Quality and Performance Improvement in Healthcare

Theory, Practice, and Management

Sixth Edition

Instructor’s Manual

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Introduction

This instructor’s guide includes examples of possible responses to the case study questions in chapters 3 through 21. To view the illustrations in the answer key, the instructor should use the page layout view of the document.
Chapter 1

Introduction and History of Performance Improvement

Learning Objectives

- Trace the historical events that have contributed to modern performance improvement programs
- Identify the key legislation that has influenced healthcare quality initiatives
- Describe the key individuals and organizations that have shaped the theory and developed models for use in performance improvement activities

Key Terms

- Accountable Care Organization (ACO)
- Affordable Care Act (ACA)
- Core measures
- Cost
- Effectiveness
- Efficiency
- Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)
- Outcome
- Process
- Quality assurance (QA)
- Retrospective payment system
- Structure
- Total quality management (TQM)
- Value-based purchasing
Answers to Review Questions

1. a
2. b
3. c
4. b
5. Patient/caregiver care experiences; Care coordination; Patient safety; Preventive health; and, At-risk population/frail elderly health.

Application Activity

1. Identify a specific historical event described in the chapter and articulate how this event has shaped current performance improvement or quality initiatives in the modern era.

Sample answer: The Flexner report identified unacceptable variations in medical school curriculum that would ultimately result in variations in the patient care being delivered by these physicians. This is the early stages of peer review processes, medical licensing, and credentialing activities that are prevalent in healthcare organizations today.

Test Bank Answer Key

1. During the mid-1700s, the citizens of Philadelphia, PA, recognized the need to sequester newly arrived immigrants, who often contracted diseases during their long voyages to America. This procedure is an example of early _____.
   a. infection control
   b. utilization management
   c. performance improvement
   d. life safety management

2. This association was established in 1840 to represent the interests of physician across the United States.
   a. American College of Surgeons
   b. American College of Physicians
c. American Medical Association
d. American Association of Physicians

3. Which of the following individuals volunteered to perform the first review of medical college curriculum and education processes leading to more rigorous academic standards for medical schools?
   a. Dr. Thomas Bond
   b. Benjamin Franklin
   c. Dr. Samuel Gross
   d. Henry Pritchett

4. The practice of reporting patient outcomes to the Hospital Board of Trustees was begun at which of the following hospitals?
   a. Massachusetts General
   b. Mayo Clinic
   c. Pennsylvania Hospital
   d. Bellevue Hospital

5. Which state was the first to pass legislation that required nurses to be registered?
   a. Massachusetts
   b. New York
   c. North Carolina
   d. Pennsylvania

6. In 1965, the United States Congress passed Public Law 89-97, an amendment to the Social Security Act of 1935. This law established:
   a. Children’s Health Insurance Plan
   b. Funds for hospital construction
   c. Hospital accreditation
   d. Medicare and Medicaid

7. Which of following individuals was instrumental in bringing attention to the formal training needs for nurses?
   a. Dr. Thomas Bond
b. Benjamin Franklin

c. Dr. Samuel Gross

d. Henry Pritchett

8. In the 1700–1800s, this hospital became a model for the development of hospitals in other communities.
   a. Massachusetts General
   b. Mayo Clinic
   c. Pennsylvania Hospital
   d. Bellevue Hospital

9. **True or false?** TQM mobilizes individuals directly involved in a work process to examine and improve the process with the goal of achieving a better product or outcome. It does not matter what the product or outcome might be.

10. Which of the following is NOT a type of managed care?
   a. HMO
   b. PPO
   c. POS
   d. TQM

11. **Value-based purchasing** is a system in which purchasers hold providers of healthcare accountable for both the costs of healthcare and its quality.

12. This organization developed a set of National Patient Safety Goals (NPSGs) that all institutions participating in accreditation must promote and train their staffs providing care to adhere to?
   a. Joint Commission
   b. American Hospital Association
   c. Institute of Medicine
   d. American College of Surgeons

13. Which of the following is the act that stimulated investment in the information systems infrastructure of professional practices, clinics, and hospitals?
   a. Hill-Burton
b. HITECH

c. Social Security

d. Standardization

14. **True** or false? The following organizations: the American Medical Association (AMA), the American College of Physicians (ACP), the American Hospital Association (AHA), and the Canadian Medical Association (CMA)—decided to join the ACS to develop the Joint Commission on Accreditation of Hospitals.

15. This act established a quality reporting program for skilled nursing care in the United States.

  a. ARRA
  
  b. HITECH
  
  c. IMPACT
  
  d. PPACA
Chapter 2

Defining a Performance Improvement Model

Learning Objectives

- Explain the cyclical nature of performance improvement activities
- Define terminology and standards common to performance improvement activities
- Distinguish between organization-wide performance improvement activities and team-based performance improvement activities
- Outline the organization-wide performance improvement cycle
- Delineate the team-based performance improvement cycle

Key Terms

Benchmark
Continuous monitoring
High Reliability Organizations (HROs)
Leadership
Lean
Opportunity for improvement
Performance improvement (PI) team
Process redesign
QI toolbox techniques
Six Sigma
Systems Thinking
Answers to Review Questions

1. Six Sigma uses statistics for measuring variation in a process with the intent of producing error-free results. Sigma refers to the standard deviation (SD) used in descriptive statistics to determine how much an event or observation varies from the estimated average of the population sample.

Lean has been adopted by healthcare organizations as a way to streamline their processes and eliminate waste. Successful implementation of Lean techniques in a healthcare organization must include attention to the customer (patient-centered care) and their perspective while attempting to reduce unnecessary waste.

HROs have learned to manage the unexpected. These organizations know that unexpected change can sometimes be prevented or at least anticipated or even prepared for. HROs have learned that mistakes and errors occur because of employees’ mindlessness and distraction, and mindlessness and distraction occur when employees are hurried or overloaded.

2. a

3. b

4. d

5. b

Test Bank Answer Key

1. True or false? Healthcare leaders and their boards of directors are responsible for the quality of the organizations’ services.

2. Monitoring performance based on internal and external data is the foundation of all PI activities.

3. Organizations that pay close attention to weak signals of trouble to catch problems or errors in the earliest stage are applying the principles of _____.
   a. HRO
   b. Lean
   c. Six Sigma
   d. Systems thinking

4. True or false? Quality and performance monitoring is a data-driven process?

5. A quantitative tool that provides an indication of an organization’s performance in relation to a specified process or outcome is a/an _____.
6. The regular and frequent assessment of healthcare processes and their outcomes and related costs is considered _____.
   a. continuous monitoring  
   b. continuous data 
   c. continuum of care 
   d. continuum of data 

7. Joint Commission requires healthcare organizations to appoint a leadership group to oversee organization-wide PI activities.

8. A standard of performance or best practice for a particular process or outcome is called a/an _____.
   a. performance measure  
   b. benchmark 
   c. improvement opportunity 
   d. data measure 

9. Which of the following terms does the textbook use to identify a variety of methods PI teams can use to accomplish their goals?
   a. PI processes 
   b. QI toolbox techniques  
   c. QI actions 
   d. PI skills 

10. This quality improvement methodology uses statistics for measuring variation in a process with the intent of producing error-free results?
    a. HRO 
    b. Lean  
    c. Six Sigma
11. A team may redesign a process or product if
   a. measurement indicates there is room for further improvement
   b. new board members are appointed
   c. the team adds a new member
   d. data cannot be collected on the process

12. Root-cause analysis is a key technique used in this quality improvement methodology?
   a. HRO
   b. Lean
   c. Six Sigma
   d. Systems thinking

13. Process redesign is the steps in which focused data are collected and analyzed, changes are incorporated, the new process is implemented, and staff are educated about the new process.

14. Each healthcare organization must identify and prioritize which processes and outcomes (in other words, which types of data) are important to monitor. This data collection should be based on the scope of care and services it provides and _____.
   a. the number of employees they employ
   b. their mission
   c. the QI methodology used
   d. their accreditation status

15. Performance improvement data collection results that fall outside the established benchmark often trigger further study or more focused data collection on a performance measure.
Chapter 3

Identifying Improvement Opportunities Based on Performance Measurement

Learning Objectives

- Define the principal aspects of healthcare that are targeted for performance measurement
- Describe the significance of outcomes and proactive risk reduction in performance improvement methodology
- Explain how brainstorming and the nominal group technique can be used in performance improvement activities

Key Terms

- Affinity diagrams
- Benchmarking
- Brainstorming
- Nominal group technique
- Outcome measure
- Outcomes
- Performance measurement
- Performance measures
- Process measure
- Sentinel events
- Systems

Answers to Review Questions

1. b
2. c
3. d
4. a
5. d

Case Study

Answers to this case study will be dependent on the video, television program, or film that is watched for this case.

Application Activity:

Due to increased patient volumes in the facility, the coding manager at Community Hospital is faced with an increased discharge not final bill (DNFB) rate. The management staff of the HIM department has brainstormed the following list of potential solutions to rectify this problem. Working in teams or individually, students should determine the appropriate categories for the brainstormed solutions and create an affinity diagram using the categories and potential solutions.

Potential Solutions

- Implement computer assisted coding (CAC)
- Send coders home to work remotely
- Implement flex time
- Perform a work imaging study to see how the coders are spending their time
- Hire a coding support person to handle the clerical activities
- Have all coders code only one patient type (i.e., inpatients, outpatients, emergency room, ancillary)
- Hire more coders
- Provide more coding training
- Change encoders
- Change the coding workflow
- Train coders to code more than one patient type
- Send all coders to a regional coding meeting

Possible Answer:
Test Bank Answer Key

1. The foundations of care giving, which include buildings, equipment, professional staff, and appropriate policies are included in what area of performance measurement?
   a. outcomes
   b. processes
   c. systems
   d. benchmarks

2. The interrelated activities in healthcare organizations, which promote effective and safe patient outcomes across services and disciplines within an integrated environment, are included in what area of performance measurement?
   a. outcomes
   b. processes
   c. systems
   d. benchmarks
3. The final results of care, treatment, and services in terms of the patient’s expectations, needs, and quality of life, which may be positive and appropriate or negative and diminishing, are included in what area of performance measurement?

   a. outcomes  
   b. processes  
   c. systems  
   d. benchmarks

4. This type of performance measure focuses on a process that leads to a certain outcome, meaning that a scientific or experiential basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome:

   a. outcome measure  
   b. data measure  
   c. process measure  
   d. system measure

5. This type of performance measure indicates the result of the performance or non-performance of a function or process:

   a. outcome measure  
   b. data measure  
   c. process measure  
   d. system measure

6. The percentage of antibiotics administered immediately prior to open reduction internal fixation (ORIF) surgeries or percentage of deliveries accomplished by cesarean section are both examples of a(n) _____.

   a. outcome measure  
   b. data measure  
   c. process measure  
   d. system measure

7. The incidence of postoperative wound infections occurring in ORIF procedures in which antibiotics were and were not utilized is an example of a(n) _____.

   a. outcome measure  
   b. data measure  
   c. process measure  
   d. system measure
a. outcome measure
b. data measure
c. process measure
d. system measure

8. The process of benchmarking against an organization’s established norm, which may be based on best practice, state or national standards, or some combination of these thresholds, helps the organization determine whether its processes fall within the acceptable standard deviations of the norm. When items fall outside the norm this signals that _____.

a. a PI project may be appropriate
b. the organization must contact their accrediting organization immediately to report this
c. the organization is on target
d. the organization should benchmark against hospitals that are located at a greater distance

9. Which of the following would be an example of a reviewable sentinel event?
   a. incidence of hospital acquired infection
   b. incidence of an unruly patient
   c. incidence of infant abduction
   d. incidence of blood transfusion reaction

10. During a PI team meeting, the leader asked members of the team to provide ideas on how to reduce the coding backlog. Each team member offered their ideas on how to reduce the coding backlog as they came up with them and the team leader recorded them on the white board. What PI tool is being used in this example?
   a. structured benchmarking
   b. structured brainstorming
   c. unstructured benchmarking
d. unstructured brainstorming

11. Which of the following techniques is commonly used by the PI team after completing brainstorming session to rank the ideas generated from least to most important?
   a. benchmarking
   b. brainstorming
c. decision making technique
d. nominal group technique

12. The percentage of unplanned returns to the operating room would be collected to measure procedure performance and patient monitoring. This would be an example of a(n) _____.
   a. outcome measure
   b. data measure
   c. process measure
   d. system measure

13. The number of incidences of violence in the workplace would be collected as a risk management measure. This is an example of a(n) _____.
   a. outcome measure
   b. data measure
   c. process measure
   d. system measure

14. Optimizing treatment of heart failure patients across the continuum of care to improve care and reduce hospital readmissions is an example of a(n) _____.
   a. outcome measure
   b. data measure
   c. process measure
   d. system measure

15. Discuss the importance of focusing on the customer and their requirements as a foundation for performance improvement.

   Answer: The customer is anyone who receives the outcome or end product of the process. Understanding who these individuals are and what their level of expectation is from the process is key to evaluating how well the process is working.
Chapter 4

Applying Teamwork in Performance Improvement

Learning Objectives

- Identify the effective use of teams in performance improvement activities
- Discuss the differences between the roles of the leader and the members in performance improvement teams
- Describe the contributions that team charters, team roles, ground rules, listening, and questioning can make to improve the effectiveness of performance improvement teams

Key Terms

- Action plan
- Agenda
- Blitz team
- Cross-functional
- Functional
- Ground rules
- Mission statement
- Performance improvement council
- Team charter
- Team facilitator
- Team leader
- Team member
- Team recorder or scribe
- Timekeeper
- Values statement
- Vision statement
**Review Questions Answers**

1. What process is to be improved? For whom is the process performed? What products does the process produce? What is not working with the current process? How well must the process function?

2. b

3. b

4. a

5. c

**Case Study**

1. The reasons why this case presents opportunities for improvement should come directly from the case itself. This case study definitely provides an opportunity for improvement for Western States Hospital. Some of the reasons include

   - The frustration and anger demonstrated by both the cath lab scribe with the admissions clerk
   - The fact that the cath lab scribe often has to call admitting when a patient is transferred
   - The fact that the admissions clerk states she was too busy to know the patient was taken to the cath lab
   - The fact that the cath lab staff cannot view the medication list or enter patient information as the procedure is being performed until the change has been made to the patient type. The fact that the cath lab staff is reliant on the admissions clerk to make the patient type change in the electronic health record (EHR) and they are not able to do this themselves

2. A performance improvement team would be appropriate in this context. Any opportunities for improvement may affect multiple departments, patient care, accurate quality data reporting (core measure), and numerous personnel.

3. The performance improvement team should consist of the following people:

   - **Admitting department supervisor or manager:** The supervisor of the admissions clerks, who are responsible for entering the status and location of patients in the EHR
   - **Admitting clerks:** The individuals primarily responsible for entering the patient type changes in the EHR
   - **Information systems staff:** The individuals responsible for the EHR role and access control
   - **Cath lab supervisor or manager:** The cath lab supervisor
   - **Cath lab scribe or technicians:** The staff responsible for entering cath lab procedure information and patient information into the EHR
   - **Administration staff:** Individuals responsible for coordinating the work of the departments and assessing the financial impact of potential and required computer systems changes
Test Bank Answer Key

1. A type of PI team that constructs relatively simple and quick "fixes" to improve work process without going through the complete PI cycle is called a _____.
   a. blitz team
   b. functional team
   c. cross-functional team
   d. TQM team

2. A PI team that involves staff from more than one department, service area, or discipline is called a _____.
   a. blitz team
   b. functional team
   c. cross-functional team
   d. TQM team

3. A PI team role responsible for championing the effectiveness of PI activities in meeting customers’ needs and for the content of a team’s work is the _____.
   a. team leader
   b. team member
   c. team recorder or scribe
   d. team facilitator

4. A PI team role responsible for maintaining the records of a team’s work during meetings, including any documentation required by the organization, is the _____.
   a. team leader
   b. team member
   c. team recorder or scribe
   d. team facilitator

5. A PI team role primarily responsible for ensuring that an effective performance improvement process occurs by serving as advisor and consultant to the PI team, remaining a neutral, nonvoting member, suggesting alternative PI methods and techniques to keep the team on target and moving forward,
maintaining group dynamics, acting as coach and motivator for the team, assisting in consensus building when necessary, and recognizing team and individual achievements is the _____.

a. team leader  
b. team member  
c. team recorder or scribe  
d. team facilitator

6. A broad statement describing what a healthcare organization does or a statement of the goals and purpose of a performance improvement initiative is called the _____.

a. team charter  
b. team mission  
c. team charge  
d. team vision

7. A description of the ideal end state or a description of the best way a process should function is called the _____.

a. team charter  
b. team mission  
c. team charge  
d. team vision

8. Which of the following is a set of initiatives that are to be undertaken to achieve a performance improvement goal?

a. action plan  
b. agenda  
c. ground rules  
d. mission statement

9. When a PI team first meets and discusses participation expectations, communication methods, and plans for decision making techniques to be used, these are examples of team _____.

a. action plan  
b. agenda  
c. ground rules
10. A statement that describes the standards governing the operation of an organization and its relationship with customer, suppliers, employees, the local community, and other stakeholders is called _____.
   a. mission statement
   b. purpose statement
   c. values statement
   d. vision statement

11. Which of the following is the group that oversees all PI activities within a healthcare organization?
   a. ethics committee
   b. risk management
   c. peer review committee
   d. performance improvement council

12. This statement describes what the organization or PI initiative will look like in the future or may describe some milestone the PI team will reach in the future.
   a. mission statement
   b. purpose statement
   c. values statement
   d. vision statement

13. A tool used to ensure that every team members knows which items will be discussed or worked on during a meeting is called a:
   a. action plan
   b. agenda
   c. flow chart
   d. dashboard

14. A team organized in the HIM Department to look at errors in the release of information process would be considered a
   a. blitz team
b. functional team
c. cross-functional team
d. multi-disciplinary team

15. Mission statements should answer the five questions listed in the textbook regarding mission statements. The following is an example of a mission statement. Using the sample mission statement below, answer the questions from the textbook or explain that the statement doesn’t answer them.

Mission Statement: To evaluate and monitor technical factors associated with patient radiation exposure, ensuring that the radiology department provides physicians and families with the highest quality image at the lowest possible dose.

