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JCAHO announces upcoming shift to unannounced surveys

New policy requires change in approach to compliance activities

The Joint Commission on Accreditation of Healthcare Organizations' recent announcement that it will switch to unannounced surveys beginning January 2006 means quality improvement professionals will have to dramatically change the way they think about compliance with standards and ensure that the rest of the organization follows suit. Failure to do so will put your accreditation in jeopardy, says a top Joint Commission official.

And while the switch to unannounced surveys is likely to be seen as a positive move by many, it may come with some drawbacks. The new system will create much more pressure to monitor standards compliance every day, and it may remove some of the incentives that a hospital often employs to motivate employees in preparation for a survey.

Unannounced surveys will be pilot tested in volunteer organizations during 2004 and 2005; then all surveys will be unannounced in 2006. The switch is part of the Joint Commission's much ballyhooed revamping of the accreditation process known as Shared Visions — New Pathways. That new process, previously announced, already is a radical departure from the current system that health care providers are used to, putting more emphasis on a self-assessment by the provider.

Starting in 2006, organizations will be surveyed anywhere from two to four years after their last surveys. The arrival within that time period will be completely unannounced.

And when surveyors do show up, they will not focus much on documentation and other administrative proof that you're complying with standards, as they have in the past. Instead, the surveyors will use "tracer methodology" so that they follow the experience of actual patients, using their real experiences to investigate how your organization complied with appropriate standards. Switching to unannounced surveys in 2006 is another step in making the new survey process more consistent with the goal of continuous quality improvement, says **Russell Massaro**, MD, executive vice president for accreditation operations with the Joint Commission.

"The bottom line on Shared Visions — New Pathways is to better embed

the accreditation process into the ongoing operational improvement efforts of an organization as opposed to making it an every-three-year event," he tells *Hospital Peer Review*. "Organizations told us that the icing on that cake would be if the surveys were unannounced. They told us that even though there will no longer be an incentive to ramp up for the survey under the new process, the organization's tendency might still be to do that, which is counterproductive."

Children's Memorial Hospital in Chicago, is the first hospital in the country to seek a totally unannounced accreditation review by the Joint Commission. The hospital requested the unannounced full survey, which will take place sometime in 2004, to demonstrate its continuous compliance. During 2004, the Joint Commission expects to initiate pilot testing of the unannounced triennial survey process in up to 100 hospitals that have volunteered to be among the first participants. Four multihospital systems and alliances — Ascension Health, Tenet Healthcare, Veterans Health Administration, and North Shore-Long Island Jewish Health System — have committed to having a number of their hospitals participate in unannounced triennial surveys in 2004 or 2005.

In 2005, JCAHO will continue to conduct voluntary unannounced surveys on a limited basis — opening up the option to all types of accredited organizations, and then transition to a completely unannounced survey program in 2006. The Joint Commission plans to continue to conduct one-day random, unannounced surveys in an annual 5% sample of the health care organizations it accredits through the end of 2005.

Not a 'gotcha' game

Making the surveys a surprise is not an attempt at playing "gotcha" with accredited organizations, Massaro says. Rather, the unannounced survey is more consistent with the overall goal of encouraging organizations to comply with Joint Commission standards every day rather than taking a more lax attitude until survey time, he says.

"If people use the new survey process the way it's set up and work on a more continuous basis, they will have a constant trickle of activity around operations instead of a tidal wave at the end to try to get a good score," he says. "Then it doesn't matter when the surveyors come, and hopefully, the surveyors will find nothing. That is the goal, and we'll be very happy if we find nothing."

So what do you need to change in order to be ready for unannounced surveys? "Organizations that are accredited by us won't have to do anything different with the future process just because surveys will be unannounced," Massaro says, "other than what we already are asking them to do: Stop ramping up for the surveys, and focus on continuous improvement."

Massaro suggests that the change should be welcomed by anyone who has been dismayed at the way some hospitals put on a nice front for the surveyors' visit and didn't necessarily put the same effort into standards compliance after the surveyors left. He says currently the survey is the lever for change every three years, but "in the future, it will be validation of change that is ongoing. It will make the survey process more of a genuine quality improvement effort rather than

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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**.

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Editorial Questions

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

simply an inspection."

