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Final APC rule soothes critics — but experts warn there's hard work ahead

Quality managers face boom in outpatient denials

First, the good news: The Health Care Financing Administration's (HCFA) final rule on ambulatory payment classifications (APCs) probably won't lead to anything like the 15% decrease in outpatient reimbursement some experts originally had predicted. The bad news, according to several leading experts, is that virtually no hospital in the country is ready for the July 1, 2000, implementation date that HCFA has set for its new outpatient prospective payment system (PPS).

Mason Smith, MD, FACEP, president and CEO of Lynx Medical Systems in Bellevue, WA, says hospitals that act quickly to achieve full compliance with the new PPS may actually put themselves in a position to earn increased reimbursement under the APC system.

Smith notes that the final rule addressed several of the largest concerns hospitals had with the initial rule, which appeared in the *Federal Register* on Sept. 8, 1998. Most significantly, he says, HCFA has improved the distribution of revenue among hospitals. "The most important issue was, would the hospitals providing expensive outpatient services be harmed by a payment averaging system that didn't recognize high-end outpatient service? In the initial rule, there was a lot of potential damage there. That's largely been mitigated now," Smith says.

Also encouraging is HCFA's addition of "transitional protection" for hospitals that can't immediately comply with the new PPS. "For the first four

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years of prospective payment, there is transitional protection that mitigates any losses that hospitals incur as a result of the transition," Smith says. "That's important, because there's no negative on the upside. If you perform really well, you can make more money. And if you perform poorly, your losses will be mitigated by incremental payments based on cost reports."

Other changes include the following:

- There is no APC for a medical screening exam, which could have a positive impact on reimbursement.
- Hospitals can continue to use the current charge structure and correspond present levels of service with the appropriate CPT visit level.
- Hospitals will have to unbundle visit levels to separately list nursing and physician procedures as specific line items.
- An APC has been added for "special technology," in response to critics who argued that lumping high-cost technology in with other expenses could lead to serious financial losses and discourage the use of cutting-edge equipment.

In the final rule, HCFA also made some changes to the list of procedures that will be reimbursed only if conducted on an inpatient basis. Most notably, laparoscopic cholecystectomy, partial mastectomy, and coronary and noncoronary angioplasties were removed from the list and now will be covered in the outpatient setting. "But, all through the final rules, [HCFA] talks about the fact that it would expect that when these procedures are done in the outpatient setting, it should be only those that are the simplest and least intense," says **Deborah Hale**, CCS, president of Administrative Consulting Services in Shawnee, OK.

HCFA's conservative stance on inpatient vs. outpatient procedures is unfortunate, given the changing nature of health care, says **Sue Prophet**, RHIA, CCS, director for coding policy and compliance at the Chicago-based American Health Information Management Association. "Things are changing all the time," she says. "Lots of things that a few years ago you would never have thought to do except as inpatient have been safely moved to the outpatient setting. So it's a bit concerning to have the government basically say you can only have this procedure done on an inpatient basis."

While Prophet appreciates the fact that HCFA moved some procedures off the inpatient-only list, she wishes the agency had gone further. "I was hoping to see [the list] reduced down to a bare minimum — really super-major surgeries

Where to find APC regulations

The new hospital outpatient prospective payment system regulations were published in the April 7, 2000, *Federal Register.* The *Federal Register* is available at many libraries. For copies of the *Federal Register,* send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue and enclose a check or money order payable to the superintendent of documents, or enclose your Visa or MasterCard number and expiration date. The cost for each copy is $8. Credit card orders also may be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250.

Issues of the *Federal Register* also are available from an on-line database through GPO Access, a service of the U.S. Government Printing Office. The address of the home page of the superintendent of documents is www.access.gpo.gov/su_docs/aces/aces140.html. The regulations also can be downloaded from the HCFA Web site at www.hcfa.gov. ■

that it's just impossible to even conceive they could be done on an outpatient basis," she says. She adds that it isn't clear yet how frequently HCFA will re-evaluate the list in light of new clinical developments.