What process is to be improved? Highest quality image at the lowest possible dose.
For whom is the process performed? Physicians and patients
What products does the process produce? Quality images
What is not working with the current process? This could have been better explained in the mission statement. The organization may be operating under an assumption that the images were of poor quality with the use of a higher level of radiation exposure than needed. The mission statement does not reflect this very well.
How well must the process function? At the highest quality and lowest dose, but this could use more specificity.
Chapter 5

Aggregating and Analyzing Performance Improvement Data

Learning Objectives

- Differentiate between internal and external benchmark comparisons
- Identify common healthcare data collection tools
- Introduce the concept of data aggregation in support of data analysis
- Describe the various data types
- Recognize the correct graphic presentation for a specific data type
- Design graphic displays for a given set of data
- Analyze the data for changes in performance displayed in graphic form

Key Terms

- Absolute frequency
- Bar graph
- Check sheet
- Continuous data
- Control chart
- Discrete or count data
- Histogram
- Likert scale
- Line chart
- Mean (M)
- Median
- Nominal data
Ordinal data
Pareto chart
Pie chart
Pivot table
Relative frequency
Sampling
Skewing
Standard deviation (SD)

Review Question Answers
1. a
2. d
3. c
4. b
5. c
# Case Study

**Western Healthcare System**

**HIM Corporate Dashboard**

**March, 20x**

<table>
<thead>
<tr>
<th>Charts Received</th>
<th>Scan Days</th>
<th>Index Days</th>
<th>Quality Review of Scanning/Indexing Process (in days)</th>
<th>Deliquency Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (IP)</td>
<td>IP SDS ED</td>
<td>OP</td>
<td>IP SDS ED OP</td>
<td>IP SDS ED</td>
</tr>
<tr>
<td>next day</td>
<td>1.0 2.0 3.0</td>
<td>1.0 2.0 3.0</td>
<td>1.0 2.0 3.0</td>
<td>1.0 2.0 3.0</td>
</tr>
<tr>
<td>Same Day (SDS)</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
<td>2 days</td>
</tr>
</tbody>
</table>

1. **The data is showing that Western Healthcare System’s HIM departments are outside of the normal range for best practices.** As noted in the figure above, the highlighted red and yellow indicators are showing metrics where hospitals within the corporation are not meeting the best practice standards. The yellow highlighted metrics are showing a slight variance from the standard, while the red highlighted metrics are showing a significant variation from the standard. Overall, the Urban Regional Hospitals are outside of range in most metrics, and are significantly out of range in the Quality Review of Scanning/Indexing Process.

2. **More information should be collected from each hospital about their staffing levels during the month (i.e., open positions, vacations, short-term or long-term leave) to see if this is a contributing factor for the variance in the metrics.** Other examples of additional data and information that might be helpful is: Was staff involved in any mandatory training during the month that might have been a contributing factor as well? Was there any significant computer down time during month?

3. **Although many of the metrics have concerning numbers for the month, the two largest areas of concern are the Quality Review of Scanning/Indexing Process and Analysis Days.** The Corporate HIM Director may want to trend and/or graph these specific metrics over time to see if there are in consistencies found in the longitudinal data. (As instructors for this course, you may want your students to graph this data as part of their assignment.)
Test Bank Answer Key

1. This type of data is also called ranked data and expresses the comparative evaluation of various characteristics or entities, and relative assignment of each, to a class according to a set of criteria:
   a. nominal data
   b. **ordinal data**
   c. discrete data
d. continuous data

2. These types of data are numerical values that represent whole numbers:
   a. nominal data
   b. ordinal data
   c. **discrete data**
d. continuous data

3. This type of data assumes an infinite number of possible values in measurements that have decimal values as possibilities:
   a. nominal data
   b. ordinal data
   c. discrete data
d. **continuous data**

4. This type of data display tool is used to display discrete categories:
   a. **bar graph**
   b. histogram
c. pie chart
d. line chart

5. This type of data display tool is used to show the relationship of each part to the whole:
   a. bar graph
   b. histogram
c. **pie chart**
6. This type of data display tool is a plotted chart of data that shows the progress of a process over time:
   a. bar graph
   b. histogram
   c. pie chart
   d. line chart

7. In the following data set the absolute frequency for 99/min is:

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Pulse Rate Recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 5, 8:00 a.m.</td>
<td>100/min</td>
</tr>
<tr>
<td>Jan. 5, 12:00 noon</td>
<td>102/min</td>
</tr>
<tr>
<td>Jan. 5, 4:00 p.m.</td>
<td>99/min</td>
</tr>
<tr>
<td>Jan. 5, 8:00 p.m.</td>
<td>99/min</td>
</tr>
<tr>
<td>Jan. 5, 12:00 midnight</td>
<td>102/min</td>
</tr>
<tr>
<td>Jan. 6, 4:00 a.m.</td>
<td>98/min</td>
</tr>
<tr>
<td>Jan. 6, 8:00 a.m.</td>
<td>99/min</td>
</tr>
</tbody>
</table>

   a. 1
   b. 2
   c. 3
   d. 4

8. Using the data set from Question 7, the relative frequency for 102/min would be _____.

a. 42.9  
b. 28.6  
c. 14.3  
d. 57.1

9. Examples of this type of data include: weight, time, and temperature _____.
   a. nominal data  
   b. ordinal data  
   c. discrete data  
   d. continuous data

10. In a patient satisfaction survey the patient is asked to rate their level of satisfaction with the healthcare organization, from 1 to 5. This type of method is called?
   a. continuous data  
   b. count data  
   c. likert scale  
   d. sliding scale

11. This type of chart can help the PI team focus on problems and their causes, and demonstrate which are most responsible for the problem.
   a. bar graph  
   b. pareto chart  
   c. pie chart  
   d. line graph

12. Which of the following tools may be used to summarize charges from a department?
   a. plot table  
   b. pareto chart  
   c. pie chart  
   d. pivot table

13. If Sue has three children and Bob has two children, the value representing the number of children in their family is considered this type of data:
a. nominal data
b. ordinal data
c. discrete data
d. continuous data

14. If there are 45 instances of patients with lung cancer last year and you need to draw an appropriate sample of these cases to abstract, how many patient charts should you abstract?
a. no sampling is required
b. 10% or 4.5 cases
c. 20% or 9 cases
d. sample 30 cases

15. Which of the following terms describes the occurrence of a lot of very high or very low values in the observations that distort the calculated mean in data?
a. skewing
b. standard deviation
c. mean
d. mode
Chapter 6

Communicating Performance Improvement Activities and Recommendations

Learning Objectives

- Apply communication tools such as minutes, quarterly reports, and presentations in performance improvement processes
- Recognize the key elements in a PI presentations and critique a presentation layout

Key Terms

- CRAF Method
- Minutes
- Quarterly reports
- Report cards
- Storyboard
- Storytelling

Review Question Answers

1. B
2. Include headers for each section of the presentation; ensure that the title is easy to read. Use clear and succinct wording throughout the poster; the font should be large enough to read, but small enough that you can include the required information (24 point or greater). Leave some space as you design your poster. Keep it neat and uncluttered. The writing should be succinct and include information that is important and relevant to your project; and organize the layout well. Try out different layouts and graphics until you find a format that works well (i.e. use a variety of fonts and colors to bring attention specific content).
3. C
4. Conclusions of group discussion; Recommendations made by the committee or team; Actions that the committee, team, or individual members decide to take; and Follow-up activity.
Example 1 student project:

**Inpatient Billing Project Improvement**

**Mission**
- Evaluate the inpatient billing process for the Clinic Consult Service, to ensure attending participation, adequate documentation, and consults seen vs. consults billed while maintaining a 95% completion and submission rate.

**Vision**
- The Clinic consult service consisting of an on-call fellow, a Resident and an Attending physician who provide timely inpatient consults. Provide EMR documentation within 24 hours noting the physical presence of the attending physician. This will ensure Federal Regulations are met and the services can be billed. Resulting in an environment that preserves patient safety and delivers the best quality of care.

**Customers & What They Require**
- Patients
- Fellows and Residents
- Division Faculty
- All customers identified require the attending to be present during a consult and document appropriately.

**Survey Methods**
- Faculty surveyed in January Facult meeting regarding knowledge of inpatient Consult billing and documentation process.
- Data obtained showing consultants ordered and actual consults billed for October – December.
- Data analyzed to determine if it was lack of documentation or physical presence that was producing uncollectable services.

**Action Plan**
- Provide education to all attend physicians, fellows, and residents regarding what the CMS Federal Guidelines are for inpatient consultations in a teaching setting.
- Reevaluate data after 3rd qtr available to ensure an increase in compliance. Provide feedback to all more education as needed.

**Follow-Up & Recommendations**
- At the end of the 3rd quarter, the rate increased for the 3rd month again. Other methods and best practices were identified including lag time for documentation submission with data reporting. Alterations and implemented and data will be reviewed again when the 4th quarter data is in.
- Develop EMR templates that require language for attending to utilize. Will serve as reminder requirements.
- Provide data at monthly faculty meeting regarding billable and unbillable services. Focusing on revenue lost.

<table>
<thead>
<tr>
<th>Month</th>
<th>Billed</th>
<th>Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCT</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>NOV</td>
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<tr>
<td>DEC</td>
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<td>83</td>
<td>83</td>
</tr>
<tr>
<td>MAR</td>
<td>78</td>
<td>78</td>
</tr>
</tbody>
</table>

**ORDERS VS. BILLED**

- IMPRIME CONSULT BILLED
- IMPRIME CONSULT ORDERS
Example 2 of student project:

Case Study

1. It is difficult to assess whether the presentation is pleasing to look at, colorful, and easy to read when viewed in this format. The main problem with this presentation is that different fonts and font sizes have been used and the survey is difficult to read.
2. The presentation is set up in a logical manner and flows well from left to right.
3. Yes, all of the required elements of a PI presentation are included.
4. Yes, the steps in the process are clear and understandable.
5. Students should refer to chapter 4 to determine whether the statement includes all of the required elements in a good mission statement.
   a. *What process is to be improved?* Discharge summary documentation in regard to timeliness and completeness.
   b. *For whom is the process performed?* Patients, hospital staff, payers, and accreditors.
   c. *What products does the process produce?* Timely and complete documentation of the discharge summary for its patients.
   d. *What is not working with the current process?* This mission statement does not address this issue.
   e. *How well must the process function?* The PI team did not include this element within its mission statement.
6. All elements of a good vision statement are present. The ideal state is projected in the PI team’s statement.
7. Both internal and external customers are identified.
8. This presentation identifies specific customer requirements. These are accurately assigning reports to be dictated, maintaining a functioning dictation system, and producing reports into the medical record in a timely manner.
9. All of the team’s findings are presented in graphical form in this presentation.
10. Not all of the PI team’s recommendations are supported by the data found in the outcome section of this presentation. The vision statement indicates that the threshold for completion of discharge summaries is 48 hours or 2.0 days. All three departments, orthopedics, OB/GYN, and MICU are over this standard. The incentive recommendation is supported by the data in that no departments are meeting the current standard so this may be a method that can be implemented to improve this outcome.

**Test Bank Answer Key**

1. A graphic display tool used to communicate the details of performance improvement activities is called ______.
   a. storyboard
   b. minutes
   c. report
   d. follow-up report
2. List the 7 keys to successful storytelling.

   - Organization
   - Structure
   - Timeliness
   - Frequency
   - Connection
   - Celebration
   - Feedback

3. List the rules for creating effective storyboards.

   - Map the board in advance with labels for each section
   - Prepare clean boards for group presentation and display
   - Keep detailed information in a team record binder for reference
   - Plan the presentation to fit the size of the storyboard and the general size of the panels
   - Use large fonts so that people can read the boards from a distance

4. True or false? Various regulatory and accreditation agencies require evidence of PI activities by healthcare organizations to prove their compliance?

5. Which section of the CRAF minutes should document the results of the discussion and any decisions the group makes?
   a. conclusions
   b. recommendations
   c. actions
   d. follow-up

6. Which of the following is often used as a powerful tool of teaching and learning?
   a. lecture
   b. reports
   c. display
   d. storytelling
7. **True** or false? A benefit from storytelling is that it documents team accomplishments over an extended period of time in an organized and succinct way.

8. Which of the following is a common standing committee in most healthcare organizations responsible for coordinating and reporting PI and safety activities?
   a. risk management committee
   b. incidence response committee
   c. **PI and patient safety committee**
   d. ethics committee

9. Which section of the CRAF minutes documents whether the actions were accomplished and whether the group is ready to make decisions and recommendations for further activities?
   a. conclusions
   b. recommendations
   c. actions
   d. **follow-up**

10. How is the board of directors informed of team-based PI activities in a healthcare organization?
    **Answer: The PI team submits quarterly reports of their activities to the PI and Patient Safety Council which in turn summarizes and reports these activities to the board of directors.**

11. Which section of the CRAF minutes documents who was assigned to accomplish which activities during the next work period?
    a. conclusions
    b. recommendations
    c. **actions**
    d. follow-up

12. This type of report is based on the documented meeting minutes and should include information about PI activities such as: summaries of data collection, conclusions, and recommendations.
    a. annual report
    b. dashboard
    c. storyboard
    d. **quarterly report**
13. Which section of the CRAF minutes captures the teams plan for putting its decision in effect, with justification points if necessary?
   a. conclusions
   b. recommendations
   c. actions
   d. follow-up

14. Why would a PI team create a poster presentation using words, pictures, and graphs?
   Answer: A PI team would do this to summarize the entire PI project in a graphic form to tell the story of the project in a fashion that permits listeners to grasp the teams thought process and to understand its specific applications of PI tools.

15. Which of the following can be used by a healthcare organization to communicate performance information that emphasizes the organization’s mission within the community and their efforts to provide the community with high quality care?
   a. annual report
   b. dashboard
   c. storyboard
   d. charter
Chapter 7

Measuring Customer Satisfaction

Learning Objectives

- Identify the differences between internal and external customers
- Summarize the reasons customers’ perspectives are important to the performance improvement process
- Describe the differences between surveys and interviews
- Outline the characteristics that make surveys and interviews effective
- Critique a survey or interview format

Key Terms

Customers
Direct observation
Expectations
External customers
Funneling
Internal customers
Interviews
Operational definition
Survey tools

Review Question Answers

1. a
2. b
3. Dr. Jones would be an internal customer if she is an employed physician of the healthcare organization. This is because internal customers are individuals within the organization who receive products or services from an organizational unit or department. If Dr. Jones is not employed by the healthcare organization, she would then be considered an external customer of the HIM department.

4. a
5. c

Application Activity

Students should brainstorm and identify internal and external customers of the health information management department of a hospital.

*Possible answers might be:*

Internal—physicians, other hospital staff that use patient information, other departments within the hospital, patients, hospital administration.

External—all recipients of ROI, payers, government agencies, auditors, accreditation bodies, patients, physician offices outside of the hospitals, other healthcare facilities.

Case Study

This survey presents the student with many design issues. Some of the problems found in this survey include the following items:

- The questions should be numbered for easier data collection and aggregation.
- The survey is formatted inconsistently throughout. For example, two types of check boxes are used.
- Wording was straightforward and understandable up until the questions referencing treatment by other hospital personnel. The questions about which personnel the patient should evaluate are unclear, and they do not take into account that more than one person may care for the patient in each of the areas listed.
- In the question that asks, “Did they answer your questions about SSS satisfactorily?” it is unclear who “they” refers to, and the acronym SSS is not explained.
- The open-ended question, “How did you choose the physician who provided your care?” could be structured similarly to the previous question regarding hospital selection.
• Terms that may be unfamiliar to patients are not explained in the survey, for example, short-stay surgery, SSS, recovery, surgery, and x-ray. The writers of the survey should not assume that patients understand clinical terms and abbreviations.

Test Bank Answer Key

1. True or false? The customer is the receiver of a product or service as a result of an organizational process.

2. When developing a survey the use of structured questions to limit the number of possible responses helps to:
   a. standardize the data collected
   b. generate more responses
   c. elicit more information
   d. maximize the number of write-in responses

3. A staff member is assigned to sit in the waiting room of the physician’s office to collect data on patient waiting times. The staff member records the time in which the patient comes in the door and when the patient is called back to the examining room. This is an example of what type of data collection?
   a. survey
   b. interview
   c. direct observation
   d. qork imaging

4. When the customer (patient) has judged that the healthcare worker is continuously monitoring both the customer’s condition and his or her satisfaction with services, what aspect of quality of care or meeting the customer requirement is being met?
   a. assurance
   b. empathy
   c. reliability
   d. responsiveness

5. True or false? Internal customers are individuals from outside the organization who receive products or services from within the organization.
6. In this type of interview, a predetermined list of questions is used:
   a. structured interview
   b. unstructured interview
   c. planned interview
   d. unplanned interview

7. The health information professional is a customer of the admitting department. What type of customer is the health information professional?
   a. external customer
   b. experienced customer
   c. internal customer
   d. investment customer

8. Which of the following techniques, used in unstructured interviews, helps the interviewer establish trust with the respondent and address the pertinent quality issues by moving questions from a broad theme to a narrow theme?
   a. funneling
   b. skewing
   c. nominal group
   d. brainstorming

9. An important strategy in survey design involves the use of terms, phrases, and words that are known to both the PI team and respondents. This clarity of terminology is called _____.
   a. assurance
   b. responsiveness
   c. operational definition
   d. direct observation

10. The level at which an organization can provide an offered product or service when requested and as advertised is called _____.
    a. responsiveness
    b. reliability
c. assurance  
d. empathy  

11. Healthcare customers expect that staff and providers will understand their emotional reactions to their illness and will help them cope with their circumstances. This is an example of _____.  
a. responsiveness  
b. perceived quality  
c. empathy  
d. assurance  

12. The health information professional relies on the patient registrar to accurately identify the patient in the EHR this is an example of a _____.  
a. benchmark  
b. customer expectation  
c. dashboard  
d. operational definition  

13. What are the three broad goals of the HCAHPS survey?  

Answer: Collect consistent data on patients’ perspectives of their care that allow for comparison between hospitals. 2. Publicly report survey data in order to incentivize hospitals to improve their quality of care. 3. Enhanced accountability for care provided.  

14. The organizations reputation for the quality of its services and consumer reaction to these services and products based on their experiences with the organization is called _____.  
a. reliability  
b. assurance  
c. features  
d. perceived quality  

15. In order to monitor and improve customer satisfaction, what must an organization know?  

Answer: Exactly who its customers are, what its customers want and value, and what improvements could be made to better meet its customer’s needs.
Chapter 8

Refining the Continuum of Care

Learning Objectives

- Explain that processes were developed to optimize the continuum of care
- Discuss the method used to develop a continuum of care in a community healthcare setting
- Identify and discuss the steps in the case management function
- Describe how criteria sets and core measures contribute to the management of care in the US healthcare system

Key Terms

- Case management
- Community needs assessment
- Continuum of care
- Critical Pathway
- Gantt chart
- Indicator
- Utilization Review

Review Question Answers

1. b
2. a
3. d
4. a
5. d

Case Study
The student should review the criteria set in table 8.3 (p. 155) and the history and physical report in figure 8.5 (p. 158). After this review, the student should be able to determine whether or not

- The patient meets the severity of illness criteria: acute loss of the ability to move a body part. Although the loss of movement is not permanent, it is episodic and persistent since the catheterization procedure performed 10 days earlier.
- The patient meets the intensity of service criteria: inpatient-approved surgery or procedure within 24 hours of admission. The patient will be taken to surgery for operative intervention to repair the injury to the femoral artery.