While Massaro says the change to unannounced surveys shouldn't require any different tactics than what providers already are planning for under Shared Visions — New Pathways, he emphasizes that this latest revision should prompt a different way of thinking. If Shared Visions — New Pathways didn't already change the way you think about Joint Commission compliance, this latest change should, he says.

"You have to divest yourself of your current mindset about accreditation in order to embrace the future model, because all the drivers and incentives are reversed," he says. "For example, now you worry about preparation and getting a bad score. In the future, the process has been designed to eliminate the need for an artificial ramp-up and to incentivize you to use this as a management tool, as an internal asset. Just use the new process as it's intended, and you will be prepared."

Massaro says it is vital that quality improvement professionals realize that the unannounced surveys are intended as a tool to be used within accredited organizations, not as an attempt at catching more standards deficiencies. The new process is designed to enable continuous compliance that is more consistent with the spirit of the accreditation process, he says. If used correctly, the new system should result in quality improvements and less stress, he says.

"All the rewards in the process are set up for people who use it that way. If the organization chooses to ignore the design of the new process and leave everything to the last minute, and they don't know when we're coming, then they're putting themselves in great unnecessary peril," Massaro says. "On the other hand, if they understand what the new model is all about and how they are rewarded for using it as a continuous model, it is highly likely they will be accredited."

More daily pressure to confirm compliance

Unannounced surveys are a good improvement to the process, at least in concept, says **Patrice Spath**, RHIT, a consultant in Forest Grove, OR, who watches Joint Commission developments closely.

She agrees with Massaro that unannounced surveys better serve the spirit of accreditation standards and should relieve organizations of the massive effort to prepare for triennial surveys. But even if it's a good idea in principle, she cautions that the change will bring added pressure to quality improvement professionals.

"The challenge will be making sure that new Joint Commission standards get disseminated throughout the organization in a timely fashion," she says.

"One of the things that happens now is that as you gear up for the survey, you check to be sure everyone is aware of the new standards and get everyone on board. You won't have a survey date to build your schedule on, so you'll have to build in to your process your own tickler file to be sure that happens," Spath points out.

You also may need to act more quickly to address new standards and any deficiencies you discover. In the past, you might get word of a new standard or patient safety goal in December, but you knew your next survey was scheduled for July. So you might not start working seriously on that issue until April. You won't have that luxury three years from now.

"This could amount to more work," Spath says. "You'll have to be your own policeman, checking all the time for compliance and moving quickly on everything."

Will new focus become a burden?

For those who were never entirely satisfied with the validity of Joint Commission standards, the switch to unannounced surveys will be more of a burden. The new process will force accredited organizations to focus on the standards all the time, not just every three years, which Spath says is fine unless you think the standards are not beneficial.

"There have been questions about validity before, but before we could basically fudge it until three months before the survey and not do a whole lot with the standards you thought were no good," she says. "Here, they're asking us to be continually ready for something we're not sure has been proven to make a difference. It's not a new concern but it becomes an issue when [they're] asking you to be always ready, continually compliant with these standards when in fact you're not sure these standards are valid."

But that kind of dissatisfaction is a moot point if you want to keep your accreditation, so Spath advises providers to assess how well their systems can adapt to the new survey process.

Continual readiness will require superb communications processes, for instance. Do you have effective communication channels and feedback

processes for when new standards come out? Can you communicate new patient safety goals to the appropriate people and then monitor to see what's happening with compliance? she asks.

"In the past, we've often disseminated them but didn't check for compliance until close to the Joint Commission survey," she says. "Now you will need continual feedback systems. First, test those systems and make sure they are working OK. If not, start improving them now."

The party's over?

Spath also points out another drawback that might come with unannounced surveys.

Organizations have long prepared for their triennial surveys by launching a campaign to get all employees involved in getting a good score and trying to create a sense of fun and accomplishment. That motivational tool may be gone in three years.

"Now it's common to get everyone geared up for the Joint Commission visit, get them excited, then the surveyor would come and you would get a score, and you'd say all of that work was worth it," she says. "You'd say, 'We got a 92. We did a good job,' and you'd celebrate everyone's hard work."

But now it appears the unannounced survey is going to be more of a validation of whether your self-assessment was done accurately and whether you followed up on any problem areas that you identified. There won't be any numerical scores — just a decision that you are accredited, conditionally accredited, or not accredited.

