'Kane**, NCQA president.

She says the encouraging results in the report reflect the health care available to 71 million Americans enrolled in various health care organizations that measure and report on their performance. Information about the performance of the rest of the U.S. health care system is either nonexistent or unavailable.

"This year, 13 health plans delivered beta-blockers to 100% of patients who had a heart attack. That's the payoff for measuring quality," O'Kane says. "But we have work to do. A large part of the health care system still doesn't measure anything."

Among the positive findings in this year's report were substantial gains on a range of clinical measures reported by commercial health plans. For example, between 2000 and 2001, the percent of patients who had their high blood pressure under control rose from 51.5% to 55.4%. In 1999, this rate was 39%.

Fifty million Americans have high blood pressure, which, left uncontrolled, can cause stroke, coronary heart disease, kidney failure, and blindness. Cholesterol control rates have registered similar increases.

Among commercial managed care organizations, 59.3% of heart attack patients had their cholesterol under control in 2001, nearly a six-percentage-point increase from the previous year, and up 14 percentage points from 1999 levels. High cholesterol can cause coronary artery disease, a condition afflicting 15 million Americans.

Medicaid, Medicare strong performers

NCQA's report includes performance results from Medicaid and Medicare organizations for 2000. When viewed against results from the same year for the commercial sector, the data reveal that on the whole, the care received in the three sectors is comparable, a finding of special note considering the demographic and access issues faced by the public programs.

For example, in 2000, 89.4% of heart attack patients in commercial organizations received beta-blockers, vs. 89.3% in Medicare plans and 82.9% in the Medicaid program. Beta-blockers are extremely effective in reducing the chances of a second heart attack and increase long-term survival rates by as much as 40%.

Notably, Medicaid and Medicare organizations actually outperformed commercial plans in several measures. In terms of chlamydia screening for women ages 16 to 20, 23.6% of women enrolled in commercial organizations were screened, vs. 37.4% in Medicaid. And Medicare plans outscored the commercial sector on every single measure of diabetes care when comparing rates for 2000.

As has been the case in the commercial sector, there was a considerable difference in performance between Medicare organizations accredited by NCQA and those that were not.

In one key example, 57.8% of heart attack patients enrolled in accredited Medicare organizations in 2000 had properly controlled cholesterol levels, as opposed to 44.1% in nonaccredited plans.

That difference should hold a lesson for quality and peer review professionals, says **John Rother**, director of legislation and public policy for the American Association of Retired Persons in Washington, DC.

"The gaps between accredited and nonaccredited plans are compelling. They suggest that Medicare beneficiaries would benefit tremendously from a plan that is accredited and accountable," he says.

"In light of these results, all Medicare managed care should commit to meeting the NCQA accreditation standards, for the sake of their patients and their public standing."

Measurement promotes quality

Also for the first time, the report examines the impact of physician-level quality measurement and reporting. Since 1997, NCQA and the American Diabetes Association have cosponsored the Diabetes Physician Recognition Program (DPRP), which recognizes physicians who deliver superior diabetes care.

To participate in the DPRP, individual physicians or medical groups voluntarily submit data related to the treatment of their patients with diabetes. If their performance meets or surpasses national benchmarks, they earn recognition and receive referrals from the two sponsoring organizations. The cumulative performance of participating physicians demonstrates in no uncertain terms that measurement at the provider level is an effective means of promoting quality.

Performance scores among DPRP-recognized physicians far exceed national averages on every single measure of diabetes care, making patients

of these providers far less likely to suffer adverse health conditions (such as blindness or diabetes-related nephropathy) as a result of their disease. For example, 98% of patients with diabetes who saw a recognized provider received at least one hemoglobin A_{1c} (blood sugar) test, as opposed to 81.4% of patients enrolled in commercial organizations.

The rate of patients with poorly controlled blood sugar levels was 9% among recognized physicians, as compared to the commercial rate of 36.9%. (For this measure, a lower rate indicates better performance.)

The NCQA also announced that draft standards for its Human Research Protection Accreditation Program (HRPAP) soon would be released for public comment. The standards address areas identified by the Institute of Medicine's (IOM) Committee on Assessing the System for Protecting Human Research Participants.

Jessica Briefer French, NCQA assistant vice president for human research protection says accreditation can help investigators, sponsors, and research organizations demonstrate their commitment to protecting the rights and well-being of research participants.

Since last year, NCQA has accredited the human research protection programs of Veterans Affairs Medical Centers through its Veterans Affairs Human Research Protection Accreditation Program (VAHRPAP).