**Additional Student Activities**

**Activity 1**

Using the admission criteria for medical and surgical patient admissions located in table 8.3 (p. 155), students should compare the patient history of 6 patient records from the AHIMA Virtual Lab to the criteria. (Alternately, you may use 6 medical records that you have available for student use). These charts are identified in the table below by MRN from the AHIMA Virtual Lab. The assignment is to determine whether the patient meets the criteria for admission to the hospital. The patient must meet at least one criterion in severity of illness and one criterion in intensity of service.

Answers to application Activity 1:

<table>
<thead>
<tr>
<th>V-Lab chart identification</th>
<th>Admissions Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>MRN</td>
</tr>
<tr>
<td>Vlabfemale,ORTHO2</td>
<td>70043065</td>
</tr>
<tr>
<td>Vlabfemale,ONCO2</td>
<td>70003078</td>
</tr>
<tr>
<td>Vlabfemale,VASC</td>
<td>70003081</td>
</tr>
<tr>
<td>Vlabfemale,VASC4</td>
<td>70003086</td>
</tr>
<tr>
<td>Vlabmale,VASC2</td>
<td>70003091</td>
</tr>
</tbody>
</table>
Activity 2

Assignment

1. Review the criteria and indicators for pre-certification for a pediatric tonsillectomy outpatient surgery procedure.
2. Review the medical records provided. (These pages are best viewed in print. Please print these pages for your students.)
3. Compare clinical documentation to determine if the pre-certification criteria were met or not.

Pre-certification Assignment Instructions

Most healthcare insurance plans require that every planned hospital admission or outpatient procedure be pre-certified. This means that the physician’s office, on behalf of the patient, has contacted the insurance company with information about the patient’s condition and treatment plan. The purpose for this contact is so that the insurance company authorizes the treatment for payment.

In this assignment, you will be conducting this pre-certification authorization for three patients that need a tonsillectomy/adenoidectomy procedure performed. You will need to open the PDF file in this module to complete this assignment. In this PDF file you will find the pre-certification criteria and the history and physical for the three patients. The criteria are triggered by the patient’s diagnosis. For example, if a patient has been diagnosed with Obstructive tonsillar hypertrophy, then criteria 400 will apply. In criteria 400, all three indicators (410 Symptoms (Sx)/findings; 420 3+/4 tonsillar enlargement by physical exam (PE); and 430 Normal palate by PE) must be met for approval. Under the indicator 410 Sx/findings - one item in 411-415 must be present, and if the indicator is 415 - one item list under 415, -1 Weight loss, -2 Failure to thrive, or -3 Dysphagia with solids must be present.

Using the pre-certification criteria and patient histories (shown in the figures that follow), compare the three patients’ histories to the criteria for tonsillectomy/adenoidectomy. Determine whether the patient should be approved for the procedure or not. Submit to your instructor for grading a summary page that includes the patient number and which criteria you used for each patient (for example, 200 Chronic Tonsillitis), and then identify the specific criteria that the patient met (for example, 211 Throat pain and 212-4 documented increase in tonsil size) or explain why the patient did not meet the criteria for the procedure.
Procedures Criteria
Tonsillectomy (Pediatric)

PATIENT: Name D.O.B.
CPT/ICD: Code Facility ID# GROUP #
PROVIDER: Name Signature

ICD-9-CM: 292.28.0
CPT: 42020, 42021, 42025, 42026

INDICATIONS (choose one and see below)
- 100 Peritonsillar abscess
- 200 Chronic tonsillitis
- 300 Recurrent acute tonsillitis
- 400 Obstructive tonsillar hypertrophy
- 500 Suspended tonsillar malignancy
- 600 Tonsillic hemorhage
- 700 Tonsillar cryoglobulin
- Indication Not Listed (Provide clinical justification below)

100 Peritonsillar abscess (ONE)
- 110 Acute airway obstruction
- 120 Needle aspiration contraindicated because of age
- 130 Peritonsillar abscess ≥ 2x by Rx

200 Chronic tonsillitis (BOTH)
- 210 Sx/findings (BOTH)
  - 211 Throat pain ≥ 8 wks by Rx
  - 212 Findings (ONE)
    - 1. Tonsillar exudate/swell
    - 2. Tonsillar pain/swell
    - 3. Temperature > 100.4 F
    - 4. Documented increase in tonsil size

- 220 Rx ≥ 10 days ≥2

300 Recurrent acute tonsillitis (BOTH)
- 310 Sx/findings: during acute episode (BOTH)
  - 311 Throat pain
  - 312 Other findings (ONE)
    - 1. Tonsillar exudate/swell by PE
    - 2. Temperature > 101 F
    - 3. Cervical lymph nodes (ONE)
    - 4. Tonsil enlarged
    - 5. Documented increase in tonsil size
    - 6. Group A Beta-hemolytic strep by culture

- 320 Frequency of documented acute episodes (ONE)
  - 321 ≥ 3/yr for 3 yrs
  - 322 ≥ 4/yr for 2 yrs
  - 323 ≥ 5/yr for 1 yr

400 Obstructive tonsillar hypertrophy (ALL)
- 410 Sx/findings (ONE)
  - 411 Hyporesal/hyporesal speech
  - 412 Snoring/mouth breathing ≥ 6 months
  - 413 Suspended sleep apnea
  - 414 Persistent drooling
  - 415 Swallowing impairment ≥ 8 mcs with (ONE)
    - 1. Weight loss
    - 2. Failure to thrive
    - 3. Dysphagia with solids

- 420 3+ or tonsillar enlargement by PE
- 430 Normal palate by PE
Outpatient Surgery Order

Patient's Name: Patient 1

Doctor's Name:

Date of Outpatient Surgery:

INSTRUCTIONS TO THE PATIENT

1. Please come to the main Admitting Office two to seven days before scheduled surgery, for preoperative testing and registration.
2. Be sure to bring Medicaid, Medicare or other insurance cards with you when you come.
3. Please bring this form with you.
4. The night before surgery, DO NOT eat or drink anything (including water) after midnight.
5. Other instructions:

LABORATORY REQUESTS

☐ Auto Count  ☐ Proteine
☐ CBC  ☐ PTT
☐ Urinalysis  ☐ Type & Screen
☐ K+  ☐ EKG
☐ Pregnancy  ☐ Other:

MEDICATION ORDERS

☐ Cefazolin 1 gm IV 1 hour pre-op (give intraoperative dose 3 hours later for prolonged procedures)
☐ Cefotetan gm IV 1 hour pre-op (for abdominal procedures only)
☐ No pre-op antibiotic
☐ Other:

X-RAY REQUESTS

☐ Chest  ☐ Other:

PROPOSED POST-OP PAIN MANAGEMENT:

☐ PCA  ☐ Epidural  ☐ Other:

OTHER ORDERS

HISTORY

10 yo w/t w 1/6 Recurrent Strep throat. 6 episodes of Strep in the past 12 mos. Last episode 1 month ago. Required 2 courses of ABX. Sxs: fever, stomach ache, sore throat, fatigue, missing 1-3 days of school & each episode 5 days difficulty swallowing

Allergies: NKDA
Adult Illness:
Medications:
Prior Operations: Broken @ ARM (both radius & ulna)
Childhood Illness: Snoring, difficulty swallowing
Habits: Ethyl ☐  Tobacco ☐
Family History:

PHYSICAL EXAM

VITAL SIGNS: B/P  Pulse
Heart 2-3+ pink tonsils & prominent Heart RRR
Lungs clear
Mental Status ☐
Other:

DIAGNOSIS: Chronic Tonsillitis, Recurrent Strep

ANESTHETIC

☐ Local  ☐ Monitored Anesthesia
☐ IV Regional  ☐ Curarized (MAC)
☐ Spinal  ☐ General
☐ Other:

OPERATIVE PROCEDURE:

Tonsillectomy + Adenoidectomy

Physician Signature:

Date:

Outpatient Surgery Order

Revised: 9-6-10
Outpatient Surgery Order

Patient's Name: Patient 2
Doctor's Name: __________
Date of Outpatient Surgery: 10-17-05

INSTRUCTIONS TO THE PATIENT

1. Please come to the main Admitting Office two to seven days before scheduled surgery, for preoperative testing and registration.
2. Be sure to bring Medicaid, Medicare or other insurance cards with you when you come.
3. Please bring this form with you.
4. The night before surgery, DO NOT eat or drink anything (including water) after midnight.
5. Other instructions: ____________________________

PHYSICAL EXAM

VITAL SIGNS: B/P: _______ Heart: _______

Heent: _______

Heart: _______

LABORATORY REQUESTS

☐ Auto Count
☐ CBC
☐ Urinalysis
☐ K+
☐ Pregnancy
☐ Protime
☐ PTT
☐ Type & Screen
☐ EKG
☐ Other:

MEDICATION ORDERS

☐ Cefazolin 1 gm IV 1 hour pre-op (give intraoperative dose 3 hours later for prolonged procedures)
☐ Cefotetan _______ gm IV 1 hour pre-op (for abdominal procedures only)
☐ No pre-op antibiotic
☐ Other:

X-RAY REQUESTS

☐ Chest
☐ Other: ____________________________

PROPOSED POST-OP PAIN MANAGEMENT:

☐ PCA  ☐ Epidural  ☐ Other: ____________________________

OTHER ORDERS

MANAGEMENT:

☐ Monitored Anesthesia
☐ Local
☐ IV Regional
☐ Spinal
☐ General

OPERATIVE PROCEDURE:

Tonsillectomy + Adenoidectomy

Physician Signature: ____________________________
Date: 10-11-05

Outpatient Surgery Order

Revised: 06-05

Diagnosis:

Obstructive Adenotonsillar hypertrophy

HISTORY:

3 year old female with history of tonsillitis + Adenotonsillar hypertrophy. Otitis media 4 weeks last week. Just finished 10 days of Amoxicillin + 10 days of Amoxicillin. Portrait of throat but back. Sore throat but back. Spiking fevers, lost all the time except for getting good nights rest. æ Næ

Allergies:

Adult Illness: ☐

Medications:

Prior Operations:

Childhood Illness:

Habits: Etch ☐ Tobacco ☒

Family History:

BLEEDING ANESTHESIA COMPLICATIONS

Blood urea nitrogen: _______

Creatinine: _______

Urine proteins: _______

Blood count: _______

Other:

Blood type: _______

Blood crossmatch: _______

Heart rate: _______

Pulse: _______

Mental Status: _______

Other:

LABORATORY REQUESTS

☐ Auto Count
☐ CBC
☐ Urinalysis
☐ K+
☐ Pregnancy
☐ Protime
☐ PTT
☐ Type & Screen
☐ EKG
☐ Other:

MEDICATION ORDERS

☐ Cefazolin 1 gm IV 1 hour pre-op (give intraoperative dose 3 hours later for prolonged procedures)
☐ Cefotetan _______ gm IV 1 hour pre-op (for abdominal procedures only)
☐ No pre-op antibiotic
☐ Other:

X-RAY REQUESTS

☐ Chest
☐ Other: ____________________________

PROPOSED POST-OP PAIN MANAGEMENT:

☐ PCA  ☐ Epidural  ☐ Other: ____________________________

OTHER ORDERS

MANAGEMENT:

☐ Monitored Anesthesia
☐ Local
☐ IV Regional
☐ Spinal
☐ General

OPERATIVE PROCEDURE:

Tonsillectomy + Adenoidectomy

Physician Signature: ____________________________
Date: 10-11-05

Outpatient Surgery Order

Revised: 06-05
Outpatient Surgery Order

Patient's Name: Patient 3
Doctor's Name:
Date of Outpatient Surgery: 10-17-05

HISTORY
3 year old male with history of loud snoring + bad breath x1 also pausing + gasping. Nasal congests all year round. P-p ear infor tonsill

PMH
- Allergies: NKA
- Adult Illness: G
- Medications: G
- Prior Operations: G
- Childhood Illness: G
- Habits: EthG
- Tobacco: G
- OB history: G bleeding or Anesthesia Complications

PHYSICAL EXAM
VITAL SIGNS: B/P
Heart
Heart
Lungs
Mental Status
Other

DIAGNOSIS
Obstructive adenotonsillar hypertrophy

ANESTHETIC
- Local
- IV Regional
- Spinal

OPERATIVE PROCEDURE:
Tonsillectomy + Adenoidectomy

Physician Signature:
Date: 10-11-05

OTHER ORDERS

AHIMA PRESS
Answers to the Pre-Certification Cases

**Patient 1** Diagnosis is Chronic Tonsillitis, so the 200 criteria are applied.

210 Sx/findings (both)
- 211 Throat pain ≥ six weeks by history: history states that the patient currently has a sore throat and has had six episodes of strep throat in the past 12 months. Last episode was one month ago requiring two courses of antibiotics. Criteria are met.
- 212 Findings (one)
  - o -1 Tender cervical lymph nodes – not documented
  - o -2 Tonsillar erythema/exudates – not documented
  - o -3 Temperature > 100.4F – not documented
  - o -4 Documented increase is tonsil size: The physical exam documents that the patient has 2–3+ pink tonsils (indicating tonsillar enlargement or increase in size). Criteria are met.

220 Abx Rx ≥ 10 days x2: history states last episode was one month ago requiring two courses of antibiotics. Criteria are met.

Patient 1 would be approved for the tonsillectomy.

**Patient 2** Diagnosis is Obstructive Adenotonsillar hypertrophy, so the 400 criteria are applied.

410 Sx/findings (one)
- 411 Hyponasal/hypernasal speech – not documented.
- 412 Snoring/month breathing ≥ six months: history documents bad snoring. Criteria are met.
- 413 Suspected sleep apnea – not documented
- 414 Persistent drooling – not documented
- 415 Swallowing impairment ≥ six months with (one)
  - o -1 Weight loss – not documented
  - o -2 Failure to thrive – not documented
  - o -3 Dysphagia with solids – not documented

420 3+/4+ tonsillar enlargement by PE (physical exam): physical exam documents R tonsil 4+ touching uvula and L tonsil 3+ pink. Criteria are met.

430 Normal palate by PE – not documented

Patient 2 would not meet criteria based on this documentation because the palate was not mentioned in the physical examination. This case would be referred to the next level of review.
Patient 3 Diagnosis is Obstructive adenotonsillar hypertrophy, so the 400 criteria are applied.

410 Sx/findings (one)
- 411 Hyponasal/hypernasal speech – not documented.
- 412 Snoring/month breathing ≥ six months: history documents bad snoring. Criteria are met.
- 413 Suspected sleep apnea – not documented
- 414 Persistent drooling – not documented
- 415 Swallowing impairment ≥ six months with (one)
  o -1 Weight loss – not documented
  o -2 Failure to thrive – not documented
  o -3 Dysphagia with solids – not documented

420 3+/4+ tonsillar enlargement by PE (physical exam): physical exam documents 3–4+ pink tonsils bilaterally. Criteria are met.

430 Normal palate by PE – not documented

Patient 3 would not meet criteria based on this documentation because the palate was not mentioned in the physical examination. This case would be referred to the next level of review.

Test Bank Questions

1. The principal process by which organizations optimize the continuum of care for their patients is _____.
   a. utilization management
   b. services management
   c. case management
   d. resource management

2. In this case management step, the case manager confirms that the patient meets criteria for the care setting and that the services can be provided at the facility:
   a. preadmission care planning
   b. care planning at the time of admission
   c. review the progress of care
   d. discharge planning

3. Monitoring the patient throughout the entire episode of care is considered this case management step:
   a. preadmission care planning
   b. care planning at the time of admission
c. **review the progress of care**

d. discharge planning

4. Follow-up on a patient after discharge to ensure that the transition has gone smoothly and that the patient is receiving all of the services required is considered this case management step:

a. care planning at the time of admission

b. review the progress of care

c. **postdischarge planning**

d. discharge planning

5. A project management tool used to schedule important activities is called a _____.

a. cause-and-effect diagram

b. Pareto chart

c. **Gantt chart**

d. fishbone diagram

6. Criteria that have been developed by many of the same agencies for use across the continuum of care and in various regions of the country are referred to as _____.

a. internal

b. **generic**

c. external

d. basic

7. Which of the following is one of the tools utilized to help HMOs address their specific members’ needs?

a. admission planning

b. post-discharge assessment

c. **community needs assessment**

d. discharge planning

8. A multidisciplinary outline of anticipated care within an appropriate time frame to aid a patient in moving progressively through a clinical experience that ends in a positive outcome is called a _____.

a. **critical pathway**
b. care plan
c. care assessment
d. continuum of care pathway

9. Which of the following is an integral component of case management that helps to improve patient outcomes, lower healthcare spending, while still providing appropriate care to patients at the appropriate time?
   a. clinical practice standards
   b. continuum of care review
c. value-based purchasing
d. utilization review

10. True or false? Data from a community needs assessment expands the body of knowledge related to behavior changes that promote healthier lifestyles and have the potential to promote wellness in at-risk populations.

11. Caitlin’s physician suspects that she has cholecystitis and has ordered a gallbladder ultrasound to be performed. The staff at the physician office contacts Caitlin’s third-party payer to determine benefits and coverage for this procedure prior to scheduling the cholecystectomy. What is this process called?
   a. utilization management
   b. explanation of benefits
   c. payment adjudication
d. preauthorization

12. True or false? Organizational leadership does not use indicators to identify cases in which a patient did not receive the best care. Indicators are not helpful in monitoring care processes.