"I just don't see a whole of celebration after something like that," Spath says. "It might all be very anticlimactic at that point, and you will have lost one of the strategies for getting everyone on board with compliance.

"How do you celebrate success in that kind of environment?" she asks. "You may need to build some success celebrations into your process because the survey isn't going to be such a dramatic event any more."

[For more information, contact:

- ***Joint Commission on Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.*
- ***Patrice Spath**, Brown-Spath & Associates, 2314 19th Ave., Forest Grove, OR 97116. Telephone: (503) 357-9185.]* ■

HIPAA prep continues after deadlines pass

Policies, training, solutions need to be priorities

Quality improvement and peer review professionals must continue to focus on Health Insurance Portability and Accountability Act (HIPAA) compliance long after the deadlines pass, say experts, who caution that protecting sensitive data will be a constant worry even after you have the appropriate mechanisms in place.

The first deadline for complying with HIPAA was April 14, when health care providers were required to comply with the rule laying out standards for electronic health care transactions to "protect and guard against the misuse of individually identifiable health information." Small health plans — those with annual receipts of $5 million or less — have until April 14, 2004, to comply.

If you didn't quite finish everything on your list for HIPAA compliance by April 14, don't panic, says **Jack A. Rovner**, JD, partner and co-chair of the Chicago Health Law Practice Group with the law firm of Michael Best & Friedrich in Chicago. You're not alone.

"The likelihood of everyone getting everything done by April 14th never was great because a lot of people were slow in getting to developing their policies and procedures," he says.

"Just hope that nothing really bad goes wrong with a privacy matter, because then you'll have a problem if your program isn't complete. But it's not like the government is going to send people out to check your HIPAA compliance as soon as the deadline is passed," Rovner explains.

Don't panic, but don't stop working on HIPAA compliance either, he says. Ensuring the privacy of sensitive information will be an ongoing challenge, he says, and for now, you should at least be able to show that you have made a good-faith effort to comply.

"Can you show that you've allocated resources and allocated the budgets, and that you have an action plan for implementing what you need to?" Rovner asks. "If something happens and you have to show HIPAA compliance, that's what will matter right now — whether you were working in good faith. The statute is even written to include reasonableness as a means to forgive HIPAA oversights in civil litigation."

Providers will continue to adjust to HIPAA for

years, says **Matthew Rosenblum**, chief operations officer for privacy, quality management, and regulatory affairs at CPI Directions, health care consultants in New York City. He cautions that HIPAA compliance is "a marathon, not a hundred-yard dash." It took 20 years for health care providers to internalize Medicare and Medicaid regulations into their operations, he says, and the HIPAA regulations are as significant as those were back in the 1970s.

Accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations may be the biggest motivation to move quickly on HIPAA compliance, he says. Even though government regulators aren't likely to confirm your compliance any time soon, a surveyor from the Joint Commission or any other accrediting body might, he says.

"They have their own patient rights standards, and they will be the first ones to come in and

NCQA, JCAHO to offer business associate certification

URAC releases standards for security accreditation

The National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations announced recently they jointly will offer a Privacy Certification Program for Business Associates. The move is in response to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which establishes specific expectations for "covered entities" and "business associates" in limiting access to protected health information (PHI).

The planned program would evaluate applicant business associates to determine whether they are meeting standards for safeguarding PHI based on the HIPAA privacy regulation, says **Margaret E. O'Kane**, NCQA president.

"Collaborating with the Joint Commission on this program will promote efficient, consistent privacy oversight across diverse sectors of the health care system," O'Kane says. "All of us in health care bear the responsibility of keeping protected health information safe, and a collaborative effort will help more organizations meet their end of the privacy bargain."

NCQA released draft standards for a privacy certification program in December 2002, and Joint Commission representatives served on the advisory committee that developed those standards. The final standards for the program, scheduled for release this month, will track closely with the final HIPAA privacy regulations. O'Kane says program requirements will relate to privacy protections for oral, written, and electronic PHI; processes and practices for the storage, use, and disclosure of PHI; employee training in PHI protections; consumer access to PHI; and contracting between covered entities and their business associates.