"It's very interesting that at the same time this is being implemented, the PROs [peer review organizations] in their Payment Error Prevention program are looking at one-day stays to determine whether or not those stays were appropriate admissions," Hale says. "And technically [under the outpatient PPS], the hospital doesn't have any reimbursable alternatives."

Another problem with the inpatient-only list concerns the issue of emergency admissions that go immediately to surgery, Smith says. "Say you have a patient with a gunshot wound to the chest who needs immediate open thoracotomy for trauma to the lung. That's an excluded outpatient procedure, which makes sense; you wouldn't usually do that in the outpatient treatment room," Smith says. "However, if that patient expires in the operating room before his status is changed to inpatient — even though he is getting inpatient surgery — he will die as an outpatient. Those services will be paid as outpatient, and any excluded services will not be paid."

Because of this admission rule, it's more important than ever to decide quickly whether or not to admit a patient to the hospital and start the ball rolling as quickly as possible, Smith says. That's likely to involve changes to admission policies and procedures and place an additional burden on access managers.

Quality managers and utilization review personnel are also likely to shoulder additional burdens as hospitals adjust to the new PPS. "The major responsibility that I see we will have will be fighting denials," says **Joel Mattison**, MD, physician adviser in the department of utilization management and quality assurance at St. Joseph's Hospital in Tampa, FL. Mattison says quality personnel also may get pulled into discussions of whether patients should be treated as inpatients or outpatients. "When they start to say that sicker patients can be done as inpatients and healthier patients can be done as outpatients, then you get into a real argument, because the payer sees everybody as young, healthy, and without comorbidities, and that's just not so," he says. "So then you get into quality questions."

A further challenge posed by the outpatient PPS is that, at least for the time being, hospitals will be forced to learn new rules for Medicare patients while maintaining business as usual for all other payers, Prophet notes. But that state of affairs may not last long. Smith says private payers are likely to move to the PPS system as well before long. "There's a very pragmatic reason for that," he says. "The PPS system is no different than the physician fee schedule. The payment rules and the edits on the payment rules from a compliance perspective are the Medicare Correct Coding Initiative edits. So it's one uniform set of rules. Why have two systems?"

Whatever action private payers take, HCFA is sticking to its July 1 implementation date, despite pleas for more time from industry groups like the Chicago-based American Hospital Association. "I know some people are hoping that some big group will convince HCFA to postpone it beyond July," Prophet says. "The biggest thing is for people not to assume that that's going to happen and instead really get their hands around these regs and get started trying to put all this in place."

Prophet recommends first looking at your information systems to determine what data you

Know these key deadlines

The Baltimore-based Health Care Financing Administration has established key dates for implementation of the ambulatory payment classifications for outpatient services. They are:

- **May 30, 2000:** Determine what copayment discounts, if any, the hospital elects to offer to Medicare beneficiaries for the period from July 1, 2000, to Dec. 31, 2000.
- **July 1, 2000:** Process claims under outpatient prospective payment system rules for claims with a date of service on or after July 1.
- **Nov. 30, 2000:** Determine what copayment discounts, if any, the hospital elects to offer to Medicare beneficiaries for the period of Jan. 1, 2001, to Dec. 31, 2001.

currently capture. "Hopefully, you've already done the part about analyzing the chargemaster and making sure that's completely up to date," she adds. It's also important to perform an updated financial assessment based on the final rule, "to see where you're going to be making money, where you're going to be losing money, and where you have weaknesses in documentation or in capturing charges," she recommends.

Prophet adds that the outpatient PPS represents "a huge opportunity for people to really get involved in a lot of collaboration among a variety of different departments within the hospital. Now, it remains to be seen whether or not the actual payment rates for some of these things are reasonable and whether hospitals in general are going to be losing a lot of money or not." ■

Credentialing becomes a priority for JCAHO

New guidelines go into effect this year

Your medical staff credentialing and peer review policies may be coming under careful scrutiny in the months ahead as the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) takes aim at the effectiveness and professionalism of evaluation processes.