13. If a patient comes into the emergency room with left-sided hemiparesis that started within the last three hours, which admission criterion would be used to justify admitting this patient as an inpatient?
   a. intensity of service
   b. indicator
c. severity of illness
d. standard of care
14. During a hospitalization the case manager is concerned that Sam’s intensity of service is not meeting the criteria for continued hospitalization. The case manager speaks to Sam’s physician who updates the patient’s care plan to reflect the high level care being provided to the patient. Which part of the case management process is being performed?
   a. preadmission care planning
   b. care planning at the time of admission
   c. review the progress of care
   d. discharge planning

15. A patient presents to the emergency room acutely dehydrated and is admitted to the hospital for IV therapy to rehydrate the patient. Which admission criteria would be used to justify admitting this patient as an inpatient?
   a. intensity of service
   b. indicator
   c. severity of illness
   d. standard of care
Chapter 9
Improving the Provision of Care, Treatment, and Services

Learning Objectives

- Identify four core processes or elements in the care, treatment, and service of patients and to recognize the common means by which healthcare organizations monitor and improve the quality of these elements of care
- Describe how the National Patient Safety Goals interface with the performance improvement cycle during the patient care process
- Define the roles that clinical practice guidelines and evidence-based medicine play in standardizing patient care
- Explore how partnering with agencies and consumer groups has improved the quality of patient care

Key Terms

- Clinical guidelines
- Clinical Laboratory Improvement Amendments (CLIA)
- Clinical practice standards
- Core processes
- Evidence-based medicine
- Facility quality-indicator profile
- Minimum Data Set (MDS) for Long-Term Care
- Patient-centered care
- Standards of care
- Transfusion reaction

Review Question Answers
1. Core Process 1: Assessing the Patient’s Needs; Core Process 2: Planning Care, Treatment, and Services; Core Process 3: Providing Care, Treatment, and Services; Core Process 4: Coordinating Care, Treatment, and Services.

2. a
3. b
4. c
5. d

Case Study

The following example demonstrates the type of experience that the student should consider:

An elderly woman named Liza who showed symptoms of near syncope was admitted via ambulance to a small community hospital. She experienced an inability to move on her own and almost lost consciousness while watching her grandson play basketball. Her symptoms occurred during a visit to her daughter’s home, which is approximately 150 miles from Liza’s home. When Liza was admitted to the hospital, her daughter explained the numerous types and dosages of medications her mother was taking. She also mentioned that Liza had not been taking her Coumadin as directed by her physician for the past week or so. Liza was admitted to the intensive care unit for evaluation. Over the course of hospitalization, Liza’s condition worsened. Approximately 18 hours after her admission, the nursing staff began performing nervous system checks on Liza and contacted the physician-on-call to obtain an order for a CT scan. The scan showed evidence of a cerebral infarction. Appropriate treatment for the infarction then was provided.

1. The most important aspect of this case involves the medical indication for a CT scan. The physician did not order the test until the nursing staff pursued the issue. Types of data that should be used to monitor the process include how many patients admitted with a diagnosis of near syncope are determined to have had a stroke and how often and how soon a CT scan is ordered and performed. A possible variation to this situation is that Liza became lightheaded because of medication mix-ups and did not have a stroke. Also, one needs to consider whether the outcome would have been different if the CT scan had been performed earlier.

2. What was working? The patient was admitted as soon as possible. The daughter was knowledgeable about Liza’s medications and medication problems. The nursing staff pursued the nervous system checks on Liza and contacted the on-call physician, who ordered the CT scan. Ultimately, Liza’s condition was treated. What was not working? A protocol for near-syncope patients had not been established. The admitting physician did not know Liza and did not contact
her family physician. Liza’s family may have suspected that she had suffered a stroke but did not pursue this idea further with the admitting physician.

### Additional Student Activity

Download the Core Measure Criteria for stroke patients from the Joint Commission’s website at [http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measure_s.aspx](http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measure_s.aspx). Using the data collection form provided below record the patient information from the stroke cases. There are two patient records provided here for students:

- Case 1 is on John Doe.
- Case 2 is on Catherine Brown.
- Case 3 is 70003091 from the AHIMA V-Lab Cerner system.

Next, students should abstract the stroke criteria from these three patient records. Finally, the students could also develop a report of their findings.

**Stroke Data Collection Form Blank**

<table>
<thead>
<tr>
<th>General Data Element Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Number</td>
</tr>
<tr>
<td>Admission Date</td>
</tr>
<tr>
<td>Discharge Date</td>
</tr>
</tbody>
</table>

**STK 1 Venous Thromboembolism (VTE)**

Prophylaxis - Ischemic or hemorrhagic stroke patients who received VTE prophylaxis or have documentation why not VTE prophylaxis was given on the day of or the day after hospital admission. (VTE = low-molecular-weight heparin (LMWH), low-dose unfractionated heparin (LDUH), or fondaparinux. Aspirin alone is not recommended.
STK-2 Discharged on Antithrombotic Therapy - Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge

STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter - Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge

STK-4 Thrombolytic Therapy - Acute ischemic stroke patients who arrived at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well

STK-5 Antithrombotic Therapy by End of Hospital Day 2 - Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.

STK-6 Discharged on Statin Medication - Ischemic stroke patients with LDL greater than or equal to 100 mg/dl, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.

STK-8 Stroke Education - Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
STK-10 Assessed for Rehabilitation - Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
Stroke Core Measure Abstracting Answers:

Stroke Data Collection Form Blank

General Data Element Name

<table>
<thead>
<tr>
<th>Case Number</th>
<th>John Doe</th>
<th>Catherine Brown</th>
<th>V-Lab case 70003091</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>1/27/xx</td>
<td>2/8/xx</td>
<td>1/10/xx</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>1/30/xx</td>
<td>2/11/xx</td>
<td>1/15/xx</td>
</tr>
</tbody>
</table>

STK 1 Venous Thromboembolism (VTE) Prophylaxis - Ischemic or hemorrhagic stroke patients who received VTE prophylaxis or have documentation why not VTE prophylaxis was given on the day of or the day after hospital admission. (VTE = low-molecular-weight heparin (LMWH), low-dose unfractionated heparin (LDUH), or fondaparinux. Aspirin alone is not recommended. Started patient on antiplatelet medication (found in consult and progress note) Seen at another hospital prior to admission so this may have been prescribed but this is not documented in this record Started on Aggrenox

STK-2 Discharged on Antithrombotic Therapy - Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge Aspirin prescribed at discharge (discharge summary) Not prescribed Discharged on Aggrenox

STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter - Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge No atrial fibrillation or flutter documented No atrial fibrillation or flutter suspected not diagnosed
| STK-4 Thrombolytic Therapy - Acute ischemic stroke patients who arrived at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well | TPA not given because patient was out of the window (found in H&P) | Seen at another hospital prior to admission so this may have been prescribed but this is not documented in this record not prescribed

| STK-5 Antithrombotic Therapy by End of Hospital Day 2 - Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2. | Started patient on antiplatelet medication (found in consult and progress note) | Not prescribed Aggrenox

| STK-6 Discharged on Statin Medication - Ischemic stroke patients with LDL greater than or equal to 100 mg/dl, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge. | Patient prescribed Atorvastatin at discharge (discharge summary) | No statin prescribed on discharge Lopid prescribed at discharge

| STK-8 Stroke Education - Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke. | Stroke education provided per discharge summary | No documentation of stroke education

| STK-10 Assessed for Rehabilitation - Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services. | No residuals so patient did not need rehab | PT/OT will continue via home health (discharge summary)
Test Bank Answer Key

1. The core care process that determines the patient’s appropriateness for admission to the facility and the level of care and service to be rendered is called _____.
   a. assessing the patient’s needs
   b. planning care, treatment, and services
   c. providing care, treatment, and services
   d. coordinating care, treatment, and services

2. Large population based studies are used to identify the care processes or interventions that achieve the best healthcare outcomes in different types of medical practice. This research concept is called _____.
   a. clinical pathway
   b. evidence-based medicine
   c. patient centered care
   d. morbidity indicators

3. True or false? A facility quality indicator profile shows what proportion of a long-term care facility’s residents have deficits in each area of assessment during a reporting period.

4. The outcome of this flow of care is an improvement in the patient’s condition that allows discharge to the patient’s home or to a different care setting:
   a. assessing the patient’s needs
   b. planning care, treatment, and services
   c. providing care, treatment, and services
   d. coordinating care, treatment and services

5. All of the following are Joint Commission core measure criteria sets except _____.
   a. heart failure
   b. acute myocardial infarction
   c. pneumonia
   d. diabetes mellitus
6. The established criteria against which the decisions and actions of healthcare practitioners and other representatives of healthcare organizations are assessed in accordance with state and federal laws, regulations, and guidelines are called _____.

a. clinical practice standards  
b. clinical guidelines  
c. clinical pathways  
d. clinical standards

7. CLIA and the CDC have established protocols for _____.

a. core measures  
b. surgery protocols  
c. emergency departments  
d. laboratory departments

8. The minimum data set for long-term care collects assessment information on residents in what areas?

Answer: delirium, cognitive loss/dementia, communication, vision function, activities of daily living function and rehabilitation potential, urinary incontinence, and indwelling catheter status, psychosocial wellbeing, mood and behavior symptoms, activity pursuit patterns, falls, disease diagnoses, oral and nutritional status, oral and dental status, dehydration and fluid maintenance, pressure ulcer status, medication use, treatments and procedures, pain, and return to community referral.

9. The care pathway is the model used for outlining this core process step:

a. assessing the patient’s needs  
b. planning care, treatment and services  
c. providing care, treatment and services  
d. coordinating care, treatment and services

10. True or false? One of the key aspects of the federal government’s initiatives to advance the use of health information technologies was to provide greater emphasis on patient-centered care.

11. Signs, symptoms, or conditions suffered by a patient as the result of the administration of an incompatible blood products is called _____.

a. blood verification
b. core measure  
c. comorbidity  
d. transfusion reaction

12. Explain how the implementation of the National Patient Safety Goals has improved healthcare.

**Answer:** In spite of the tremendous amount of data collection that has occurred in healthcare, we still have errors that occur in care. The NPSGs have provided a wide-spread, national focus on safety. Some of the seemingly simple requirements of the NPSGs, such as identifying patients correctly, have had a significant impact on safety. This is just one example of the many improvements that have occurred with the implementation of the NPSGs.

13. The establishment of an interactive treatment plan that is specific, individualized, and based on a thorough assessment of the patient’s physical, emotional, social, cognitive, and cultural needs is which core process step?

a. assessing the patient’s needs  
b. planning care, treatment, and services  
c. providing care, treatment, and services  
d. coordinating care, treatment, and services

14. How do the NPSGs for long-term care differ from the NPSGs for hospitals?

**Answer:** There is a focus on preventing patient falls and bedsores for long-term care residents that is not seen in acute care NPSGs.

15. Which core process area is concern addressed for: social, spiritual, and cultural variables that influence the patient’s and family members’ perception of their lives?

a. assessing the patient’s needs  
b. planning care, treatment, and services  
c. providing care, treatment, and services  
d. coordinating care, treatment, and services
Chapter 10

Preventing and Controlling Infectious Disease

Learning Objectives

- Describe why the control of infection is so important in healthcare organizations
- Differentiate healthcare-associated infections from community-acquired infections
- Explain the various approaches that healthcare organizations use to incorporate risk reduction strategies regarding the occurrence of infection
- Identify the governmental organizations that develop regulations in this area, and explain the regulatory approaches often taken by healthcare facilities
- Review the National Patient Safety Goals related to infectious disease and their impact on healthcare providers

Key Terms

- Blood-borne pathogen
- Community-acquired infection
- Flow charts
- Healthcare-associated infection (HAI)
- Icons
- Multiple drug-resistant organisms (MDROs)
- Standard precautions

Review Question Answers

1. c
2. a
3. a
4. c
5. c

**Application Activity**

Students should create a flow chart demonstrating the HIM Department workflow or some other process that they are familiar with (course registration process at a college or university, ordering a product online, etc.) to demonstrate their understanding of flow charting techniques.

**Case Study**

1. The UTI rate for specimens collected by parents is two times that of the specimens collected by the nurse via catheterization. Reasons for this may be the difficulty of collecting a specimen from a child. For example, a child of 12 may be able to provide the urine sample in the cup but may “fill it to the rim” or drop the cover in the toilet, both of which could contaminate the specimen. A child may find stopping the stream of urine for a clean catch confusing or difficult, so that the specimen might be contaminated. In fact, just by involving a second person in the specimen collection one adds to the risk that the specimen will be contaminated.

2. In table 10.1 (p. 205), it can be noted that the average time to point-of-care screening for the house staff is at least twice as long as that of the nursing staff. In table 10.2 (p. 205), Random STAT Processing Clean Catch/Cath Urine Specimens, the UTI rates are about the same in all clinics for specimens collected by a nurse or the house staff. But in table 10.3 (p. 205), Routine Processing Clean Catch/Cath Specimens, the UTI rates are two and three time greater for the house staff than for the nursing staff. Some possible explanations may include

- A different procedure for urine specimen processing may exist in the various clinics.
- The house staff rotates through the clinics and may be unfamiliar with each clinic’s procedures.
- The house staff may be required to handle the specimen processing in one clinic but not in the next.

In this particular case, it was found that the house staff was not screening and forwarding specimens to the lab in a timely fashion.

3. On the flowchart illustrated on page 202 of the text and prior to steps 3 and 4, a step before “Place lid on container” should appear and should involve pouring off an aliquot of the specimen into another container.
Test Bank Answer Key

1. **True** or false? Proper handwashing has been identified by the CDC as one of the single most important methods for preventing the spread of infection.

2. An infection that was present in the patient before he or she was admitted to the facility is called _____.
   a. healthcare-acquired infection
   b. hospital sickness
   c. community-acquired infection
   d. community sickness

3. True or **false**? The Joint Commission manages the National Nosocomial Infections Surveillance System (NNIS)?
   The CDC’s Division of Healthcare Quality Promotion manages it.

4. This decision icon symbol is used in flowcharting to indicate _____.
   ![Decision Icon]
   a. a process when actions are being performed by humans
   b. **a point in the process at which participants must evaluate the status of the process**
   c. formal procedures that participants are expected to carry out the same way every time
   d. a point in the process where the participants must record data in paper-based or computer-based formats

5. This predefined process icon is used in flowcharting to indicate _____.
   ![Process Icon]
   a. a process when actions are being performed by humans
   b. a point in the process at which participants must evaluate the status of the process
   c. **formal procedures that participants are expected to carry out the same way every time**
   d. a point in the process where the participants must record data in paper-based or computer-based formats
6. This manual input icon is used in flowcharting to indicate _____.

   ____

   a. a process when actions are being performed by humans  
   b. a point in the process at which participants must evaluate the status of the process  
   c. formal procedures that participants are expected to carry out the same way every time  
   d. a point in the process where the participants must record data in paper-based or computer-based formats

7. The symbol in flowcharting that is used to mark the point in the process where the analysis skips to another common point of the process is called _____.

   a. terminator icon  
   b. line connector icon  
   c. connector icon  
   d. process icon

8. Which of the following represents a list of potential blood-borne pathogens?

   a. HIV and hepatitis B  
   b. Colorado tick fever and pertussis  
   c. mumps and HIV  
   d. Hepatitis B and pertussis

9. Bacterial of any kind that has become resistant to many different antibiotics is called _____.

   a. CLIA  
   b. NPSGs  
   c. MDROs  
   d. SARS

10. When a hospital patient is diagnosed with one of the diseases from the health department’s communicable disease list, who is responsible for notifying the health department?

    a. administrator  
    b. attending physician
c. compliance officer  
**d. infection control team lead**

11. If the patient presents to the hospital with symptoms of cough, fever, and chills and is later diagnosed with pneumonia the incidence of this infection would be determined as _____.

**a. community-acquired infection**  
b. hospital-acquired infection  
c. comorbidity  
d. complication

12. Attach the vector for each of the transmission of the following diseases and explain the mechanism:
   Diseases: HIV, tuberculosis, West-Nile Virus, Hantavirus  
   Vector: airborne, droplet, direct contact, insect-borne  
   **Answer:** HIV—direct contact; tuberculosis—droplet, West-Nile Virus—insect-borne, Hantavirus—airborne

13. This component of a healthcare organization’s infection surveillance program is responsible for documentation and tracking of follow-up procedures related to staff exposure to blood-borne pathogens:
   a. facility safety program  
   **b. facility infection surveillance**  
c. community infection surveillance  
d. community health program

14. Defend why healthcare organizations require their staff to have certain vaccinations in order to be employed at the facility.

   **Answer:** Employee vaccination protects patients from getting exposed from staff and also protects staff from getting exposed from patients. In the event of an epidemic having protected healthcare workers that are available allows the facility to meet the needs of the community by being able to provide care.

15. Which of the following reportable diseases require immediate reporting by phone?
   a. malaria  
   b. chicken pox  
c. **yellow fever**
d. tetanus
Chapter 11

Decreasing Risk Exposure

Learning Objectives

• Describe the importance of managing risk exposure in today’s healthcare organization
• Analyze the importance of using occurrence reporting to decrease risk exposure
• Define the concept of a sentinel event
• Discuss how sentinel events can point to important opportunities to improve safety in healthcare organizations
• Explain how risk managers use their skills in patient advocacy to lessen the impact that potentially compensable events can have on healthcare organizations
• Emphasize the importance of National Patient Safety Goals for healthcare organizations and strategies for proactive risk reduction activities

Key Terms

Cause-and-effect diagram
Failure mode and effects analysis (FMEA)
Fishbone diagram
Incident report
Medication error
Occurrence report
Potentially compensable events (PCEs)
Risk
Root-cause analysis

Review Question Answers

1. c
5. The five essential steps of Robust Process Improvement are: 1) specifying the improvement target that requires participants to narrow the issue to its core impacts on patient care and safety; 2) measuring the size of the problem with current data, identifying the absolute frequency of occurrence over recent periods of time and remembering that these issues are often so risk-intensive that even one occurrence is unacceptable; 3) identifying the SPECIFIC causes for the occurrence from all vantage points: leadership, personnel policy, standardized procedures, information systems and technology, communication pathways, management and supervision philosophies and processes, teamwork and coordination, staffing patterns and levels, equipment, care environment, and individuals; 4) targeting interventions to the most important, modifiable causes; [and] 5) embedding interventions into routine work processes.

Application Activity

Students should create a cause-and-effect diagram for the case study provided in chapter 4 on page 70. Causes in the areas of manpower, materials, methods, and machinery should be identified.

Possible Answer:
Case Study

1. The hospital had no checks and balances in place regarding the distribution of narcotics from the anesthesia lockbox located in the operating room area. Only a clipboard log was kept to control the narcotics. Physicians’ orders for injections of narcotics were not required or documented in patient records, and medical necessity was not established for those patients who, as indicated by the clipboard, received a morphine injection. Also, no monitoring occurred to determine whether the patient actually did receive the medication.

2. The hospital placed complete trust in the anesthesiology staff to control, use, and monitor the stock within the narcotics lockbox. The hospital should enact an accounting system that monitors use of all controlled substances. Also, the institution did not have and was not willing to commit to a procedure for reporting medical staff behavior or practice issues. The hospital also lacked an established chain-of-command procedure for the nursing staff to follow when the chief of the anesthesia service refused to act on the nurse’s concerns about Dr. Johnson’s behavior.