In the 2001 report, "Preserving Public Trust: Accreditation and Human Research Participant Protection Programs," the IOM cited NCQA's VAHRPAP standards as being "the strongest basis for use in the accreditation of research institutions." As such, the VAHRPAP standards were used as the foundation for the new program. The IOM's latest report highlighted accreditation's "considerable potential to systematize and accelerate quality improvement [QI] processes," and specifically noted NCQA as having "identified numerous areas in which it will review program QI activities."

In addition to addressing QI, the draft standards incorporate other key areas identified in Responsible Research as meriting increased attention. These include comprehensive reviews of research protocols, participant-investigator interactions, risk-appropriate safety monitoring, conflict of interest management, and ongoing informed consent. The draft HRPAP standards will be posted on NCQA's web site Dec. 2, and NCQA will accept comments through mid-January.

[For more information, contact:

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THE QUALITY - CO$T CONNECTION

Part 1 of 2

Improve quality with systems thinking

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

Is your organization plagued by performance-improvement initiatives that fail to achieve their intended goals? Are gains short-lived? All too often, desired change takes time, and we're on to the next project without realizing the last one wasn't successful.

Why are plans to change people's performance so often thwarted? If we don't ever ask this question, we won't learn. If we don't learn, we are more likely to continue wasting resources on ineffective improvement projects. The cost of failure goes far beyond the price tag of the project.

Demoralization of physicians and staff involved in the project is a frequent and costly consequence of failure.

To gain success from improvement projects, we need to understand more about what actually governs people's behavior. It's been demonstrated over and over again that people's actions are influenced by the system in which they work. When improvement projects fail, it generally is because the actions taken to affect performance were non-systematic — meaning that no attempt was made to change the system in which people work.

For example, after training everyone in customer service, we expect people to do the right thing and customer satisfaction scores will improve. In practice, staff behavior in front of patients and their families is governed by the system. If the system makes it hard to provide outstanding customer service, no amount of training will change staff behavior.

This is the first of a two-part series on the

fundamentals of systems thinking. By applying systems thinking, people in health care organizations can gain a better understanding of the causes of improvement project failures.

To achieve performance improvement successes, we must learn how to view our organization as a system and understand the implications of the system on the performance of individuals. A system is a whole made up of parts.

Each part can affect the way other parts work, and the way all parts work together will determine how well the system works. The Joint Commission on Accreditation of Healthcare Organizations transitioned the accreditation standards to a systems approach many years ago, and now we need to do the same in our thinking.

Traditionally, we have improved performance in our health care organizations by managing the separate pieces (nursing, pharmacy, medical staff, laboratory, operating room, etc.). Managing in this way can cause friction when parts of the organization set about achieving improvement goals at the expense of the whole.

It's time to come to terms with the system issues that affect poor performance. Studying failure is a good way to learn how your organization works as a system. For instance, when customer satisfaction scores don't improve following organizationwide training, determine why the system doesn't support the delivery of outstanding customer service. Find and fix the features of the system that impact quality of service and consequently impact the behavior and attitude of frontline staff.

Changing the perceptions of patient care

Systems thinking requires that we change the way we perceive patient care services.

Traditionally, we've had a top-down hierarchy, with decisions about how work is performed separated from those who actually do the work. Most health care organizations are designed and managed this way.

While we have learned to think of our organizations as top-down hierarchies, they don't look like that to our patients. Our customers have a much different view of the organization. When you look at health care services from the patient's point of view, the organization may appear fragmented and very unproductive.

While we might think of health care services as being managed and controlled through functional hierarchies, in practice, work "flows" through the organization. System design can impede workflow; thus the first step toward improvement is learning to manage the flow. To manage the flow, you must think of how your organization should respond to the needs of patients and their families. Think of it this way: If your health care facility responds to patient demands by doing what the patient wants, your service will improve.

If your goal is to manage workflow, then you need measures that tell you about how well the work is flowing through the organization.

Here's an example: The hospital pharmacy

CE *questions*

CE subscribers: This concludes the CE semester. An evaluation form has been enclosed. Please return in the envelope provided.

21. What score did Tift Regional Medical Center in Tifton, GA, receive on its most recent triennial survey?
    A. 95
    B. 96
    C. 97
    D. 98

22. Which of the following is not one of the 14 areas of critical focus identified by the Joint Commission on Accreditation of Healthcare Organizations?
    A. equipment use
    B. risk management expertise
    C. information management
    D. staff orientation and training

23. According to data from Harris Interactive, what percentage of consumers have changed health care providers or plans based on quality reports and ratings?
    A. 12%
    B. 8%
    C. 5%
    D. 1% or less

24. According to a report from the National Committee for Quality Assurance, more than 6,000 deaths and 22 million sick days could be avoided annually if the "best practice" care found at the nation's top organizations were adopted universally.
    A. true
    B. false

Answers: 21. C; 22. B; 23. D; 24. A

department receives many calls each day from nursing staff, physicians, billing office personnel, former patients, and other customers. The purpose of the pharmacy is to create value for the customers who call by providing accurate and timely information. The pharmacy manager has been measuring "time to answer" the phone. Investigation showed that more than half the incoming calls might have never occurred had people throughout the organization done what customers expected the first time. Many of the phone calls concerned billing errors originating from the finance department; failures to notify the pharmacy of a new physician order; inadequate communication between pharmacists, nurses, and physicians; and other customer service failures throughout the organization.