When JCAHO met for its most recent annual Executive Briefings Conference, the peer review process was a topic that commanded specific attention. A list of characteristics for peer review was developed that could eventually be incorporated into JCAHO standards.

Current standards require that peer recommendations and results be considered in credentialing and privileging decisions (MS.5.7, MS.5.12 – MS.5.12.3). The standards charge the medical staff with responsibility for conducting peer review activities when issues relevant to an individual's performance are raised (MS.8.4).

The object of the changes is to make life easier for the surveyors. If the hospital's peer review process follows the Joint Commission's guidelines, surveyors should be able to determine whether a peer review process exists in a well-designed, functional mode. The Joint Commission says it will not take decision-making or judgement outcomes away from the hospital. Essentially, surveyors will be looking at the design and function of peer review and credentialing processes.

'Peer review can vary quite a bit'

"From the point of view of the standards right now, there is only a loose reference to peer review [MS.8.3]," says **Herman Williams**, MD, MPH, MBA, medical director for peer review at the Greeley Company in Marblehead, MA. He notes that with the new guidelines, "they're paying attention to the evaluation of quality work of physicians by physicians. Peer review can vary quite a bit from medical staff to medical staff around the country," he adds. "Everybody is performing it, but the problems inherent in the peer review process are addressed [in the JCAHO memorandum]."

"This all became necessary because the Joint Commission's standards were lacking in specificity regarding peer review," agrees **Christine Otto**, CMSC, CPCS, CPHQ, president of Christine E. Otto & Associates, a health care consulting firm in Pasadena, CA. She serves on the JCAHO Professional Technical Advisory Committee (PTAC) for the Hospital Accreditation Program, representing the Austin, TX-based National Association Medical Staff Services. "Information regarding an applicant should be provided by peers of that applicant," Otto says. "The Joint Commission surveyors had the additional burden of trying to determine if meaningful information resulting from peer review activities was utilized and considered during the credentialing process."

The design and function of a peer review process

According to the Joint Commission memorandum addressing peer review processes, a properly designed peer review process should:

- define those circumstances requiring peer review;
- specify participants in the review process, including a definition of "peer" developed by the medical staff;
- define a method for selecting peer review panels for specific circumstances;
- identify time frames in which peer review activities are to be conducted and the results reported;
- specify circumstances under which external peer review is required;
- provide for participation of the reviewee in the peer review process.

An effectively functioning peer review process should include:

- consistency in all cases meeting the organization's definition of reviewable circumstances;
- timeliness in which procedures are reasonably adhered to;
- defensible conclusions reached through processes which include, as appropriate, reference to the literature and relevant clinical practice guidelines;
- balanced consideration of minority opinions and views of the review;
- usefulness in practitioner-specific credentialing and privileging decisions and, as appropriate, the organization's performance improvement activities;
- ongoing monitoring of peer review decisions and actions for effectiveness. ■

The characteristics JCAHO has determined to constitute an acceptable peer review process are outlined in the box accompanying this article. **(See box, above.)** Facilities that base their peer review plans on the itemized characteristics face a likelihood of making "reasonable" peer review decisions, according to the Joint Commission's article on process changes in *Joint Commission Perspectives* (2000; Jan./Feb.:10).

The article states that surveyors will gauge the effectiveness of an organization's peer review and credentialing processes and determine how effectively the two are joined. Surveyors will use meeting minutes, incident logs, and other information as they sample cases selected for peer review.

Otto further explains that PTAC established that there was a real need for strengthening the peer review process, so the new guidelines can be expected to benefit hospitals and their medical staffs.

But hospitals should begin preparing their peer review processes now. "Many organizations already have peer review guidelines in place," Otto says. "But hospitals will have to look at their methods carefully relative to the new guidelines. As I understand it, surveyors will be looking at medical executive committee minutes and peer review policies."