Any business associate that handles PHI for health plans, providers, or health care clearinghouses would be eligible for the program. Such entities include, but are not limited to, software firms; health care information technology firms; data collection, analysis, and processing firms; practice-management firms; third-party administrators; disease management organizations; and survey vendors.

URAC also released a draft set of HIPAA Security Accreditation standards for public comment. When completed later this year, the new program will enable health care organizations to display a commitment to information security and demonstrate that they have adopted the necessary policies and procedures to ensure health information security in accordance with HIPAA, says **Garry Carneal**, URAC president and CEO.

"The purpose of this accreditation program is to verify that an organization has put in place the necessary infrastructure and implemented the necessary processes to comply with HIPAA," he says.

Carneal says URAC HIPAA Security Accreditation will provide value to health care organizations by providing a guide for internal verification of HIPAA security compliance efforts, providing a source of documented and demonstrated due diligence, and allowing organizations to treat the URAC accreditation as an evaluation by external reviewers, among other benefits.

"This accreditation program is designed to be relevant to all health care organizations expected to comply with the HIPAA Security Rule," Carneal says. "These include covered entities, business associates, and organizations that, while not legally subject to HIPAA, still wish to validate their HIPAA compliance program. Since different organization types need to comply with certain HIPAA requirements, we intend to take a situational approach in determining which of the HIPAA Security Accreditation standards apply."

[For more information, contact:

- ***Joint Commission on Accreditation of Healthcare Organizations**, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000.*
- ***National Commission for Quality Assurance**, 2000 L St. N.W., Suite 500, Washington, DC 20036. Telephone: (202) 955-3500.]* ■

start asking questions about the implementation of these HIPAA rules," he says. "They will ask staff, 'What if a patient has complaints about the privacy of information? Who do they go to?'"

Education of staff should be one of the biggest concerns with HIPAA now, Rosenblum says. Much of the preparation up to this point has concerned developing new policies and procedures, but staff education takes a long time. Be prepared for a long learning curve and a period of adjustment for the new policies and procedures.

Business associate agreements are another common problem for providers when organizing a HIPAA compliance program. **(For more on business associate agreements, see article, p. 65.)**

"We're now seeing a battle of the forms," says Rovner. "Many of the associations that do business with health care providers have drafted business associate agreements that tend to favor them, then the hospitals tend to draft agreements that favor them. When they clash, you have to deal with that, and it will take time."

The best thing to do in the short run is to be sure you have policies and procedures in place, he says. Write your policies, implement them, and start training staff on how to comply. He cautions against letting a quest for perfection keep you from implementing policies immediately.

"You're going to learn how well they work as you implement them, and you will have to improve them as you go along," Rovner says. "One big thing is writing your minimum necessary protocols for the routine and recurrent things that you send out — claims, customer service, dealing with other routine third-party vendors. You'll have to constantly update those protocols so they make sense."

Rovner and Rosenblum recommend asking yourself if you have accomplished these tasks yet to comply with HIPAA:

- Developed and distributed the notice of privacy practice.
- Documented that you gave the notice to patients.
- Produced an authorization form, or at least a template for one, for those uses and disclosures that may occur in your organization.
- Tested your system.

Most covered entities have applied for the extension that will allow them to wait until

Web site can help coordinate HIPAA efforts

Site intended to reduce repetition, legwork

Two leading health care industry coalitions have launched a universal web site aimed at standardizing Health Insurance Portability and Accountability Act (HIPAA) communications between health plans and the provider community, including hospitals, physicians, billing services, vendors, and clearinghouses. The site is a collaboration of the Council for Affordable Quality Healthcare (CAQH) and the Workgroup for Electronic Data Interchange (WEDI).

The free web site is intended to make HIPAA compliance easier by reducing much of the legwork and repetition among businesses that work together, says **Jim Schuping**, executive vice president of WEDI, a health care industry coalition dedicated to improving health care through electronic commerce. "HIPAA specifies what payers must do to comply with HIPAA regulations, but it does not regulate how payers communicate this information to the provider community," he says. "If they were to visit every health plan's site to access its proprietary HIPAA information, providers would be subjected to an overwhelming administrative burden."

The CAQH-WEDI web site eases the transition to HIPAA compliance by enabling participating health plans to communicate their information about changes in one place, using one format, so that providers can access multiple plans' information quickly and conveniently.