3. A root-cause analysis and cause-and-effect diagram are presented on this page and the next.
Proximate cause

Drugs not monitored in lockbox

Why?

No procedure in place to control narcotics

No process in place to access medical necessity

Head of anesthesiology not willing to discuss behavior of Dr. Johnson

No chain of command for reporting M.D. practice problems

Proximate causes

Level I

Level II

Root causes

Two people are needed to monitor use of controlled substance

Why?

Two people are needed to verify that patient received dose

Why?

Hospital relied solely on professional ethics and did not question Dr. Johnson’s practice

Why?

Facility did hold the chief of anesthesiology accountable for investigation of his staff

Why?

Acceptance of responsibility for Dr. Johnson’s behavior and subsequent care needs

Why?
4. Discharging Dr. Johnson is probably the first reaction and likely response of the governing body of Community Hospital of the West. After the lack of control and lack of a checks-and-balances system is considered, an alternative solution should be considered for Dr. Johnson. The hospital will most likely be required to send him to a drug rehabilitation program and then monitor his care activities and performance closely upon his return. The hospital would also have to accept responsibility for the cost of the physician’s rehabilitation treatment.

Test Bank Answer Key

1. Occurrences involving liability for injury or property loss are called _____.
   a. potentially compensable events
   b. risk management
   c. risk occurrences
   d. potentially harmful occurrences

2. True or false? Risk management only involves the process of working through a malpractice suit.
   Answer: It often spends more time trying to identify organizational conditions that increase risk exposure before occurrences of injury happen.

3. The four components in a fishbone diagram include _____.
   Answer: men, methods, machines, and material

4. Analysis of a sentinel event from all aspects to identify how each contributed to the occurrence of the event and to develop new systems that will prevent recurrence is called _____.
   a. flowcharting
   b. statistical analysis
   c. root-cause analysis
   d. nominal group technique

5. In risk management terminology, an exposure to the chance of injury or financial loss and their associated liability is _____.
   a. incident
   b. occurrence
   c. rights
6. This technique promotes systems thinking and includes the use of flowcharts to define high-risk processes.
   a. failure mode and effect analysis
   b. root cause analysis
   c. cause and effect diagram
   d. incident report.

7. True or false? Occurrence reports are generally open to view by the plaintiff’s attorney in a malpractice suit.

8. Discuss the role of the risk management department.

   Answer: Most people think of risk management as the process of working through a malpractice suit. Although that is sometimes the case, risk managers are more often trying to identify organizational conditions that increase risk exposure before occurrences involving injury happen. Identification before injury allows the organization to be proactive in improving care processes prior to incurring the exposure. Most healthcare organizations use an incident or occurrence reporting system to collect and report data. The system is set up to track all different types of incidents and rate them anywhere from “no harm” to “severe harm or death” This team is involved in investigating incidents and is usually directed by legal support from the healthcare facility or a contracted agency. Some risk management teams also are active in the patient advocacy program. They help track patient grievances and many times act as an intermediary between the patient and the organization to resolve conflicts that, if left unaddressed, could lead to incidents. The goal of the risk management team is to spot patterns in incidents and, through an intense investigative process, identify problems or concerns. They work through the PI council to address the patterns and problems identified and to develop interventions to resolve the problems.

9. A high-performing and organized system of care and financing that can provide the full continuum of care to a specific population over an event, episode, or a lifetime while assuming accountability for clinical and financial outcomes is called _____.
   a. ACO
   b. HMO
   c. PPO
   d. CAH
10. Explain how risk managers use their skills in patient advocacy to lessen the impact that potentially compensable events can have on healthcare organizations.

**Answer:** The risk manager as patient advocate must be sure that the patient knows the facts associated with an occurrence. The patient advocate must accept responsibility for the occurrence in the customer’s eyes when the organization’s employees were responsible for the situation during which the incident occurred. If the organization’s employees were not responsible for the situation but the customer believes that they were, the patient advocate should continue to serve a neutral role in resolving the situation. The challenge for the patient advocate is to investigate the complaint and address the issues specific to the event in such a way as to avoid legal action against the organization. Sometimes just listening to the patient’s concerns, offering an apology, or negotiating monetary compensation can resolve the complaint without any further legal action against the organization.

11. This section of a cause and effect diagram examines influences of the human worker on the situation:
   a. manpower
   b. material
   c. methods
   d. machinery

12. Discuss the importance of patient’s rights as they receive services at a healthcare facility.

**Answer:** It is important to recognize that patients, residents, and clients have very special relationships with the healthcare organizations that provide their healthcare services. Those relationships are built on a set of mutual and very complex expectations of each other, which, when not valued by either participant in the relationship, can lead to unanticipated negative occurrences that neither really desires. For the patients, residents, and clients, the expectations are based on a set of rights that are willingly accorded by healthcare organizations with ethics-based practices and that have become codified by federal mandates for most healthcare organizations in the United States. Patients need to be aware of their rights when they accept care from providers in a healthcare setting.

13. A patient was taken into surgery at a local hospital for treatment of colon cancer. A large section of the colon was removed during surgery and the patient was taken to the medical floor after surgery. Within the first 24 hours post-op, the patient developed fever, chills, and abdominal pain. A abdominal CT scan revealed the presence of a foreign body. This situation describes a _____.
   a. near miss
   b. sentinel event
   c. security incident
   d. time out
14. A family member of a patient is walking through the hall in the hospital and slips and falls on a recently mopped floor. A nurse on the floor observes the fall and helps the family member. This nurse should report this event to the risk manager using which of the following?
   a. failure mode and effect analysis
   b. root cause analysis
   c. cause and effect diagram
   d. incident report

15. This section of a cause and effect diagram examines influences of major pieces of equipment on the situation.
   a. manpower
   b. material
   c. methods
   d. machinery
Chapter 12

Building a Safe Medication Management System

Learning Objectives

• Identify how health policy, national initiatives, the private sector, and professional advocacy all contribute to the design of safe medication management systems

• Recognize the important functions included in a safe and effective medication management system

• Use the failure mode and effects analysis (FMEA) tool as a proactive risk reduction strategy in anticipating medication system failures

• Become familiar with the process of monitoring and reporting medication errors and adverse drug events

• Describe patient safety issues and the legal consequences associated with medication errors and adverse drug events

Key Terms

Adverse drug events (ADEs)
Adverse drug reaction (ADR)
Brand name
Diversion
Drug pedigree
Formulary
Generic
Medication administration record (MAR)
Medication reconciliation
Near miss
Pharmacy and therapeutics (P and T) committee
Review Question Answers:

1. a
2. b
3. Figure 12.2. The Joint Commission’s “Do Not Use” abbreviations is located in the text on page 249. It can also be downloaded from http://www.jointcommission.org/assets/1/18/dnu_list.pdf.
4. a
5. d

Case Study

1. Use of a bar code to scan the patient’s wrist band and the medication will identify any discrepancy of the right patient, right drug, and the right dose. The right time and right route will be captured when the nurse enters this information into the EHR at the time of administration at the bedside. So yes, the five rights were taken into account.

2. The pharmacist must verify all medications in the EHR process and select the appropriate product for dispensing, or the order for the medication is never activated or triggered for the nurse to administer it.

3. This automated process for medication reconciliation meets the Joint Commission standards related to medical management. The process takes into account the patient’s home medications as well as any new ones order. The EHR process requires that home medications be reviewed by the attending physician before ordering any new ones. This however, is dependent on the home medications being entered into the system by the nurse at the time of admission.

Additional Case Studies for Open-ended Discussion

Case Two:

A newborn infant died after receiving penicillin G benzathine IV. An order for penicillin G benzathine 150,000 units was written for the infant after it was discovered that the mother had contracted syphilis while residing in another state. Laboratory tests were also ordered, but a decision to treat the infant before results were available was made due to a fear that the mother may not return with the infant for follow-up treatment. The order was misinterpreted by pharmacy at 1.5 million units. Subsequently, two prefilled syringes of 1.2 million units/2mL were dispensed with directions to administer 2.5mL of the drug by the IM route. Due to the volume that would have to be administered to the infant, two nurses investigated if the medication could be given intravenously. After misinterpreting information about the drug in
reference texts and via oral communication with the Department of Health, the medication was administered by the IV route, which ultimately caused the infant’s death.

Case Three:

Mivacurium (Mivacron), instead of metronidazole, was accidentally administered to several patients at a large hospital. Three patients went into respiratory arrest, and one died. A multidisciplinary team was assembled to analyze the event and determine actions that could be taken to prevent similar errors from recurring. Here’s what they found:

A technician pulled several bags of foil-wrapped IV items from the bulk IV storage area. At the time, it was thought that metronidazole was the only medication in the pharmacy that was packaged in foil outer wraps. However, the anesthesia department had ordered samples of mivacurium from a drug representative without notifying the pharmacy. A shipment of sample products had been delivered to the pharmacy the previous day and placed into stock without notice. The technician placed pharmacy-generated labels that said "metronidazole" on the foil outer wrap of each bag. The pharmacist checked the bags and the computer-generated labels against the physician’s order. No one noticed that the foil-wrapped bags actually contained mivacurium. The mivacurium was sent to the nursing unit mislabeled as metronidazole.

When the nurses received the bags, they noted the pharmacy label for metronidazole on the outer foil wrap. They verified the drug name on the pharmacy label with the transcribed order on the patient’s MAR. The medication was administered IV to four patients, still packaged in the foil outer wrap. All four patients went into respiratory arrest and one died several days later as a result of the error. The incident resulted in the termination of a pharmacist and a pharmacy technician and the suspension of several nurses.

**Test Bank Answer Key**

1. A Joint Commission accredited organization must review their formulary annually to ensure a medication’s continued _____.
   a. safety and dose
   b. efficiency and efficacy
   c. efficacy and safety
   d. dose and efficiency
2. **True** or false? The five rights of medication administration include: right patient, right drug, right dose, right route, and right time.

3. **True** or false? A patient can bring their own and take their own medications to the hospital during a hospitalization.

   **This is true, but they can only be administered in response to orders that permit their administration and only after the medication has been evaluated and identified as the correct medication.**

4. Once a patent for a brand drug expires, other manufacturers may copy the drug and release it under its pharmaceutical or _____.
   - a. specific name
   - **b. generic name**
   - c. patent name
   - d. brand name

5. Inappropriate timing of dose, transcription errors, missed doses, and extra doses given are all examples of this type of medication error _____.
   - a. administration
   - b. pharmacy
   - c. discharge
   - d. prescribing

6. The removal of medication from its usual stream of preparation, dispensing, and administration by personnel involved in those steps in order to use or sell the medication in non-healthcare settings is called _____.
   - a. prescribing
   - b. adverse drug reaction
   - c. sentinel event
   - **d. diversion**

7. This record is used in the healthcare organization to document each dose of medication that is given to the patient during their hospitalization.
   - a. occurrence report
8. A patient is transferred from the critical access hospital (CAH) to the university medical center. The CAH sent a list of her current medications with the transfer documents. This list is then compared to the physician’s admitting orders at the university hospital for consistency in order to provide continuity of care. This process is called _____.
   a. drug formulary evaluation
   b. medication administration
   c. drug diversion
   d. medication reconciliation

9. True or false? Many organizations treat near misses in the same way that they treat sentinel events, using error-reduction tools such as root-cause analysis or failure mode and effects analysis in an effort to prevent future occurrences.

10. The chain of custody of a drug as it moves through the supply chain from manufacturer to pharmacy is called _____.
    a. diversion
    b. drug pedigree
    c. generic drug
    d. patent

11. Which committee has a leadership role in the organization’s medication safety efforts and consists of pharmacists, physicians, nurses, hospital administrators, and other healthcare professionals?
   a. P and T Committee
   b. Ethics Committee
   c. Risk Management Committee
   d. Procedure Review Committee

12. What are the patient safety issues associated with medication errors and adverse drug events?
    **Answer:** The patient safety issues are: ensuring that the five rights are adhered to at all times: right dose, right patient, right route, right time, right drug; appropriate administration instructions are
provided to the patient; safe storage and handling; organizations know what medication is on hand at all times; medication orders are completed appropriately; the effects of the drug on the patient is monitored; having a mechanism in place to evaluate the process.

13. A physician provided an order for a patient to receive Tylenol if their temperature was “ > 99.5 degrees F.” Is this an acceptable medication order? If so, why? If not, why?

Answer: This is not an acceptable medication order because the use of the symbol “>” is on the official Do Not Use list and can be misinterpreted as the “7” or can be confused with the less than sign. The physician should actually write “greater than” for the medication order to be appropriate.

14. Identify whether each of the drugs listed are generic or brand name drugs.
List of drugs: Tylenol, Prilosec, Cefalexin, Cipro, Losartan, Plavix

Answer:
Generic: Cefalexin, Losartan
Brand Name: Tylenol, Prilosec, Cipro, and Plavix

15. According to the Joint Commission a well-planned, well implemented medication management system supports patient safety and improves the quality of care by doing what?

Answer: Reducing variation, errors, and misuse; using evidence-based practices to develop medication management processes; managing critical processes to promote safe medication management throughout the [healthcare organization]; monitoring medication management processes with regard to efficiency, quality, and safety; standardizing equipment and handling processes, including those for sample medications, across the [healthcare organization] to improve the medication management system.
Chapter 13

Managing the Environment of Care

Learning Objectives

- Explain the seven programs and plans that are key elements in a healthcare organization’s environment of care
- Identify the relationship between the Joint Commission Environment of Care (EC) standards and the National Incident Management System (NIMS) in the development of an emergency operations plan
- Describe a risk assessment and a hazard vulnerability analysis
- Outline the safety monitoring process

Key Terms

- All hazards approach
- Emergency
- Emergency operations plan (EOP)
- Hazard vulnerability analysis (HVA)
- National Incident Management System (NIMS)
- Safety data sheets (SDSs)
- Total program approach

Review Question Answers

1. b
2. c
3. a
4. a
5. d
Case Study

Question for the Case Study

1. The Joint Commission requires each healthcare organization to have seven written safety standards or plans for the environment of care? Which of these plans would apply to this case and why?

The following plans should have addressed the Code Blue call system in its planning stages:

- Safety Management Program – this plan requires that an individual be designated to develop, implement and monitor the safety management activities and to intervene whenever conditions immediately threaten life or health. This safety management coordinator should have been part of the planning process for this new call system and ensured that the room numbers were inputted into the system correctly.
- Medical Equipment Management program – this program is responsible for the selection and acquisition of medical equipment. The Code Blue call system could have been reviewed as part of this program.
- Utilities Management Program – because the Code Blue call system is tied to telephone system and the hospital operator duties, this program should have been involved in the implementation of the new technology.

Additional Case Study

Students should search the Internet for the SDS information for five common household products. They should list the item description information, effects of exposure, and safe handling and disposal procedures for each of the five products. Product information may be located at http://hazard.com/msds/index.php.

Product safety information and safety data sheets (SDS) may be found at http://hazard.com/msds/index.php. Students should be encouraged to investigate common household cleaners such as Lysol and Tilex.

Additional Student Activity

Conduct a Hazard Vulnerability Analysis using the tool (spreadsheet file "Hazard & Vulnerability Analysis_kaiser_model_ch_13.xls") provided to you in the text table 13.3 (p. 302) for your home or work.
environment, score it, and summarize by identifying the likely hazards you would need to address in an emergency operations plan. Remember that there are four major sections of this analysis: Technological Events, Hazardous Materials, Human Events, and Naturally Occurring Events. This master file may also be obtained in a spreadsheet format by using your search engine on the Internet and searching “Kaiser Hazard Vulnerability Analysis.” The spreadsheet format will automatically calculate the risk impact for the student.

Test Bank Questions

1. This plan demonstrates the master planning and outlines the design of the safety functions for the organization:
   a. safety management plan
   b. security management plan
   c. hazardous materials and waste management plan
   d. emergency management plan

2. This program provides safe and reliable equipment to patients, trains care providers in the safe and effective use of the equipment, and ensures that the equipment is maintained by qualified individuals:
   a. safety management
   b. security management
   c. medical equipment management
   d. emergency management

3. This acronym is used to train healthcare staff on the proper steps to use a fire extinguisher:
   a. RACE
   b. PASS
   c. FATHOM
   d. RATS

4. How often are healthcare facilities required to practice their emergency preparedness plan?
   a. once
   b. twice
   c. three times
5. List three examples of workplace violence that must be addressed in the facility’s security management plan.

- Threatening behavior
  - Verbal or written threats
  - Harassment
- Verbal abuse
  - Physical attacks
  - Employee to employee
  - Domestic violence
  - Stranger violence

6. True or false? OSHA requires healthcare organizations to conduct an annual hazard vulnerability analysis (HVA) to identify potential hazards, threats, and adverse events and then assess their impact on care, treatment, and services.

**Answer:** False, it is the Joint Commission.

7. What are the six critical areas that need to be addressed in a healthcare organization’s emergency operations plan (EOP)?

**Answer:** These six critical areas are: communication, resources and assets, safety and security, staff responsibilities, utilities management, and patient and clinical support activities.

8. Which of the following is a system that provides guidelines for common functions and terminology to support clear communication and effective collaboration in emergency situations?

- a. OSHA
- b. NIMS
- c. NFPA
- d. FEMA

9. This plan is based on the appropriate design and construction of the building, detection, alarm and extinguishing systems, and training to provide appropriate training for all occupants:

- a. life (fire prevention) management plan
- b. security management plan
c. hazardous materials and waste management plan
d. emergency management plan

10. Healthcare organizations often use color coded systems (such as Code Green) to alert employees about potential problems in and around the healthcare facility. Some examples of these potential problems are: suspicious vehicles, disruptive visitors, and issuing of trespass notices. Which emergency management program would generate this alert?
   a. safety management plan
   **b. security management plan**
c. hazardous materials and waste management plan
d. emergency management plan

11. The hazard communication standard is based on the premise that employees who may be exposed to hazardous chemicals in the workplace have a right to know about the hazards and how to protect themselves. This standard sets forth guidelines and requirements. What are the areas?

   **Answer:** The areas are: chemical labeling provision; safety data sheets; hazard determination provision; written implementation program; and employee training.

12. **True** or false? Postprogram assessments are the most common method used to evaluate employee knowledge of care environment and safety area issues.

13. Which of the following includes the management of toxic materials and wastes through the identification of chemicals and materials that need special handling and disposal.
   a. safety management plan
   b. security management plan
   **c. hazardous materials and waste management plan**
d. emergency management plan

14. Safety data sheets (SDSs) are provided by the chemical manufacturer, distributor, or importer to any user in order to provide details about any hazards of their products. SDSs are based on a sixteen section format. What are those sixteen sections?