She adds that the new guidelines are an interesting development because for the last several years, PTAC and the Joint Commission were trying to be less prescriptive in their recommendations and allow hospitals more flexibility with their policies. "But these guidelines were needed," she emphasizes. "There was not enough structure in place in this area."

The guidelines are not altogether rigid. For instance, each facility will now determine time lines for completing an effective peer review. "But the facility must design reasonable guidelines," Otto cautions.

Hospitals also will be expected to specify circumstances for external peer review. As an example, Otto describes a small community with two competing OB/GYN groups. "If one of the competing physicians identifies a potential peer review issue pertaining to a doctor in the other group, that is a situation which would justify going outside the hospital community to find an independent OB/GYN to act as an arbiter in the peer review process."

With the new guidelines, JCAHO defines the properly designed peer review process, as well as the characteristics of an effective peer review.

"Having peer review guidelines will be protective for those individuals being reviewed," Otto points out. "The guidelines will help eliminate some of the subjectivity previously associated with peer review by requiring the medical staff to have objective and well-defined peer review criteria in place." ■

Is your medical staff office worth more than you know?

How to conduct a thorough cost/benefit analysis

Have you given much thought lately to the productivity and worth of your medical staff office? It's generally considered a non-revenue-producing area, but a closer look could change that perception.

One of the major issues for a well-run medical staff office is the hours needed to handle the many aspects of the job and the personnel required to handle the tasks.

Linda Smith, CMSC, CPSC, manager of medical affairs at Our Lady of the Resurrection Medical Center in Chicago, recently put together a detailed benefit analysis of her office, its functions, and employee hours spent on each function.

Smith began by calculating productive hours of a full-time employee (FTE) using the following formula:

- **52 weeks x 40 hours a week = 2,080 hours**
- **minus 168 non-productive hours (holidays, vacation, sick time)**
- **= 1,812 yearly productive hours per FTE.**

She then itemized the particular functions of her medical affairs office and determined the hours allocated for each task. A chart depicting this itemization in modified form accompanies this article. **(See chart, below.)**

The chart accompanying this article is limited to Smith's basic list of credentialing functions for her department. But the work doesn't stop with credentialing. Her more extended list goes on to include:

- department and committee meetings;
- filling out reference questionnaires;
- data entry of CME and meeting attendance for each physician;
- peer review activities;
- new physician orientation;
- policies and procedures review and revision;
- preparation of new rosters;
- medical staff elections for officers and department chairs;
- committee appointments;
- calendar and meeting notices;
- social functions such as Doctors' Day, golf outings, birthdays, physician/spouse outings, and group activities;
- travel arrangements;
- secretarial activities such as time spent on the phone, mail, filing, ordering supplies, and reading and responding to e-mail;
- Joint Commission survey preparation;
- professional affairs and board of directors reports on medical staff activities;
- preparing an annual budget;
- maintaining a medical staff bulletin board;
- special projects and other activities.

Smith's complete list totals 6,368.5 hours requiring 3.06 total FTEs.

But the reality is that Smith's office consists of herself and 1.5 FTE (a full-time credentialing person and a half-time physician relations employee). "We were very overburdened," she says, "bringing home work every night."

Was her administration impressed with her analysis? "Absolutely," she says. "The analysis was presented as part of a proposed four-facility centralized credentialing program. They were impressed with the development of the analysis, and they are ready to work with us to implement it."

Smith says she helped develop a similar analysis for a hospital she worked for previously. "It resulted in three more employees that I know of," she says.

Time Spent on Medical Affairs Office Functions

Function	Time Allocated	Total Annual Hours
Initial appointment	90 applicants @17 hours each	1,530
Reappointment	150 reappnts @ 8 hours each	1,200
Temporary privileges	67 TPs @ 1.5 hours each	100.5
Provisional appointment recommendation	90 prov. appts. @ 8 hours each	720
Data entry of CME & meeting attendance per member	300 CME @.5 hours each	150
Total Hours		**3,700.5**

Source: Linda Smith, CMSC, CPSC, Our Lady of the Resurrection Medical Center, Chicago.