By participating in the CAQH-WEDI site, providers can avoid "reinventing the wheel" on HIPAA communications, says **Robin Thomashauer**, executive director of CAQH, a not-for-profit alliance of the nation's leading health plans and networks.

The CAQH-WEDI web site serves as a resource to providers in two ways: An Implementation Timeline allows health plans to complete and post their plan-specific HIPAA standards testing and production schedules on the site in a standardized format.

Providers then access the transaction schedules for plans they contract with in one location.

Also, the site offers a Best Practices Companion Guide Template. Health plans can download this template of best practices to develop provider-friendly companion guides, and then providers can access the guides from participating plan links on the site. The site already has plan participation in more than 25 states, penetrating all regions of the country. The CAQH-WEDI web site is provided at no charge to health plans and providers and updated weekly as additional plans post their timelines.

To see the web site, go to: www.wedi.org/snip/caqhimptools. ■

October to have transaction and code sets (TCS) in place, but one of the requirements for filing that extension was to begin testing the systems by April 15.

- Appointed a privacy official.
- Developed a contact person in a privacy office who can begin to field questions and requests from patients regarding access to information.

Many health care providers get bogged down in the analyses and retrospective assessment of how they have handled privacy issues in the past, Rovner says. While that kind of analysis can be useful, don't focus on it too much. What you did with private health information last year is less important than what you will do with it this year.

"People have avoided focusing on the hard work of drafting policies and procedures, and instead, they're spending time on gap assessments — saying, 'This is what we used to do, and this is what we need to do,'" he says.

Thomas R. Walsh, principal consultant for CTG HealthCare Solutions in Overland Park, KS, says your HIPAA compliance program should include regular assessments, both internal and external. Once a year, you should have the system audited by an outside entity. "Without an audit, it's just a veneer," he says.

Structure the system so security problems can be reported easily, he says. Make sure it is clear who they should be reported to and how. At the same time, set up a procedure to assure that there will be no retaliation for whistle-blowers.

He also urges providers to look for simple solutions to some everyday problems. Not all HIPAA compliance solutions have to be complicated or high tech, he says. For instance, there are a number of best practices providers can implement to prevent the overly curious from gazing at private patient information in an office setting. One solution is the use of privacy workstations, with a monitor set into the worktable or so that the information cannot be viewed except by the person who is using the computer. Anti-glare computer screens and privacy shields on monitors also can thwart the casual information thief.

A privacy concern in many health care settings is the availability to many office staff members of faxes. Faxed materials often sit around for anyone to see, and it can be difficult to make certain only the person who is being faxed confidential medical information sees it, Walsh says.

"Faxes are the lifeblood of health care, but there are many opportunities for privacy breaches. Many health care providers are learning that they may be better off buying their various computer systems — from billing to clinical — from the same vendor so that the systems work together, and they can avoid doing so much faxing," he points out.

Walsh also suggests using e-faxes, which arrive as an e-mail attachment or are accessible via a web site that can only be accessed with a special code, and fax machines that only print out the document if a security code is entered.

[For more information, contact:

- ***Jack A. Rovner**, Michael Best & Friedrich, 401 N. Michigan Ave., Suite 1900, Chicago, IL 60611. Telephone: (312) 222-0800.*
- ***Matthew Rosenblum**, CPI Directions, 10 W. 15th St., Suite 1922, New York, NY 10011. Telephone: (212) 675-6367. Web site: www.cpidirections.com.*
- ***Thomas Walsh**, CTG Healthcare Solutions, 800 Delaware Ave., Buffalo, NY 14209-2094. Telephone: (716) 882-8000.]* ■

Project hinges on top quality hospital data

Mortality rate for AMI drops 36%

A quality improvement project in Dayton, OH, achieved a 36% drop in mortality from acute myocardial infarction (AMI) among a group of hospitals cooperating on the effort, and participants say it could not have been done without high-quality data collection by peer review and quality improvement professionals.

Recently, the Dayton consortium won a Codman Award from the Joint Commission on Accreditation of Healthcare Organizations for outstanding quality improvement projects.