   **Answer:** The sixteen sections are: identification, hazards identification, first aid measures, firefighting measures, accidental release measures, handling and storage, exposure controls and personal protection, physical and chemical characteristics, stability and reactivity, toxicological information, ecological information, disposal considerations, transport information, regulatory information, and other information.
15. Which of the following agencies provides organizations guidance on the required components of a fire prevention program?

a. OSHA  
b. NIMS  
c. NFPA  
d. FEMA
Chapter 14

Developing Staff and Human Resources

Learning Objectives

- Recognize the need to integrate performance improvement and patient safety data into the management of the human resources function in healthcare
- Identify the tools commonly used to manage the recruitment and retention of human resources
- Outline the credentialing process for independent practitioners and employed clinical staff

Key Terms

- Clinical privileges
- Credentialing process
- Credentials
- Due process
- Healthcare Integrity and Protection Data Bank (HIPDB)
- Licensed independent practitioner
- Licenses
- National Practitioner Data Bank (NPDB)

Review Question Answers

1. a
2. c
3. b
4. a
5. d
Case Study

Information from the case study that can be entered into the blank physician profile (figure 14.8) is shown in italics in the partially recreated form that follows. Further explanations for these completed sections, as well as for those sections of the form that could not be completed (and are therefore not shown), are also provided.

Figure 13.8. Blank Physician Profile for Case Study

COMMUNITY HOSPITAL OF THE WEST
PHYSICIAN PERFORMANCE REVIEW SUMMARY FOR REAPPOINTMENT

<table>
<thead>
<tr>
<th>PHYSICIAN</th>
<th>Dr. Doe</th>
<th>Profile Timeframe:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE</td>
<td>OB/GYN</td>
<td>From:</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>Active</td>
<td>To:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UTILIZATION:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>52</td>
</tr>
<tr>
<td>Patient Days</td>
<td>126 add LOS</td>
</tr>
<tr>
<td>Deliveries</td>
<td>34</td>
</tr>
<tr>
<td>C-Sections</td>
<td>6</td>
</tr>
<tr>
<td>Procedures</td>
<td>169</td>
</tr>
<tr>
<td>V-BACs</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOMES:</th>
<th>#</th>
<th>%</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-Section Rate</td>
<td>6</td>
<td>17.6%</td>
<td></td>
</tr>
<tr>
<td>V-BAC Rate</td>
<td>3</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Nosocomial Inf Rate</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Surgical Wound Inf Rate</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

**Utilization**

- Admissions represent the total number of patients in the physician index summary.
- To arrive at patient days, length of stay (LOS) for all patients must be added.
- Deliveries include all patients who delivered babies.
- The number of procedures is the total of all procedures listed in the physician index summary.
• V-BACs (vaginal births after a previous Cesarean section delivery) are determined by the presence of the ICD-10-CM diagnosis code O34.21 in the final diagnosis column and the comparison of that to the performance of another Cesarean section ICD-10-PCS code 10D00Z1. If a Cesarean section, 10D00Z1, is not performed, then the patient would be included in this number.
• Whether blood was administered cannot be determined from the information in the physician index summary. The blood usage record would have to be accessed to complete this data element.

Outcomes
• To determine the Cesarean section rate, one must count all ICD-10-PCS procedure codes of 10D00Z1 and divide the result by the total number of deliveries for the period. (The codes showing a delivery has occurred would be 10E0XZZ and 10D00Z1.)
• The V-BAC rate is at 100 percent because all patients who could have a vaginal birth after a previous Cesarean section did indeed deliver vaginally.
• The nosocomial infection rate can only be determined by consulting the infection committee reports.
• Infection committee reports must also be consulted to determine the surgical infection rate.
• One computes the mortality rate by examining the discharge status for any patients who expired during hospitalization.

Performance Review

The information needed for the performance review section cannot be obtained from the physician index summary report. To complete this section of the physician profile, the Obstetrical (OB) Department Peer Review reports for Dr. Doe would be needed.

Data Quality

The information needed for the data quality section cannot be obtained from the physician index summary report. To complete this section of the physician profile, the health information management department reports on incomplete and delinquent charts would be needed.

Risk/Safety Management

The information needed for the risk/safety management section cannot be obtained from the physician index summary report. To complete this section of the physician profile, data must be supplied by the risk manager.
Meeting Attendance

The information needed for the meeting attendance section cannot be obtained from the physician index summary report. To complete this section of the physician profile, the medical staff secretary would need to access attendance information from all appropriate meetings.

The OB service chairman or the credentials committee chairman would be responsible for the remaining portions of the profile on Dr. Doe.

Discussion Questions

1. Dr. Doe’s Cesarean section rate is five percent higher than the rest of the OB service, which indicates that he may be performing Cesarean sections too frequently. However, Dr. Doe’s V-BAC rate is much higher than the OB service rate, and Dr. Doe should be commended for this rate. Finally, Dr. Doe’s mortality rate is lower than that of the OB service rate of 0.07 percent.
2. At this time, not enough information has been collected on Dr. Doe, and so any decision on whether to reappoint him to the medical staff would be premature.

Test Bank Answer Key

1. True or false? Inadequate orientation and training are the root causes of 63% of all sentinel events.

2. During the initial appointment and reappointment process of independent practitioners, healthcare organizations must obtain, verify, and assess the qualifications of the practitioner. List three of these qualifications that must be verified.
   - State licenses
   - Postgraduate studies
   - Residency
   - Fellowship training
   - Specialty board status
   - Other healthcare affiliations

3. How often does the reappraisal and reappointment process generally occur?
   a. every year
b. every two years
c. every three years
d. never

4. True or false? The type of data captured on a physician profile summary is mandated by the state board of health. It should be unique to the healthcare organization’s specific needs and the specialty type of the practitioner.

5. When a recommendation for continuing privileges is not made, or a restriction in privileges is requested, the physician must be provided means by which their application and supporting materials will be reviewed by an inpatient panel to ensure objective assessment. This procedure is called _____.
   a. amendment
   b. **due process**
   c. root-cause analysis
   d. occurrence report

6. Any individual permitted by law to provide healthcare services without direction or supervision, within the scope of the individual’s license as conferred by state regulatory agencies and consistent with individually granted clinical privileges is referred to as _____.
   a. administrator
   b. facilitator
   c. licensed independent practitioner
   d. service oriented contractor

7. Which of the following would be considered an indirect caregiver?
   a. registered nurse
   b. physical therapist
   c. chaplain
   d. **housekeeper**

8. New staff members are required to receive an overview of the organization as well as the details about their specific job responsibilities. This process is called?
   a. on-the-job training
9. Describe ways in which healthcare organizations are able to retain employees, which helps to maintain a competent workforce?

**Answer:** High retention rates communicate a strong message about the organization’s values to existing and potential employees. Beyond traditional in-house orientation programs, many organizations offer tuition and professional education reimbursement as an incentive for ongoing staff development and retention. Maintaining a competitive salary and benefits package continues to be a primary leverage point in recruitment and retention programs. Organizations that go beyond traditional incentives use employee input to create reward structures to promote employee retention. Incentives such as profit sharing, job sharing, sign-on bonuses, shared leadership, and cutting-edge technological resources are a few of the trends.

Certainly, the most compelling link to employee retention is the creation of a work environment in which organizational and personal values mesh, creating a natural synergy. Teams working together with a common vision begin with a self-directed, motivated workforce. Many times, this team factor directly influences employee retention even more than salary issues do.

10. Explain the steps in the initial credentialing process for the organized medical staff.

**Answer:** The initial appointment process includes the independent practitioner requesting, completing, and submitting an application to the medical staff along with a request for delineated clinical privileges. The credentialing and privileging process is generally initiated upon completion and approval of an application for membership and request for privileges. Letters are generally sent to at least two peer references and one healthcare organization where the applicant currently holds privileges, requesting specific information about the applicant’s qualifications and competencies in relation to the privileges requested, health status, and professional working relationships as observed by the reference source. Healthcare organizations are required by law to query for information on applicants requesting clinical privileges to the National Practitioner Data Bank (NPDB). Once applicant information has been source verified and references and data bank queries have been returned, the application and supporting documentation are reviewed by the organization’s credentials or medical executive committee(s). Individual appointment and privilege delineation recommendations are then forwarded to the organization’s governing body for final determination. When the application is approved, the appointment period must not exceed a period of two years. A provisional period is generally required (the medical staff bylaws should specify a time limit) for all new staff members. The performance of new staff members should be observed and monitored by an assigned proctor during the provisional period.

11. Which of the following is an example of a certification rather than a license?

a. RN
b. LCSW  
c. LPN  
d. RHIA

12. This tool provides significant data about a physician’s performance to the credentials committee to make decisions about reappointment to the medical staff.

   a. physician profile summary  
b. National Practitioners Data Bank  
c. medical staff bylaws  
d. post-training assessment

13. Discuss how key leadership functions are demonstrated through human resource management.

   Answer: Key leadership functions are demonstrated through human resource management through defining the qualifications, competencies, and performance expectations for all staff positions, providing competent staff, ensuring orientation and other ongoing training and education, assessing, maintaining, and improving staff competence, and promoting self-development and learning.

14. Monitoring incidents of patient’s falls can be used to measure effectiveness of hospital staff. This type of indicator would be considered a(n) _____.

   a. clinical measure  
b. human resource measure  
c. process measure  
d. employee measure

15. Individuals that hold certifications and licensure must maintain the license or certification through ongoing training and continuing education. To ensure compliance, organizations must verify that their employees complete the required training and education to maintain their license or certification. Why should this verification process be important to healthcare organizations?

   Answer: This verification process should be part of employed staff’s annual appraisal process and re-credentialing of licensed independent practitioners. In many cases providing care to patients without a current license is against the law and can put patient safety at jeopardy. The creditability of the healthcare organization can come into question if they employee individuals without a current license. Maintaining certification is also a key component for healthcare organizations as these individuals must maintain their skills and knowledge in order to better serve the organization.
Chapter 15

Organizing for Performance Improvement

Learning Objectives

- Identify both the role of an organization’s leaders in performance improvement activities and the committee and reporting structures that integrate performance improvement within the organization
- Describe the various leadership configurations responsible for performance improvement activities
- Explain how healthcare organizations train and orient their governance, leaders, and employed staff in performance improvement strategies and methods
- Delineate the best ways to organize performance improvement data for effective review by a board of directors
- Name the areas that should be addressed in the development of a healthcare organization’s performance improvement plan
- Discuss how performance improvement activities are implemented and findings are communicated throughout the organization

Key Terms

- Dashboard
- Peer review
- Strategic plan
- SWOT analysis

Review Question Answers

1. a
2. b
3. d
4. Ethical issues related to patient care, medication use, healthcare associated infections, blood and blood product use, patient safety, and utilization and documentation standards.

5. The two processes - strategic planning and organization-wide performance improvement planning must be interrelated so that the organization leaders allocate appropriate funding and support for all activities. The performance improvement (PI) in healthcare process is most effective when it is well planned, systematic, and organization-wide, and all appropriate individuals and professions work collaboratively to plan and implement activities. The strategic planning process occurs annually prior to the start of the fiscal year and coincides with organization-wide plan/program reviews and the budgeting process. Performance improvement and patient safety program review is initiated by the PI council using findings from the leaders’ strategic goals, the council’s self-assessment, and staff survey data on the program’s effectiveness. Additional information, such as aggregate outcome data from performance measures, effectiveness of corrective actions implemented as a result of process variations and adverse outcomes, input from customer surveys, status on past year’s goals, findings and actions from the annual proactive risk assessment/reduction activity, and regulatory and hospital process changes, are all reviewed and considered in the planning process and in the prioritization of performance initiatives and measures for the upcoming year.

Case Study

1. All of the data reflect degeneration in quality indicators related to nursing care. Patient satisfaction also decreased in all areas except food service. The staffing patterns for the nursing units should be reevaluated. The PI indicators reflected in table 15.1 (p. 402) should continue to be collected to assist in the evaluation of the nursing staffing patterns.

2. The current board appears to have gotten used to “rubber stamping” reports without questioning the actual data for a long time. A “good ol’ boy network” may have existed. New board members, as we see in the case study, bring in fresh ideas, especially in the areas of accountability for the quality of care in the facility. While the questions from the new board member stimulated discussion, the medical center administration squelched further exploration of data and thus did not fully carry out the responsibility for educating the board.

3. The composition and structure of the board should be examined. The board should ask more questions about the reports that are being presented to them and the administration should strive to fully answer these questions. When new procedures and policies are implemented, the board should be monitoring their effectiveness through the use of quality data. Bylaws and operating procedures should be developed for the board.

4. The board should be heavily involved in the organization’s strategic planning process, especially in the area of patient satisfaction. The board should require the collection of baseline data prior to the implementation of any major process changes and review ongoing data to evaluate the continued effectiveness of the changes.

5. Because the administration at the board meeting in this case study simply calls for an approval of the report and moves to the next item on the agenda, the minutes of the board meeting probably do not reflect the depth of board meeting discussions.
Additional Case Study

Students should look at the list of functions and opportunities (figure 15.3) and the PI and patient safety plan for Community Hospital of the West (figure 15.2) and answer the questions listed below.

For school or work experience, students should draft a PI plan that identifies specific PI priorities, measures selected to monitor improvement priorities, possible corrective actions, and any other important information that describes the PI process.

Case Study Questions

1. How is the PI plan linked to the list of functions and opportunities identified during strategic planning?
2. Can you identify items in the prioritized strategic planning process document that are related to initiatives in the PI plan?
3. Note that the items in the strategic planning process document are very specific. Were related items from the list grouped into a more general category for the final PI initiatives?
4. Are the measurements identified for the initiatives truly quantifiable? That is, will the measurements actually lead to objective data that can be evaluated for evidence of improvement?

Answers for Additional Case Study

1. Patient care opportunities for improvement were ultimately linked to goal 1.A, improving patient satisfaction through implementation of the caring model of nursing. The PI plan is directly linked to the strategic plan.

2. Other examples of items prioritized in the figure 15.3 strategic plan that are related to the figure 15.2 performance improvement plan include the following:
   a. Improvement opportunities for the management of the care environment are linked to goal 4, to develop and improve employee competence and performance; specifically, the action plan to develop and administer an organization-wide educational needs assessment program and educational calendar.
   b. Patient education, specifically the opportunity to expand patient and family education, is linked to goal 1.A, to improve patient satisfaction. The implementation of the caring model of nursing would include patient education elements.
   c. An opportunity to improve infection control, specifically universal precautions, is linked to goal 4, educational needs assessment and employee education.

3. Ultimately, leadership looked at the specific issues generated as opportunities for improvement in the strategic plan and discussed them from leadership’s point of view. It believed that the opportunities could be contained in larger, more general categories, as reflected in the appendix A goals of the plan.

4. The measurements identified for the figure 15.2 goals are quantifiable. For example, goal 1.A states, “Patient responses on the Gallup Survey will shift from satisfied or dissatisfied to increase the very
satisfied by 5%.” As such, the number of positive comments will increase by at least five percent, while the number of billing complaints will decrease by at least five percent.

**Test Bank Answer Key**

1. Governance of a healthcare organization is comprised of the board of directors and the _____.
   a. administration
   b. nursing administration
   **c. medical staff leaders**
   d. employed staff

2. Summarize the AHA’s four key elements that affect the board’s ability to carry out its PI responsibilities.
   - The board’s understanding of the quality assessment and improvement system followed in the organization.
   - Adequate reporting to the board by the staff on specific performance measures.
   - The board’s oversight and approval of the process to ensure the continued competence of physicians and other clinical and technical staff.
   - The board’s active questioning of the information supplied on the quality of care provided in the organization through PI activities.

3. Strategic planning may include a process called SWOT analysis where the leaders complete assessment of what four areas?
   - **Strengths**
   - **Weaknesses**
   - **Opportunities**
   - **Threats**

4. Identify the six main areas that must be included in a healthcare organization’s performance improvement plan.

   **Leaders decide the scope and focus of performance monitoring and data collection activities.**

   **These activities must be planned, systematic, and organization-wide.**
The organization sets priorities for PI ensuring that the scope of care, treatment, and services are represented across all disciplines.

Data are systematically collected, aggregated, and analyzed on an ongoing basis.

Improvement opportunities are identified and changes are made that will lead to and sustain improvement.

5. Name three possible criteria helpful in setting priorities for improvement opportunities.
   
   **High-risk, high-volume, or problem-prone processes**
   
   The degree of adverse impact on patient care that can be expected if an improvement opportunity remains unresolved.
   
   The degree to which patient safety is improved.

6. The regular presentation of concise, appropriately displayed monitoring data for hospital board of directors that provides minute to minute data in an organized, comparative format that maximizes the use of the board’s time and assists its members in accomplishing oversight activities is called _____.
   
   a. balance sheet
   
   b. dashboard
   
   c. strategic plan
   
   d. flow chart

7. Oversight process by like professionals established according to an organization’s medical staff bylaws, organizational policy and procedure, or the requirements of state law that allows the candid critique of colleagues without fear of reprisal is called _____.
   
   a. process review
   
   b. credentialing
   
   c. peer review
   
   d. compulsory review

8. The key to a healthcare organization’s success is the coordination and cooperation of three key groups as they work together to identify community needs and pursue organizational goals. These three key groups are _____.
   
   a. governance, management, and employed staff
b. government regulators, management, and accrediting bodies

c. accrediting bodies, employed staff, and governance

d. employed staff, management, and government regulators

9. What are three standing committees of the medical staff and what are their responsibilities?

**Answer:** Possible answers for the three standing committees are: ethics committee, pharmacy and therapeutics committee, utilization and documentation standard committee, credentials committee, environmental safety committee, and infection control.

10. **True or false?** The organization’s leaders have a central role in initiating and maintaining the organization’s PI priorities.

11. **What key questions should guide orientation and education of board members?**

**Answer:** What type of coordinated program does this facility have in place to integrate the review activities of all services for the purpose of both enhancing the quality of patient care [risk reduction] and identifying current and potential problems? How are the clinical and nonclinical activities of the institution monitored, and how are these two components integrated to ensure that the PI program is comprehensive? How is the institution organized to carry out the PI program? How are the services and departments organized for this function, and how are their activities coordinated? To whom do the various committees concerned with aspects of PI report and how often? What are the institution’s regular quality monitoring activities and how often are they undertaken? What kinds of information are reported to the board, how often, and in what form? Because boards undertake much of their activities through committee structure, how is the board organized to receive and review information?