She's since shared her plan with two medical staff office managers at two other facilities who are currently using it to promote the case for their own medical staff offices.

It is the medical staff office, after all, that turns physicians into staff members, who in turn generate the major source of revenue for the hospital. It is the medical staff office that keeps track of CME activities, organizes peer review arrangements and hearings, handles dues and payments, provides orientation for new physicians, and handles many of the details for good physician relations such as social activities, travel arrangements, special requests, and secretarial functions for the office.

Part of the success of Smith's plan lies in the specific descriptions she developed for each function on her chart. Listing more than 30 functions, she itemized the tasks involved with each individual function.

Verification imposes costs

Kim Gondzar, CMSC, CPCS, medical staff coordinator at Munson Medical Center in Traverse City, MI, also has some serious thoughts about the monetary value of her office's work and sees it in terms of real earnings potential. "There are a lot of revenue areas I would like to embark on," says Gondzar, who also is the President of the Board of Directors for the National Association Medical Staff Services in Austin, TX.

In addition to the usual revenue item of staff dues, Gondzar cites the work of the central verification office (CVO) in health care systems. "Those services require hard work," she notes. "Should they be charged back to the institutions within the system? Does your CVO offer the verification service for other, smaller facilities in your area, such as nursing homes, and should this involve a small charge?"

Gondzar also notes the labor-intensive business of verifying physician presence at your facility as doctors apply for credentials elsewhere. "We've never charged in the past to verify that a doctor has been on our medical staff. But as more physicians and more facilities come into the picture, the paperwork is becoming staggering."

She says her office gets about 20 inquiries a week, "and we're a relatively small health system. Some of these former staff members go back forever. They may have been on staff 20 years ago. For us, this means going through microfiche or going to the basement and digging through storage areas and old records to get the information."

And there's the time invested in being a helpful colleague. "For instance, suppose your facility invests heavily in CME for your medical staff services professionals, and a smaller hospital nearby doesn't have that benefit. It's not unusual for the small hospital staff to call and ask for help with a problem. It's nice to be able to answer their questions, but sometimes it involves time and research. Should we be charging for this kind of service? Where does networking end and consulting begin?"

There is much to be said for spelling out the costs and benefits of a well-run medical staff office. How to begin?

Success lies in specificity

It would be wise to take Linda Smith's approach and calculate the actual number of employee hours that are expended each year. Then itemize your medical staff office functions. And don't stop with credentialing services. Think hard about the additional functions that are inherent in a well-run office. Smith devoted much detail to the peer review process, estimating the hours spent on a basic peer review, the corrective action recommended, hearings, and appellate reviews.

Each step was broken down as a separate function. For instance, the initial peer review process noted everything from logging in the peer review request from quality management to coordinating each meeting required for the process, arranging for charts to be reviewed by each member of the peer review committee, time spent at the meetings, and documenting and reporting meeting findings.

Then, with similar attention to detail, she documented the steps for a corrective action, hearings, and appellate review.

Thoroughness is the most important thing to remember from Smith's analysis of her medical staff office benefits. The big message here for hospitals is that those who handle medical staff services are responsible for a large portion of the hospital's effective function, not to mention revenue produced by physicians. It could be bad business to undervalue those services, because a well-coordinated and satisfied medical staff is the backbone of the hospital's mission and reputation. ■

HIPAA security standards: Is your facility ready?

Before tackling HIPAA, take stock of current system

The rapid advance of technology has meant a lot of changes in the way clinicians work. And now that medical records and information have been firmly entrenched in hospital computer systems and potentially exposed to the expertise of hackers and thieves, it's time to install the deadbolts.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is now an official standard, and those deadbolts are expected to be securely in place and ready for examination within two years.