The project was one of the first tackled by the Greater Dayton Area Hospital Association, which in 1998, formed a consortium of 20 local hospitals, area employers, physicians, and quality management professionals to support the development of accurate and comparable measures of cost, quality, and patient satisfaction.

As a result of this consortium, competing hospitals began working together to raise the quality of care they provide to the community, says **Joseph M. Krella**, FACHE, president of the association. Participating hospitals agreed to annually release aggregate cost and quality indicators to local business leaders.

Beginning in year three, hospital-specific cost, quality, and patient satisfaction measures were released to local business leaders.

The three-year time frame for the release of hospital-specific performance provided enough time for individual organizations to benchmark results against the aggregate data and share best practices in a collaborative effort that would benefit all, Krella says. Setting this time frame from the outset was key to obtaining the cooperation of the hospitals involved, he says, but the hospitals compared data among themselves in the first year of the project.

"Our initial report listed a number of diagnoses and comparative data for mortality, length of stay, and costs," Krella says. "The report compared hospitals in Dayton to each other, and also counties within the state and some state-to-state comparisons."

Following that initial report, the participants realized that Dayton and Montgomery County were outliers with a higher rate of mortality for AMI than the risk-adjusted model would have predicted. So AMI was targeted as one of the initial indicators for improvement. The aggregate AMI rate for Dayton was above the Ohio state average and significantly above the predicted rate. As a result of this collaborative effort, there has been a 36% drop in AMI mortality rates in the city over a three-year period.

The work of the consortium has evolved from a report card focus to a true collaborative approach to process improvements, says **Joseph Cappiello**, vice president of accreditation field operations for the Joint Commission on Accreditation of Healthcare Organizations.

"Without a doubt, this multiorganization team effectively used performance measures — process and outcome — and performance improvement to elevate the level of care," Cappiello says. "The performance of all of the hospitals and providers in the group improved significantly while the amount of variation between them was minimized. The level of care provided by each is at a comparable level and continues to be improved. The entire community is practicing evidence-based medicine, and the quality of care in the community has improved as a result."

Data must be transparent to participants

To address the AMI outliers, the consortium formed a quality council made up of hospital CEOs, medical directors, and leaders from the business community. This quality council meets quarterly and is responsible for overseeing the entire project. The next tier down is a committee of medical directors, and then a steering committee made up of hospital quality managers and business leaders. Beneath that level is a process-of-care committee made up of clinicians and others involved in the particular quality issue being addressed, such as AMI.

"This has truly been a collaborative effort among organizations that have set aside their competing interests in order to improve the quality of health care provided to area residents," Krella says. "Our accomplishments would not have been possible without the commitment and dedication of hospital management, quality management professionals, physicians, and area business leaders."

Cooperation among the participating hospitals was crucial to the success of the project, says **Rick Snow**, DO, MPH, a physician in the community who worked with the hospital association on the project. A large part of his job with the project was to encourage cardiologists to participate by sharing data and taking a critical look at their own performance. Initially, they were concerned about whether there were problems with the data that would explain the differences in AMI outcomes, but the consortium took great pains to ensure that the data were reliable.

"One factor that came up was DNRs [do-not-resuscitate orders], which are not included in the administrative data we were using, so there were questions about how that might have affected the data," he says. "But we looked at some factors that might be associated with DNRs, like Parkinson's disease, dementia, and stroke, and we incorporated those into the data because they might be indicative of a DNR. They were predictive and had some effect on the risk of death, so we included them in the model."

Snow says it is important that physicians see the data as "transparent," meaning they fully understand where the data came from, along with any shortcomings or omissions. Otherwise, they will wonder about the real cause for the variance in mortality rates and not focus on what can be improved. "When the data are transparent, you're able to move them beyond the data and the model to get them asking questions about the processes of care, to start a dialogue," he says. "A real lesson is that you have to encourage participants to continually ask questions of the data and have the infrastructure to answer those questions."

The quality of the data was key to achieving a 36% reduction in AMI mortality over three years, Snow says, and he credits quality improvement professionals with gathering the valuable data.

"The QI professionals were very instrumental as the project evolved from a peer-review model to a process improvement model," Snow says. "They are the experts in data collection, and we turned to them for that key part of what we were doing."