12. The senior leadership and board of directors are meeting to determine the key priorities for Community Hospital for the year ahead. During this time they also used a SWOT analysis to validate the mission. The resulting document of this session is called a(n) _____.

a. operational plan

b. organizational plan

c. safety plan

d. strategic plan

13. **True or false?** The data the organizations collects about its own performance should be analyzed and considered when setting improvement priorities only if a sentinel event has occurred.
14. Findings from this process are aggregated and reported to the executive committee of the medical staff as well as placed in clinician’s professional files for consideration in the recredentialing process:

a. peer review  
b. credentialing  
c. process review  
d. compulsory review

15. How are performance improvement and patient safety activities communicated throughout the organization?

Answer: Performance improvement and patient safety activities are communicated through the established committee structure as well as through regular clinical, discipline, and staff meetings; e-mails; the annual storyboard fair; and the intranet. Members of the council are responsible for maintaining communication related to performance improvement and patient safety initiatives. The treating physician is responsible for informing patients and their families (when appropriate) about the outcomes of the patients’ care, including unanticipated outcomes such as sentinel events, and for documenting such communication in the patients’ clinical records.
Chapter 16

Navigating the Accreditation, Certification, or Licensure Process

Learning Objectives

- Explain the performance improvement perspectives of accreditation, certification, and licensure organizations
- Describe the various approaches of accreditation, certification, and licensure agencies to the site visit and survey
- Identify approaches that lead to success in the survey process

Key Terms

- Accreditation
- Accreditation standards
- Certification
- Compliance
- Compulsory reviews
- Conditions of Participation
- Deemed status
- Document review
- Exit conference
- Licensure
- Opening conference
- Quality improvement organizations (QIOs)
- Site visit
- Survey team
- Tracer methodology
- Voluntary reviews
Review Question Answers

1. a
2. d
3. d
4. b
5. a

Case Study

1. The axe had always been in that location, and so no one questioned whether it should continue to be there.
2. Many aspects of healthcare services often go unquestioned. It is another demonstration of the old problem, “This is the way Sue told me to do it, so that is why I do it this way.”
3. Healthcare professionals need to be sensitive to issues that are staring them in the face, but in many instances they choose to not notice the issues.

Test Bank Answer Key

1. The act of granting a healthcare organization or an individual healthcare practitioner permission to provide services of a defined scope in a limited geographical area is called _____.
   a. accreditation
   b. licensure
   c. certification
   d. approval

2. The act of granting approval for a healthcare organization to provide services to a specific group of beneficiaries is called _____.
   a. accreditation
   b. licensure
   c. certification
   d. approval
3. This type of healthcare organization review is conducted at the request of the healthcare facility seeking accreditation _____.
   a. voluntary review
   b. complimentary review
   c. vocational review
   d. compulsory review

4. This private, not-for-profit organization is committed to developing and maintaining practical, customer-focused standards to help organizations measure and improve the quality, value, and outcomes of behavioral health and medical rehabilitation programs:
   a. Commission on Accreditation of Rehabilitation Facilities
   b. American Osteopathic Association
   c. National Committee for Quality Assurance
   d. The Joint Commission

5. This organization accredits managed care organizations, managed behavioral health organizations, and credentials verification for physician organizations:
   a. Commission on Accreditation of Rehabilitation Facilities
   b. American Osteopathic Association
   c. National Committee for Quality Assurance
   d. The Joint Commission

6. List the 5 possible categories The Joint Commission uses to report its decisions on accreditation.
   Accredited
   Accreditation with follow-up survey
   Contingent accreditation
   Preliminary denial of accreditation
   Denial of accreditation

7. An accrediting agency’s published rules, which serve as the basis for comparative assessment during the review or survey process is called _____.
   a. accreditation guides
   b. accreditation policies
c. accreditation standards

d. accreditation controls

8. Which of the following is the process of meeting a prescribed set of standards or regulations to maintain active accreditation, licensure, or certification status?

a. performance improvement

b. compliance

c. document review

d. deemed status

9. Community Hospital of the West has recently been accredited by the Joint Commission for a full three-year period. Based on its accreditation status, CMS assumes that the Community Hospital of the West meets the Conditions of Participation. The reason CMS makes this assumption is because the Joint Commission has been granted _____.

a. performance improvement

b. compliance

c. document review

d. deemed status

10. Before the on-site survey team leaves the healthcare facility they meet with the organization’s leadership team and provide a report of their findings. This meeting is called _____.

a. preliminary report

b. exit conference

c. closing meeting

d. convening authority

11. Private or public agencies contracted by CMS to undertake examination and evaluation of the quality of healthcare rendered to beneficiaries of federal healthcare programs are referred to as _____.

a. QIOs

b. HMOs

c. PPOs

d. ACOs
12. During a recent Joint Commission survey, one of the survey team members asked a nurse in the ICU about her patient. The surveyor asked the nurse about the medications that the patient was on and also asked for the nurse to explain how those medications were ordered and received from the pharmacy. After the nurse explained this process, the surveyor then went to the pharmacy and asked the pharmacist to explain his role in the medication process for this specific patient. The surveyor is utilizing what process?

a. medication reconciliation  
b. document review  
c. drug diversion  
d. tracer methodology

13. Western States University Hospital has a contractual relationship with a municipal managed care health plan in its region. Each year, health plan quality management officials come to University Hospital to review cases against selected screens for health maintenance. What criteria are these health screens based on?

a. HIPAA  
b. CARF  
c. QIOs  
d. HEDIS

14. As part of the CARF accreditation process, reviewers examine policies and procedures, administrative rules and regulations, administrative records, human resource records, and the case records of patients. This process is called _____.

a. performance improvement  
b. compliance  
c. document review  
d. deemed status

15. **True** or false? An opening conference for an on-site accreditation or licensure survey is an important opportunity for the organization to set the tone for the survey process.
Implementing Effective Information Management Tools for Performance Improvement

Learning Objectives

- Identify the reasons that contemporary information technologies are important to quality improvement in healthcare
- Describe the information management tools commonly used in the performance improvement process
- Summarize current developments in healthcare information technologies that will enhance performance improvement activities in the future
- Enumerate how information resources management professionals can help performance improvement teams pursue their improvement activities

Key Terms

- Data collection
- Data repository
- Information management standards
- Information warehouse
- Standardization

Review Question Answers

1. Patient-specific, aggregated, and comparative.
2. a
3. b
4. c
5. c
Case Study Answers

2. See the quality code in the figure below:

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>DISCHARGE DATE</th>
<th>SER</th>
<th>QUAL CODE</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>12/23/14</td>
<td>CD</td>
<td>6</td>
<td>6; physician did not time the update</td>
</tr>
<tr>
<td>3</td>
<td>12/04/14</td>
<td>EN</td>
<td>4</td>
<td>4; H&amp;P greater than 30 days old</td>
</tr>
<tr>
<td>4</td>
<td>12/10/14</td>
<td>EN</td>
<td>6</td>
<td>6; no update stamp present; timed prior to admission</td>
</tr>
<tr>
<td>5</td>
<td>12/19/14</td>
<td>EN</td>
<td>7</td>
<td>7; physician dictated Op report after 24 hours post-procedure</td>
</tr>
<tr>
<td>6</td>
<td>12/09/14</td>
<td>EN</td>
<td>5</td>
<td>5; H&amp;Ps require date &amp; time to be properly authenticated</td>
</tr>
<tr>
<td>7</td>
<td>12/26/14</td>
<td>GS</td>
<td>4</td>
<td>4; H&amp;P greater than 30 days old</td>
</tr>
<tr>
<td>8</td>
<td>12/26/14</td>
<td>GS</td>
<td>7</td>
<td>7; physician dictated Op report after 24 hours post-procedure</td>
</tr>
<tr>
<td>9</td>
<td>12/26/14</td>
<td>GS</td>
<td>4</td>
<td>4; H&amp;P greater than 30 days old</td>
</tr>
<tr>
<td>10</td>
<td>12/30/14</td>
<td>GS</td>
<td>7</td>
<td>7; physician dictated Op report after 24 hours post-procedure</td>
</tr>
<tr>
<td>11</td>
<td>12/23/14</td>
<td>NE</td>
<td>5</td>
<td>5; no pre-op H&amp;P</td>
</tr>
<tr>
<td>12</td>
<td>12/20/14</td>
<td>NE</td>
<td>4</td>
<td>4; H&amp;P greater than 30 days old</td>
</tr>
<tr>
<td>13</td>
<td>12/11/14</td>
<td>NE</td>
<td>5</td>
<td>5; no pre-op H&amp;P</td>
</tr>
<tr>
<td>14</td>
<td>12/16/14</td>
<td>NE</td>
<td>n/a</td>
<td>no Quality; H&amp;P dictated after admission and prior to procedure</td>
</tr>
<tr>
<td>15</td>
<td>12/23/14</td>
<td>OB</td>
<td>7</td>
<td>7; physician dictated Op report after 24 hours post-procedure</td>
</tr>
<tr>
<td>16</td>
<td>12/03/14</td>
<td>OP</td>
<td>n/a</td>
<td>no Quality; Op report dictated within 24 hours of procedure</td>
</tr>
<tr>
<td>17</td>
<td>12/04/14</td>
<td>OR</td>
<td>7</td>
<td>7; physician dictated Op report after 24 hours post-procedure</td>
</tr>
<tr>
<td>18</td>
<td>12/17/14</td>
<td>OR</td>
<td>6</td>
<td>6; no update stamp present; no handwritten update</td>
</tr>
</tbody>
</table>
3. Analyze the data.
   a. Which code is most common?
      7 = No Operative report within 24 hours after surgery
   b. Is there one service that seems to be a problem?
      Several services have a documentation problem but the OR service has the most significant problem. As an HIM manager I would watch EN, GS, and NE services as well.
   c. What can you conclude from the data?
      The healthcare organization has documentation issues related to timeliness for both H&Ps and Op Reports. What we do not know from this data is how many patient discharges there were in the month of December to determine how significant the problem might be in relationship to all patients.

4. Establish a plan. How are you going to fix the problem?
The first step should be to determine how significant a problem this might be in relationship to the total patient volume. Second, would be determine what documentation issues and services are exhibiting the biggest problems. Report these findings to the Medical Staff Committee responsible for patient record documentation to come up with a plan of action. Training of medical staff may be appropriate at medical staff department meetings, or just a reminder from the Chief of the Medical Staff. Finally, conduct ongoing monitoring.

**Additional Student Activity**
1. Students should review the following patient records in the AHIMA V-Lab Cerner system: 70043065, 70003078, 70003075, 70003082, 70003093.
2. Students should go to the report tab and locate the dictated operative report and note the date of surgery, the date the report was dictated, the date the report was transcribed.
3. The student should also look for the post-op progress note in the record.

4. Using this information from steps 2 and 3 complete the following report on these patients.

<table>
<thead>
<tr>
<th>MRN #</th>
<th>QUAL CODE</th>
<th>Date of Surgery</th>
<th>Documentation Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>70043065</td>
<td></td>
<td>04/18/xx</td>
<td></td>
</tr>
<tr>
<td>70003078</td>
<td></td>
<td>01/11/xx</td>
<td></td>
</tr>
<tr>
<td>70003075</td>
<td></td>
<td>11/23/xx</td>
<td></td>
</tr>
<tr>
<td>70003082</td>
<td></td>
<td>01/05/xx</td>
<td></td>
</tr>
<tr>
<td>70003093</td>
<td></td>
<td>06/24/xx</td>
<td></td>
</tr>
</tbody>
</table>

Key

4 = Operative report dictated within 24 hours of surgery
5 = No Operative report dictated within 24 hours after surgery
6 = Operative report dictated within 24 hours, but not transcribed within 24 hours
7 = Operative report dictation within 24 hours, but no post-op note immediately following surgery

Answers:

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>MRN #</th>
<th>QUAL CODE</th>
<th>Date of Surgery</th>
<th>Documentation Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>70043065</td>
<td>7</td>
<td>04/18/xx</td>
<td>Operative report dictated the day of surgery</td>
</tr>
<tr>
<td>3</td>
<td>70003078</td>
<td>6</td>
<td>01/11/xxx</td>
<td>Operative report dictated the day of surgery, not transcribed immediately post-op note documented immediately after surgery, but there is something to manage from a transcription standpoint.</td>
</tr>
</tbody>
</table>
Operative report dictated the day of surgery. No post operati

Cath procedure dictated the day of surgery, but not transcrib
procedure was transcribed on 01/12/xx. There is a post-op n
after surgery, but the delayed transcription would be someth
transcription standpoint.

There is an invasive procedure report and a post-op note in t

**Key**

4 = Operative report dictated within 24 hours of surgery

5 = No Operative report dictated within 24 hours after surgery

6 = Operative report dictated within 24 hours, but not transcribed within 24 hours

7 = Operative report dictation within 24 hours, but no post-op note immediately fo

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**Additional Student Activity**

**Core Measure Comparison**

- Research websites (for example, www.jointcommission.org, or www.cms.gov) and identify what other core measure data sets are required for reporting.

- Next go to http://www.hospitalcompare.hhs.gov/ and enter any zip code and compare three different hospitals’ reported data on any of the reported measures. Give a detailed description of the measure and your reaction to the data set. What are the findings for the three hospitals? How can you see this data being used for payers? For consumers? For the government? For a specific hospital? Going forward, how do you see this data being used with the current emphasis being placed on quality of care and accountability? This report should be about 2–3 pages.

---

**Test Bank Answer Key**

1. List the Joint Commission Information Management Standards.

**IM.01.01.01—The [healthcare organization] plans for managing information**
IM.01.01.03—The [healthcare organization] plans for continuity of its information management processes
IM.02.01.01—The [healthcare organization] protects the privacy of health information
IM.02.01.03—The [healthcare organization] maintains the security and integrity of health information
IM.02.02.01—The [healthcare organization] effectively manages the collection of health information
IM.02.02.03—The [healthcare organization] retrieves, disseminates, and transmits health information in useful formats
IM.03.01.01—Knowledge-based information resources are available, current, and authoritative
IM.04.01.01—The organization maintains accurate health information

2. Which type of data collection summarizes the experience of many patients regarding a set of aspects of their care?
   a. patient-specific
   b. aggregated
   c. comparative
   d. detailed

3. A report developed by a PI team on the occurrence of methicillin-resistant *Staphylococcus aureus* infection in a neonatal intensive care unit was subsequently used by the perinatal morbidity and mortality committee in a monthly review of infant morbidity. Access to this report was possible because it was housed in the organization’s _____.
   a. computer hard drive
   b. comparative performance data
   c. PI database
   d. information warehouse

4. As part of ARRA, this Act requires that healthcare organizations and providers make significant investments in information systems to have a positive impact on the care that they provide:
   a. Hill-Burton
   b. HITECH
   c. HIPAA
   d. HCQIA
5. Data found on sites such as Hospital Compare use aggregated data to describe the experiences of unique types of patients with one or more aspects of their care. What is this data collection called?
   a. patient-specific
   b. aggregated
   **c. comparative**
   d. detailed

6. **True** or false? Paper-based records are data repositories, but they cannot be accessed as easily as computer-based repositories.

7. Deploying this type of technology can be used to allow everyone in a healthcare organization to be informed of the current status of performance improvement projects:
   a. intranet-based communication
   b. Internet access
   c. newsletter
   d. information warehouse

8. Which type of data collection pertains to the care services provided to each patient?
   a. patient-specific
   b. aggregated
   c. comparative
   d. detailed

9. **True** or false? Expert users should be identified and made available to PI teams to optimize the use of information technology resources.

10. The HIM Department has been receiving complaints about the turnaround time for release of information (ROI) requests. A PI team is created to investigate this issue. What data source would be appropriate to use to investigate this issue further?
    a. ROI employee evaluations
    b. survey requestors
    **c. ROI tracking system**
    d. ADT system
11. The Joint Commission has categorized its performance measures into **accountability** and non-accountability measures.

12. Which of the following organizations mobilizes employer purchasing power to promote healthcare safety, quality, and customer value and recognize improvements with rewards?
   a. Center for Medicare and Medicaid Services  
   b. Leapfrog  
   c. National Quality Forum  
   d. Premier

13. **Standardization** facilitates the use of data by multiple individuals and multiple teams.

14. Which of the following is NOT an organization currently collecting data on quality of healthcare?
   a. AHRQ  
   b. CMS  
   c. IOM  
   d. AMCAS

15. The Joint Commission’s quality measures are designed in order to produce the greatest impact on patient outcomes when a hospital demonstrates improvement. Identify and define the four criteria these are based on.

   Demonstrating that compliance with a given process of care improves health outcomes (either directly or by reducing risk of adverse outcomes); Proximity: The process being measured is closely connected to the outcome it impacts; there are relatively few clinical processes that occur after the one that is measured and before the improved outcome occurs; Accuracy: The measure accurately assesses whether the evidence-based process has actually been provided. That is, the measure should be capable of judging whether the process has been delivered with sufficient effectiveness to make improved outcomes likely; Adverse effects: The measure construct is designed to minimize or eliminate unintended adverse effects.
Chapter 18

Managing Healthcare Performance Improvement Projects

Learning Objectives

- Describe the function of project management in performance improvement programs
- List specific knowledge and skills required for team leadership
- Outline project life cycles and the group dynamics of team life cycles
- Identify the steps a team leader should follow to successfully implement and complete a project
- Illustrate the importance of closure with regard to reporting back to organizational leadership

Key Terms

- Gantt chart
- PERT chart

Review Question Answers

1. b
2. d
3. a
4. A technically competent individual may not necessarily be a good project team leader unless he or she also possesses behavioral competencies that enable him or her to understand team dynamics and positively influence team members. Situational leadership is a useful model for understanding and leading project teams. A team leader who understands which level of maturity his or her team has reached can select an appropriate, effective leadership style. The team leader should be more task oriented and directive with newly formed groups, and more relationship oriented and supportive of team members as they mature.
5. First define the critical success criteria for each phase; second, organize the work on a weekly and monthly basis; third, make the project calendar public; fourth, standardize status reporting for the entire organization; and fifth, manage resource conflicts.

**Case Study**

Because this project will have impact on most departments within the clinic, broad representation is essential.

1. Individuals who are knowledgeable about their area of expertise and who are capable of understanding how their department interacts with other departments in the clinic should serve on this team. Each team member should be someone who can speak authoritatively for his or her area of activity. Each individual should show some degree of computer literacy. Individuals who have been reluctant to learn about and engage in new technology in the past should be avoided.

2. Clinical, ancillary support, and administrative departments should be represented on a multidisciplinary project team.