However, with the rush to get up to speed for Y2K, many hospitals already will have some of the more important and expensive procedures in place. If not, here is a short checklist from QuadraMed, a health care information technology company based in San Rafael, CA, to help get you started. The list includes these basic steps:

- Add HIPAA compliance to your strategic plan.
- Designate an information security manager to take responsibility for HIPAA compliance.
- Ensure that your current or future vendors / contracts are obligated to comply with legislation.
- Purchase new or update current information technology systems to satisfy HIPAA requirements.
- Evaluate current security and confidentiality policies and procedures and modify them, as necessary, to meet the requirements.
- Evaluate your exposure to password security breaches.

Sandra Fuller, MA, RHIA, vice president of professional development services for the Chicago-based American Health Information Management Association (AHIMA), notes that the regulations are technology-neutral, meaning they do not mandate what system, hardware, or software to use. "They address policy and accountability over technology," she says. She suggests that although "the theft of a personal computer may be an annoyance, it is likely to be less expensive than the value of the data stored on that computer." To determine your exposure, she suggests you ask the following questions:

- What precautions are taken for a physical disaster (flood, fire, earthquake)?
- How will this type of emergency affect computer operations?
- What safeguards are in place to protect equipment from theft or vandalism?
- Are special physical security procedures in place for computer rooms or network closets? Are these locked? Are a limited number of people given access?
- Are these physical precautions tested, and are the results of these tests used to improve the security going forward?

Preparation needs to start now. **William Spooner**, senior vice president and chief information officer for Sharp Healthcare in San Diego, also recommends a thorough review of current policies and practices. "Forget HIPAA for the moment and look at what you have in place," he advises.

He then suggests shopping around for someone who has specific expertise and knowledge about HIPAA. "We brought in a consulting firm to review our current policies. They interviewed all the executives throughout the organization and got their opinion on security and how well they thought we were doing. They looked around for problems and even tried getting into our secure systems."

Since then, Spooner and his colleagues have given high-level briefings to their board of directors. "Our legal department is reviewing everything, and our compliance and finance people are looking at the regulations and recommendations," he says. "We've started to meet informally and compare notes. Within the next quarter, we'll be briefing our entire management team. We're currently recruiting for someone to serve as our HIPAA coordinator."

Record processing is going to be a big factor in security standards, according to Fuller. "The regulations require that policies are in place to describe the processing of electronic records. The policies should address data receipt, manipulation, storage, dissemination, transmission, and disposal."

Fuller suggests a complete record of security activities, including all details of physician privileges (granting, modification, termination). She also recommends a comprehensive record of all those with electronic access to sensitive areas at any time. This will provide useful information if a security breach appears.

Those who do have access to health records should be properly trained in the organization's security policies. And those policies need to be

documented in writing and maintained for the record. That means documentation of terminations and additional written records on the return of all security devices such as keys and key cards plus a change of combination locks to the computer rooms. Excessive? Possibly, but these measures are important if you're going to be serious about security.

Both Spooner and Fuller point out the importance of having a designated security manager. This is the person responsible for making sure the HIPAA policies and measures are in place; someone who understands your organization's culture as well as the state and federal security regulations and who can quickly get the ear of your administration.

Also, Fuller explains, there must be a policy to cover the acquisition, removal, and disposal of hardware, software, and data. You also will need a policy describing how computer screens in busy areas are protected from general view. Are automatic screen savers and application timeouts in place? Are staff trained to protect the information on the screen? All these things must be documented.

Although most hospitals will have two years to comply with HIPAA's requirements, "if no policies are currently in place, they will need to be developed at the rate of one every 45 days," Fuller says. That's a tall order, as anyone can testify who's tried to push even so much as a job description through an administrative chain of command.