Data were culled from administrative data sources such as the discharge abstracts usually sent to state databases, but the consortium did not automatically accept those data as reliable. Striving to give physicians the most confidence possible in the data, the consortium had physicians compare information in actual medical records to what was in the database for a specified period. When the data checked out, the participants accepted them as true indicators of what was happening at the facilities.

Quality professionals also were instrumental in providing peer-review protection to the consortium's meetings, working through the Ohio Hospital Association to get a special law passed in the state legislature granting peer-review protection. That helped the physicians discuss their modes of care and particular cases openly, Snow says. "They would not be as willing to bring that kind of detail to the table without some protection, and rightly so. That gets very close to issues of liability."

The data proved important not only in determining which hospitals needed to improve AMI care, but in showing what methods could improve mortality. A lack of national standards meant the consortium had to develop their own local benchmarks, using risk-adjusted mortality to identify the hospitals with the best outcomes and then look to their processes for benchmarks. Reperfusion turned out to be a significant factor, with the better performing hospitals defining ideal populations for reperfusion and carefully timing reperfusion. Smoking cessation and early use of beta blockade also were identified as best practices.

The three hospitals identified as outliers saw their combined AMI mortality rate fall from 9.88% in 1999 to 6.32% in 2001, a 36% reduction. For comparison, the state of Ohio's AMI mortality rate fell from 8.29% to 7.48% in the same period, a reduction of 9.8%. Congestive heart failure, pneumonia, and patient safety are among the next targets for the consortium, Krella says. The group has moved from annual reports to giving participants quarterly data, which the institutions then share with individual physicians.

"We're collecting process measures, related very closely to the Joint Commission's core measures," Krella says. "We're feeding that information back to the institutions in almost a real-time manner, which leads to quicker analysis and a quicker implementation of improved processes."

[For more information, contact:

- ***Greater Dayton Area Hospital Association**, 32 N. Main St., Suite 1441, Dayton, OH 45402. Telephone: (937) 228-1000.]* ■

THE QUALITY - CO$T CONNECTION

Part 2 of 2

Responding to customer concerns improves quality

Four more steps to effective concern management

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

When patients have a negative encounter with a health care organization, they are less likely to use that provider again, more likely to talk negatively about the provider, and more likely to switch to another provider. One way an organization can ensure repeat business is by developing a strong customer service program that includes a concern management system. An effective concern management system involves five steps. The first step — document the concerns — was described in last month's *Quality-Co$t Connection* column. The last four steps are described in this month's column.

Once information about patient/family concerns is documented, the information needs to be organized. This can be done by recording the issues from each concern sequentially in a paper log or into a spreadsheet or database software program. The log or electronic database should have sufficient space for nine columns.

Although a patient or his or her family may have lodged only one concern, there may be more than one useful problem verbalized. The issues from each concern are recorded so that the problems can

be analyzed separately. In **Table 1, below,** is a sample worksheet illustrating two issues voiced in one patient concern.

For each concern, identify the customer need behind the verbalization. For some concerns, more than one customer need may be identified. To help determine customer needs, it is often useful to start the need with the statement, "I need to . . ." **(See Table 2, below.)** Next, a clearly defined statement of what caused the customer need not to be satisfied is added in column 7.

After defining the problem, the affected processes and problem causes are analyzed. This involves finding the root cause, which should be a joint activity with people personally knowledgeable about the process. For the example in Table 2, people from the outpatient registration desk are consulted for ideas. The root cause is identified and documented in the worksheet. **(See Table 3, below.)** This step is completed for each customer need derived from a concern.

Maximize the value of concerns by exploiting or making use of the information to improve processes. Using information recorded on the worksheet, develop a basic list of unmet customer needs, as well as the number of times they were not met. **(See chart, p. 71.)** The report also lists the processes/departments related to the unmet needs. A summary report such as this can be created quarterly or semiannually.

The report findings allow the organization to focus its immediate improvement efforts on high priority, unmet customer needs.

Analysis techniques such as failure mode and effect analysis can be used to detect failure modes and develop an initial prevention plan. For example, the failure of registration staff to follow procedures for admitting patients for laboratory test might be resolved by reviewing the procedures periodically with staff to avoid lack of observance.