3. The following areas of knowledge and skill should be represented in the team members:
   - Clinical practice
   - Personnel training
   - Laboratory operations
   - Computer system operations
   - Communication systems
   - Patient scheduling
   - Coding
   - Billing
   - Medical records
   - Financial reports

Because there are more than seven areas of knowledge and skills, some team members must be selected who are knowledgeable in more than one area. A typical team should comprise representatives from the following departmental areas:

   - Clinicians (especially a representative from the medical staff)
   - The systems administrator
   - Health information management
   - Laboratory
   - Finance/Billing
   - Human resources
4. The key to the timeline is ensuring the money for purchasing and installing the new system is spent in the next 10 months. Sufficient time in phase one of the timeline should be devoted to selecting the team members and orienting them to the project. The next key phase should be identification of the system requirements and specifications. This phase is very difficult to accomplish in one or two meetings. The third phase would include solicitation of bids and selection of vendor. Phases four and five involve installation of the system and training staff to use the new system. Usually these phases will overlap. On a short timeline of 10 months this overlap is most likely imperative. The task of scanning old records into the new system should be deferred until the system is completely installed and debugged. Because the CEO has set a timeline of two years to accomplish this task, it should be scheduled for completion over the 14 months following the first five phases through installation of the system.

Test Bank Answer Key

1. This phase in the project life cycle begins with the determination that there is a gap between organization performance and expected outcomes:
   a. initiation
   b. planning
   c. execution
   d. closure

2. This phase in the project life cycle is where installation of equipment or construction begins, and any policy or procedure manuals should be prepared for distribution:
   a. initiation
   b. planning
   c. execution
   d. closure

3. This phase in the project life cycle is where the project shifts to become an integrated part of organizational operations:
   a. initiation
   b. planning
   c. execution
   d. closure
4. The forming stage of project team development in which team members tend to be very polite as they get to know one another is also called _____.
   a. cautious affiliation
   b. competitiveness
   c. harmonious cohesiveness
   d. collaborative teamwork

5. The stage of project team development in which conflicts emerge is called _____.
   a. cautious affiliation
   b. competitiveness
   c. harmonious cohesiveness
   d. collaborative teamwork

6. The stage of project team development in which team members learn to communicate and collaborate is called _____.
   a. cautious affiliation
   b. competitiveness
   c. harmonious cohesiveness
   d. collaborative teamwork

7. This planning technique provides a structure that requires the project team to identify the order and projected duration of activities needed to complete a project:
   a. Gantt chart
   b. PERT chart
   c. flowchart
   d. pie chart

8. Describe the function of project management in performance improvement programs.

   Answer: Initiating a performance improvement (PI) program requires a project team that will be responsible for formulating and implementing the program. Thus, to perform effectively, PI team members need to develop project management skills. PI projects in modern healthcare organizations range from small efforts involving only a few departments to larger ones that affect the organization in very significant ways. Healthcare professionals are likely to be assigned to project teams and, in some cases, may lead them.
9. **True** or false? Project management can be defined as a narrowly focused project with a small, task-oriented team to a much broader, organization-wide philosophy that is reflected in organizational culture, behavior, and structure.

10. This stage in the PI process cycle provides positive closure for the team members and is a time to celebrate successes and recognize team member contributions and accomplishments:
   a. initiation
   b. planning
   c. execution
   d. **adjourning**

11. In a PERT chart, the path with the greatest total duration time that represents the longest amount of time required to complete the total project is referred to as _____.
   a. benchmarking
   b. **critical path**
   c. check path
   d. due process

12. Identify two key characteristics of effective PI project team leaders.

   **Answer:** A successful team leader must possess job task competencies and behavioral competencies (Cheng et al. 2005). A technically competent individual may not necessarily be a good project team leader unless he or she also possesses behavioral competencies that enable him or her to understand team dynamics and positively influence team members. Situational leadership is a useful model for understanding and leading project teams (Hersey et al. 2000). A team leader who understands which level of maturity his or her team has reached can select an appropriate, effective leadership style. The team leader should be more task oriented and directive with newly formed groups and more relationship oriented and supportive of team members as they mature. The project team leader is usually an employee from a functional area of the organization who is assigned responsibility for leading the team to completion of a project. This may put the leader in a position that divides attention and loyalty between the project team and the parent organization if the vision, goals, and objectives of the two do not align. A key role for the team leader is to bring these three elements into harmony.

13. An effective tool used by project managers to show each phase and the associated tasks of a project, the responsible party for each task, and the time frame required for the tasks is a _____.
   a. **Gantt chart**
b. PERT chart
c. flowchart
d. pie chart

14. True or false? Organizations in which employees regularly interact across organizational boundaries are less likely to be open to project management, and their employees will have poor performance while working in teams.

15. Name three reasons why some projects fail.

**Answer:** Reasons some projects fail: mistaking half-baked ideas for viable projects, dictating unrealistic project deadlines, assigning underskilled project managers to highly complex projects, not ensuring solid business sponsorship, not monitoring project vital signs, failing to develop a robust project process architecture, and not establishing a comprehensive project portfolio.
Chapter 19

Managing the Human Side of Change

Learning Objectives

- Apply change management techniques to implement performance improvements
- Describe the three phases of change
- Identify key steps in change management

Key Terms

Change management

Review Question Answers

1. a
2. c
3. c
4. b
5. Identify the steps in the process of change management:
   - Identifying the losses
   - Acknowledging the losses
   - Providing information and asking for feedback
   - Marking the endings
   - Managing the transition
   - Clarifying and reinforcing the beginning
   - Celebrating the successes
Case Study

1. The nurses are likely to have a variety of reactions and conflicting emotions about the changes. The nurses in the obstetrics unit probably would feel anxious and worried about the possibility of losing their jobs; they might feel defensive and see the prospect of change as a negative judgment of their work; they might feel grief at the prospect of the current director’s retirement. The nurses in the pediatrics unit might also feel worried about the change and express skepticism about the wisdom of combining the two departments. The head of the obstetrics unit might feel as though everything he has worked for over the years is being discarded for financial reasons and that he is being forced into an early retirement. The head of the pediatrics department might feel that the change is unwise and will have a negative effect on the department’s reputation. The hospital’s administrators and board of directors should allow the people involved in the change to openly express and discuss their concerns in a retreat-like setting. The past accomplishments of both services should be discussed and formally acknowledged.

2. The student’s plans should include descriptions of several communications vehicles, such as open-forum meetings, newsletters, and progress reports. The plans should include a time line for the project.

3. Because the change will involve a number of nurses, physicians, and other staff, the hospital probably should engage a change management consultant with experience in working with healthcare organizations. A consultant would be able to remain objective and open during emotionally charged discussions, and a consultant who has worked with other healthcare organizations would be equipped to handle complex clinical and administrative issues.

Test Bank Answer Key

1. True or false? The change manager’s task is to help people understand that chaos is an unnecessary and abnormal part of change.

2. Forces in favor of change and forces that resist change work against each other. The analysis of such competing forces in the face or a particular plan change, is often called _____.
   a. force-field analysis
   b. root-cause analysis
   c. root-force analysis
   d. force-change analysis
3. What do healthcare organizations need to do in order to support employees during the transitional phase of change? What are some consequences for the organization if this type of support is not provided?

**Answer:** Between the ending of the old and the beginning of the new lies a transitional zone. This transitional period is experienced regardless of the desire to change or whether the perception of the change is good or bad. The transitional phase is unsettling and uncomfortable. Individuals often report feeling confusion, anxiety, and unsteadiness in the midst of change. The old way of doing things is gone, but the new way of doing things still feels untried and uncomfortable. Left to their own thoughts and feelings and without sufficient information during this phase of organizational change, individuals may decide to escape their discomfort and confusion by leaving the organization. When the change process is understood, however, the transitional period can be a time of renewal and creativity. Often certain individuals within a larger group are optimistic about change. Their enthusiasm is contagious, and a wise organization will recognize and capitalize on such individuals to infuse their optimistic attitude into groups and departments to build positive momentum for change.

4. A beginning can be a disappointing time when changes seem to have been made for no **discernable** reason.

5. Which of the following is NOT a reason that communication is an important part of change in a PI process?
   a. if people do not understand the change, they have difficulty accepting it
   b. if they are not told how the change will affect them, they will assume the worst
   c. **communication does little to effectively manage change**
   d. if they are not sure what the change will entail, they will come to their own conclusions

6. Often the best strategy for change is preparation. Which of the following often gets overlooked or is not well planned?
   a. freezing
   b. refreezing
   c. training
   d. scheduling

7. **True** or false? The three phases of change are not clear-cut steps. Rather, they overlap one another.

8. Lewin labeled the three phases of change as unfreezing, changing, and refreezing. What are the other names that these three phases are referred to as?
   a. thawing, altering, ending
b. beginning, changing, and altering

c. transition, thawing, and ending

d. ending, transition, and beginning

9. Why is change management an important aspect of performance improvement?

Answer: Like PI, change can be thought of as a process to be understood and managed. For the purposes of this chapter, change management can be defined as a group of techniques that help individuals understand the process of change and accept PI in work processes. One or more members of the PI team may become change manager(s) for the project, or a manager in the areas affected by the change may play this role. Many organizations hire consultants to handle the change management process when the planned changes will have a significant impact on employees and medical staff.

10. Employee **buy-in** more readily occurs when employees are informed of the change and are educated on the reason for the change.
Chapter 20

Evaluating the Performance Improvement Program

Learning Objectives

- Explain why performance improvement programs are evaluated
- Identify the aspects of the performance improvement program that should be evaluated
- Describe what organizations should do with the information gathered from the performance improvement program evaluation

Review Question Answers

1.  
   - To determine whether the organization’s approach to designing, measuring, assessing, and improving its performance is planned, systematic, and organization-wide.

   - To determine whether the organization’s approach and its activities are carried out collaboratively.

   - To determine whether the organization’s approach needs redesign in light of changes in the strategic plan or organizational objectives.

   - To determine whether the program was effective in the improvement of overall organizational performance.

2.  
   - Executive summary
   - Overview
   - PI structures
   - Improvement opportunities
   - PI team activities
   - Other PI Review Topics
3.
1. Patient-focused improvements
2. Organizational improvements
3. Ongoing measurements
4. Comparative summary measurements

4. The possible answers include
   - Has the team’s work resulted in measurable and sustained improvements?
   - What process changes and training occurred to support and sustain the improvement(s)?
   - Has the organization’s staff assigned to PI team projects been effectively trained to work on PI teams?
   - Is staff willing and able to take on the important roles in team activities?
   - Does staff participate and interact well at team meetings to work through PI processes?
   - Can they document important team milestones with appropriate tools?
   - Have they implemented the organization’s PI model appropriately?
   - Have they learned to listen and question effectively in interpersonal communication?
   - Can they effectively communicate the team’s process and outcomes to the rest of the organization?

5. d

Case Study

1. The group is organized, has selected appropriate team members, and has collected an enormous amount of superficial data about the process. However, the team has done nothing with the data.

2. The quality council would be pleased with the data collection but concerned that no actual analysis of this data has begun. Because the patient location is key to many other activities within the organization, a quick resolution to this issue is necessary.

3. An example of a recommendation for the team’s future activities would be that the team identify the important aspects of the collected data and define how those aspects affect the actual process.

The content of this chapter is process-based and does not lend itself to the development of test bank questions. Therefore, there are no test bank questions for this chapter. The following activity is to be used in place of test
bank questions to test student knowledge of the evaluation of a PI project process.

Chapter Activity

The process of planning and evaluating a PI program should mirror each other. Taken together they are a cyclical activity: planning leads to evaluation, and evaluation provides the impetus for new planning.

Students should look at the list of functions and opportunities (figure 15.3) and the PI and patient safety plan for Community Hospital of the West (figure 15.2) and answer the questions listed below.

For school or work experience, students should draft a PI plan that identifies specific PI priorities, measures selected to monitor improvement priorities, possible corrective actions, and any other important information that describes the PI process.

Chapter Activity Questions

1. How is the PI plan linked to the list of functions and opportunities identified during strategic planning?
2. Can you identify items in the prioritized strategic planning process document that are related to initiatives in the PI plan?
3. Note that the items in the strategic planning process document are very specific. Were related items from the list grouped into a more general category for the final PI initiatives?
4. Are the measurements identified for the initiatives truly quantifiable? That is, will the measurements actually lead to objective data that can be evaluated for evidence of improvement?

Answers to Chapter Activity Questions

1. Patient care opportunities for improvement were ultimately linked to goal 1.A, improving patient satisfaction through implementation of the caring model of nursing. The PI plan is directly linked to the strategic plan.
2. Other examples of items prioritized in the figure 15.3 strategic plan that are related to the figure 15.2 performance improvement plan include the following:
   a. Improvement opportunities for the management of the care environment are linked to goal 4, to develop and improve employee competence and performance; specifically, the action plan to develop and administer an organization-wide educational needs assessment program and educational calendar.
   b. Patient education, specifically the opportunity to expand patient and family education, is linked to goal 1.A, to improve patient satisfaction. The implementation of the caring model of nursing would include patient education elements.
c. An opportunity to improve infection control, specifically universal precautions, is linked to goal 4, educational needs assessment and employee education.

3. Ultimately, leadership looked at the specific issues generated as opportunities for improvement in the strategic plan and discussed them from leadership’s point of view. It believed that the opportunities could be contained in larger, more general categories, as reflected in the appendix A goals of the plan.

4. The measurements identified for the figure 15.2 goals are quantifiable. For example, goal 1.A states, “Patient responses on the Gallup Survey will shift from satisfied or dissatisfied to increase the very satisfied by 5%.” As such, the number of positive comments will increase by at least five percent, while the number of billing complaints will decrease by at least five percent.
Chapter 21

Understanding the Legal Implications of Performance Improvement

Learning Objectives

- Describe the legal aspects of performance improvement activities conducted in healthcare organizations
- Explain the significance and relationship of tort law to quality improvement activities
- Define the concepts of protection and privilege with respect to quality improvement activities
- Distinguish quality improvement activities from research activities

Key Terms

- Breach of duty
- Causation
- Damages
- Discoverable
- Duty to use due care
- Elements of negligence
- Generalizable knowledge
- Privilege
- Protection
- Research

No case for this chapter.

Review Question Answers

1. d
2. c
3. c
4. a
5. To foster an environment in which healthcare professionals can honestly and openly review and discuss issues involving the provision of care, including errors and systems that are not working well, the court protects these PI (or peer review) activities from being used as evidence in malpractice cases. However, the peer review protection applies only to the discussions and materials from peer review meetings. In the event of a malpractice action, the facts of what happened must be disclosed. The patient will have access to his or her health record, which should include a full description of what happened from the perspective of the clinicians involved. Additionally, providers and staff involved in the incident at issue may be compelled to testify in a deposition and at trial as to their knowledge of what happened. Only the discussions and follow-up judgments in the context of the peer review meetings are protected from discovery.

Test Bank Answer Key

1. Identify the four basic elements that must be proven in a malpractice case.
   
   1. Duty to use due care
   2. Breach of duty
   3. Damages
   4. Causation

2. True or false? The process for ensuring qualifications for medical staff members in healthcare organizations is known as peer review.

3. In the context of research, generalizable knowledge means that the results of the activity may be applied to populations outside the population being studied.

4. True or false? Peer review and performance improvement discussions, deliberations, records, and proceedings of the medical staff committees are considered "discoverable" in a court.

   They are protected communication and not “discoverable.”

5. The Federal Health Care Quality Improvement Act of 1986 confers immunity from civil liability for damages for actions taken by peer review bodies to the following individuals and entities:

   - The professional body itself
   - Any person acting as a member of or staff to the professional review body
   - Any person under a contract or other formal agreement with the professional review body
   - Any person who participates with or assists the professional review body with respect to the action
6. A healthcare organization has the responsibility for disclosing these elements of adverse events to the patient or the patient’s family:

- A factual explanation of the circumstances surrounding the adverse event
- An explanation of the impact of the adverse event on the patient’s treatment and steps that will be taken to correct or mitigate any injury
- An assurance that the physician and other members of the patient care team will remain available to discuss any concerns that the patient or family may have

7. A patient was taken into surgery at a local hospital for treatment of colon cancer. A large section of the colon was removed during surgery and the patient was taken to the medical floor after surgery. Within the first 24 hours post-op, the patient developed fever, chills, and abdominal pain. A abdominal CT scan revealed the presence of a foreign body. The relationship between the physician and the patient in this scenario represents which of the four basic elements of negligence or malpractice?

a. duty to use due care
b. breach of duty
c. damages
d. causation

8. What are the two issues that are the touchstone of ethical research?

**Answer:** The two issues are: (1) voluntary participation by the subjects as indicated by informed consent, and (2) an appropriate balance that exists between the potential benefits of the research to the subject or to society and the risks assumed by the subject.

9. Healthcare organizations required that prior to conducting human subjects’ research, all researchers must submit an application to the _____.

a. IRB or privacy board
b. compliance officer
c. administrator
d. risk manager

10. In a malpractice action, the issues is whether a physician exercised a standard of care that a responsibility prudent physician would have exercised under those circumstances. Failure to exercise due care is a _____.

a. duty to use due care
b. breach of duty
c. damages
d. causation

11. A privilege applies to discussions and correspondence between persons with a certain type of relationship that has been recognized as needing confidentiality. Privileged information is not admissible at trial unless _____.
   a. the administrator waives the privilege
   b. the holder waives the privilege
   c. the judge waives the privilege
   d. the attorney waives the privilege

12. Which of the following may be considered an adverse event with negative clinical outcomes, but not necessarily the result of clinical error?
   a. foreign body left during surgery
   b. intentional overdose of medication
   c. postoperative wound infection
   d. wrong site surgery

13. In a malpractice action, when there is evidence that failure to exercise due care is responsible for actual patient harm this is called _____.
   a. duty to use due care
   b. breach of duty
   c. damages
   d. causation

14. Discuss how quality and research are different and discuss the legal frameworks that apply to each.

Answer: Quality improvement initiatives and research studies are similar in that they typically are aimed at improving some element of care or testing the utility of some mode of care or process. However, it is important to distinguish quality improvement from research because they fall under different legal frameworks. Quality improvement generally involves using data collection and analysis activities as management tools to improve the provision of services to a specific healthcare population. These activities are not intended to have any application beyond the specific organization in which they are conducted. In fact, organizations take measures to keep the results of quality improvement activities confidential so that they do not lose their peer review protection status. In contrast, research is defined by Department of Health and Human Services regulations as “the systematic investigation, including development, testing, and/or evaluation, designed to
develop or contribute to generalizable knowledge” (45 CFR 160.510). In the context of research, generalizable knowledge means that the results of the activity may be applied to populations outside the population being studied. Participants in a research project may or may not benefit directly from the study, but a larger group may benefit from the knowledge obtained in the study. The investigator conducting the research usually intends to publish the results in a scientific or professional journal.

15. The term used to describe when information that is shielded and cannot be introduced at a trial to support a patient’s malpractice action against a hospital or physician is _____.
   a. causation
   b. negligence
   c. discoverable
   d. due care