When it comes to measurement, we often view the health care organization in parts. We put in place performance measures that account for parts of the organization separately.

The prevailing thinking seems to be that if each part of the system performs as specified, then overall, the system will perform as expected. Nothing could be further from the truth. Some performance measures should be put in place to identify how often system failures are affecting the performance of the parts.

Change for improved performance means changing the system. Any intervention in a system which does not alter people's thinking will produce no change. This is why quality improvement training often fails to improve performance over the long term. It's not just a matter of learning new tools — the everyday practical matters of workflow and systems design must be dealt with. Once people have a better understanding of how work gets done, their behaviors will change.

Altering the system means taking out things that limit or damage current performance. This means that hierarchical barriers may need to be removed, control mechanisms revised, and processes refined.

Improvement actions must be aimed at putting in place the right "system conditions" to ensure that performance is managed from a strong base of workflow understanding.

When you can see your organization as a system, warts and all, you learn about the "what and why" of current performance. You can see what could be achieved, and moreover, you can see what needs to change to realize the potential improvements.

Taking a systems view is totally different view from the traditional, hierarchical view. The traditional, hierarchical view is to look at the organization as having parts or functions. The systems view is to look at the whole and understand how the parts work together. ■

Smallpox vaccinations imminent for hospitals

The Atlanta-based Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) recently approved a plan that calls for smallpox immunization of 510,000 health care workers.

The plan suggests that all hospitals should designate a "smallpox care team" that should be immunized prior to any release of the virus. The committee recommends that the team include a minimum of 40 health care workers per hospital, with some hospitals vaccinating 100 or more, including emergency department physicians and nurses, infection control professionals, intensive care unit nurses, infectious disease consultants, radiology technicians, respiratory therapists, engineers, security, and housekeeping staff.

To help you prepare for sweeping procedural changes, American Health Consultants offers **Imminent Smallpox Vaccinations in Hospitals: Consequences for You and Your Facility**, a 90-minute audio conference Wednesday, Dec. 11, from 2-3:30 p.m., EST. This session is designed to help you and your staff answer serious questions and prepare your facility for the inevitable. How will being vaccinated affect you? How do you protect yourself, patients, and family? What are the logistics of implementing a smallpox care team? How do you deal with vulnerable populations?

COMING IN FUTURE MONTHS

- CMS targets nursing home quality
- Integrating patient safety into QI efforts
- Grading your compliance with pain management standard
- Joint Commission surveyor training — what you can learn from it

How do you minimize side effects?

This panel discussion will be led by **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville, TN. A veteran, award-winning epidemiologist who has seen actual cases of smallpox and currently oversees a volunteer smallpox vaccine study at Vanderbilt, Schaffner began his distinguished medical career as a medical detective in the CDC's Epidemic Intelligence Service. He also is a liaison member of ACIP. Schaffner and an expert panel of emergency and infection control professionals will help you prepare for this critical task.

The second speaker, **Jane Siegel**, MD, is a professor of pediatrics at the University of Texas Southwestern Medical Center in Dallas. The author of several books on infection control issues, Siegel has emerged in recent years as a key CDC advisor. As a member of the CDC Healthcare Infection Control Practices Advisory Committee, she is on a bioterrorism working group that reviewed the critical issues regarding smallpox vaccine. Showing a clear knowledge of the pros and cons of the various options, Siegel presented the working group's research to ACIP.

The third speaker, **Joseph J. Kilpatrick**, RN, NREMT-P, is an adjunct instructor with the Texas A&M University, Texas Engineering Extension Service in College Station, where he develops courses and provides training on weapons of mass destruction and emergency medical services (EMS) courses to EMS professionals throughout the United States.

The cost of the program is $299, which includes 1.5 hours of free CE, CME, and Critical Care credits. ACEP Category I credit approval for the conference is pending. You can educate your entire facility for one low fee.

The facility fee also includes handout material, additional reading and references, as well as a compact disc recording of the program for continued reference and staff education. For more information, or to register, call customer service at (800) 688-2421. When ordering, please refer to the effort code: **65341**. ■

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- 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.

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