Share the preventive steps you've taken with the

Table 1: Concerns Voiced by Customers (partial view of worksheet)

Column 1 Concern Number	Column 2 Unit	Column 3 Date/Time	Column 4 Concern
22.1	Outpatient registration	02/03/03 1545	"At the registration desk, the clerk told us we were to go directly to the lab, however, when we got to the laboratory we were told we had to return to the registration desk to complete more paperwork."
22.2	Outpatient registration	02/03/03 1545	"Upon return to registration, the clerk rudely told us that we'd have to wait because there were four other people in line before us."

Table 2: Customer Needs and Problems (partial view of worksheet)

Column 1 Concern Number	Column 6 Customer Need (I need to . . .)	Column 7 What is the Problem?
22.2	receive friendly and respectful service	Poor customer service by outpatient registration on Feb. 3, 2003

Table 3: Process Involved/ Cause of Problem (partial view of worksheet)

Column 1 Concern Number	Column 8 Affected Process	Column 9 Cause of Process Failure
22.2	Outpatient registration	Procedure for lab test registration not followed

Examples of Some Critical Customer Needs and Processes Involved

Customer Need	Number of Reported Times Need Not Satisfied
Receive friendly and respectful service	16
Get bill that is easy to interpret	12
Trouble-free hospital discharge	8
Confidence that care is safe	4
Adequate explanation of treatment	4

	Patient Reg	Billing	Nursing Care	Diagnostic Services	Physician Services	Rehab Services	Surgical Services	Environment of Care
Receive friendly, respectful service	8	2	1	3		1	1	
Get bill that is easy to interpret		9	3					
Trouble-free hospital discharge	1		2		3	2		
Confidence that care is safe			1				1	2
Adequate explanation of treatment			2	1	1			

person who initiated the concern. When a patient or family has a problem with a health care organization, but this problem is properly managed, it is highly probable that the customer will remain loyal to the organization. Acting on concerns makes customers feel respected and important. Along with an apology, the notification letter can include the identified need, the problem that was identified, its causes, and the corrective actions to be taken, as well as contact information of the person responsible for taking actions.

Health care organizations can't afford to be casual about dealing with customers. Customer responsiveness should be a strategic issue because it differentiates your organization from competitors. Do people in your organization have an "I'll get to it when I can" attitude, or are patient and family concerns a high priority?

Attitude has a lot to do with how people treat customers. What attitude do people in your organization convey to customers? Is it a casual one or is it a "customer-first" attitude?

To get at the heart of customer-relation problems, find out how staff members would answer the following questions:

- When a customer voices a concern that requires a callback, how long does it take, on average, to get back to the person?
- What are the organization's policies regarding management of concerns?
- How much training have you have had with regard to responding to customer concerns?
- At what level in this organization are customer concerns handled?

Organizations should have a clear procedure to follow when a customer is concerned. Staff members must be taught to recognize concerns and respond promptly and appropriately.

Customer concerns make a difference

The process of responding to patient and family concerns must be transformed from a minor activity to a formal evaluation process. Concerns

should not be viewed as a source of blame, but as a unique learning opportunity.

Excellent service only can be achieved when health care organizations have a good understanding of the evolving needs of patients and families. An effective process for analyzing and closing concerns is a critical success factor.

Maximize the value of concerns by communicating organizationwide the customer's needs and expectations along with the possible resolution or outcome to the concern. This communication process will improves services and ensure a consistent customer service approach. The goal is to eliminate "reinventing the wheel" among multiple departments in one organization that may encounter the same concern. ■

CE *questions*

17. All Joint Commission on Accreditation of Healthcare Organizations surveys will be unannounced beginning what year?
    A. 2004
    B. 2005
    C. 2006
    D. 2007

18. When the Joint Commission switches to unannounced surveys, survey hospitals still will receive a numerical score.
    A. true
    B. false

19. Washington, DC-based URAC has released a draft set of standards for an accreditation program that will focus on what aspect of HIPAA?
    A. security
    B. privacy
    C. transactions
    D. none of the above

20. A consortium of Dayton hospitals recently won an award from what organization for its QI project targeting acute myocardial infarction?
    A. American Hospital Association
    B. National Association for Healthcare Quality
    C. Emergency Nurses Association
    D. Joint Commission on Accreditation of Healthcare Organizations

Answer Key: 17. C; 18. B; 19. A; 20. D

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