Still, HIPAA does not consider a written policy to be adequate protection. There are also technical requirements such as physical safeguards, secure workstation location, audit controls, authorization controls, technical security services, and technical security mechanisms for transmission. **(For a more thorough report on complying with the HIPAA regulations, see Sandra Fuller's article, "Implementing HIPAA Security Standards — Are You Ready?" in the *Journal of AHIMA*, October 1999.)**

And the cost for all this? It's dependent on the individual organization, of course. "There's no question it will be significant," says Spooner. "But in the end, it seemed estimates for Y2K compliance were greatly exaggerated. We don't need to overstate the situation. But we need to be aware and ready. In this case, there may be necessary changes we haven't yet addressed."

One thing is certain: Time will not stand still. If you're going to be ready to prove your records are secure, it's time to start ordering the deadbolts. ■

THE QUALITY - CO$T CONNECTION

Analyze process changes to identify system failures

Change analysis can identify contributing causes

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

Undesirable patient incidents often are caused by slight changes in the usual process of patient care that disturb the "balance" of the system. Deviations in system operations can be planned, anticipated, and desired, or they can be unintentional and unwanted.

Change is an integral and necessary part of daily business; for example, requirements change, procedures change, policies and directives change, the personnel performing certain tasks change (i.e., staff turnover). Change can improve efficiency, productivity, and safety, or it can result in errors, loss of control, and accidents.

Change analysis is a tool used in industry to analyze the effect of process changes. This tool can be used to help people evaluate previously trouble-free activities that suddenly have problems. For example, why would a process that is correctly performed 99 times out of 100 fail to perform as expected one time? Change analysis also is a useful tool during a sentinel event investigation to help the team analyze events leading up to the incident. The root-cause analysis team uses change analysis to evaluate the difference between what was expected or planned (i.e., an event-free situation) and the actual sequence of events. Change analysis is particularly useful in identifying obscure contributing causes of sentinel events that result from planned or unplanned changes in a system. This article will discuss how to use change analysis during an accident investigation.

During the application of change analysis, the root-cause analysis team should be instructed to identify process changes, as well as the results of those changes. The distinction is important, because identifying only the results of change may not prompt the team to identify all causal

factors of an event. To illustrate the steps of a change analysis, the following sentinel event will be examined:

A 40-year-old female patient was hospitalized for treatment of delirium. The patient was not considered to be a suicide risk and therefore was not placed on suicide precautions. Early one morning, the patient began talking to herself about cats and dogs being in her bed. In addition, she told the nursing staff that she was at a local country club and not in the hospital. When the patient was found in the hallway, a nurse attempted to reorient her, but these attempts failed. Because the patient was not on any close observation precautions, the nurse left her alone in the hallway. Approximately one hour after the nurse left the patient's side, she wandered into a second-floor staff lounge, where she opened the window and jumped out. The patient fell into the bushes below and suffered serious injuries.

The team investigating this incident follows three steps to complete a change analysis.

1. Describe the event situation and describe the same or similar situation that did not result in an undesirable event.

To expand the team's thinking, these descriptions are categorized into major factors that influence performance. In this example, the categories are defined as: What, Where, When, Who, and How. The factors listed in this example are only guidelines. They may be useful in directing lines of inquiry and analysis. However, other factors may be listed by the investigation team, depending on the event being investigated.

2. For each factor that is thought to have influenced the occurrence of the event, the team is asked to describe the "event-producing situation" relevant to that factor and the "ideal or event-free" situation.

Issues the team should consider as it identifies the error-producing and ideal situation are listed below:

WHAT

—What is the undesirable outcome?

—What occurred to create the undesirable outcome?

—What occurred prior to the event?

—What occurred following the event?

—What operational activities were under way when the tasks leading to the event occurred?

—What supplies / equipment were being used?

—What barriers should have been in place to prevent the undesirable outcome?

—What barriers were in place but failed to stop the undesirable outcome?

WHERE

—Where did the activities leading up to the event occur?

—What were the physical conditions in the area(s)?

—Where was the event first identified?

—Was location a factor in causing the event?

WHEN

—When did the activities leading up to the event occur?

—Was the facility on any special status at the time (e.g., fire drill, Code Blue, emergency admissions only, etc.)?

—Did the time of day have an effect on the event? Physician / staff availability?

—Did the event occur at shift change?

—For how many continuous hours had involved physicians / staff been working?

WHO

—Who were the direct / indirect caregivers involved in the event?

—Which staff witnessed the event?

—Which staff reported the event?

—Which staff were involved in caring for the patient following the event?

—What were the training / qualifications of the physicians / staff involved?

—Who was supervising patient care activities?

HOW

—Was the event caused by an inappropriate action?

—Did procedures exist for the activities / tasks involved?

—Did the procedures related to the tasks have sufficient detail?

—Did the procedure have sufficient fail-safe mechanisms?

—Did the procedure cover work tasks in proper sequence?

3. Once all of the event situations and event-free situations are described for each factor, the team evaluates the differences or variances to determine each item's effect on the undesirable outcome.

By brainstorming all possible event-producing situations, the accident investigation team can clearly see where the process got out of balance. The results of a change analysis can stand alone,

but they are most useful when they are incorporated with other accident investigation tools such as barrier analysis. Change analysis provides a structured way for the team to combine intuition and personal experience to identify the causal factors that contribute to an adverse patient occurrence. ■

JCAHO begins surveying for new pain standards

Pain management summits scheduled

New pain assessment and management standards instituted by the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will become a part of surveys conducted this year, and could be part of the Joint Commission scores for hospitals and other agencies beginning in 2001.

The standards, which have been endorsed by the American Pain Society, call for additions to the JCAHO accreditation manual for hospitals. These additions include:

• **Requiring hospitals to include a commitment to pain management in their mission statements, patient bill of rights, or service standards.** One implementation example included in the manual is a statement posted in patient care areas in a community hospital. The statement informs patients that they have a right to information about pain and pain relief measures. It tells patients they can expect quick response to reports of pain, state-of-the-art pain management, and that "your reports of pain will be believed."

The notice also lists patient responsibilities, including communicating with doctors and nurses about pain, response to pain relief, and any concerns a patient may have about taking pain medication.

• **Provisions for assessment and management of pain of all patients.** This would include an initial assessment, periodic reassessment, and post-procedure monitoring.

Examples of implementing that standard could include recording pain intensity readings during admissions, asking screening questions regarding pain, and evaluating competency in pain assessment during staff orientation.

• **Addressing the appropriate use of patient-controlled analgesia, spinal/epidural, or IV administration of medications and other pain management techniques through policies, staff orientation, or other means.**

• **Addressing pain and pain relief in patient and caregiver education.** Examples offered include publications that stress pain management and review of computer-generated information sheets that are distributed with medication.

Susie McBeth, JCAHO's associate director in the department of standards, says the pain management additions stem from a concern that patients' pain continues to be undertreated. "We had standards in the manual that really related more to the dying patient, even though it was implied that all patients should have good pain management."

She adds the standard regarding pain assessment is key to proper pain care."Really listening to the patient is the important part of it," McBeth says. "You really need to listen to the patient and

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don't bring your own bias into it about how much pain you think that patient is feeling."

Surveyors will be asking about pain management during surveys conducted in 2000, but scores from those standards won't affect accreditation. McBeth says JCAHO will use the information as feedback to determine how much weight the standards will carry in 2001. "This is the year for people to implement the standards and get ready, and we just want to kind of see where everybody is."

In the meantime, the Joint Commission will try to assist in the education process this year by offering publications, two pain management "summits" tentatively scheduled for May and July, an educational video, and other programs.

The commission also is seeking case study information from hospitals that have developed successful pain management programs. For more information, write the Joint Commission on Accreditation of Healthcare Organizations at One Renaissance Boulevard, Oakbrook Terrace, IL 60181-4294. Telephone: (630) 792-5000. Web site: www.jcaho.org. ■

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