

CONTENTS

WEB ARTICLES

W1-3 **Do Patients Differentiate Between Aspects of Healthcare Quality?**

Tanja P. Mathiesen, Morten Freil, Ingrid Willaing, Torben Jørgensen, Anne H. Andreasen, Steen Ladelund, Henrik Harling

Although patient satisfaction surveys are widespread and are often used in healthcare quality assessment, it is commonly believed that patients are incapable of assessing technical aspects of care and furthermore tend to confuse technical quality with interpersonal or organizational quality. This study analyzed whether patients' assessment of technical quality of care was associated with their assessment of interpersonal and organizational quality in a hospital setting. The findings indicate that it was. When patients are asked to evaluate technical aspects of care, their evaluations seem to be affected by other aspects of the service they receive in a given healthcare institution.

W1-11 **Quality Toolbox: New CMS Guidelines Provide Incentive to Adopt Automated Informed Consent**

James E. Gottesman

This article explores how technology can assist healthcare facilities in meeting the new Centers for Medicare & Medicaid Services guidelines for informed consent. Issues addressed include shortcomings in the traditional informed consent process, ways that technology can facilitate meeting these new guidelines, other compliance benefits—such as achieving compliance with Joint Commission requirements—and last, criteria that healthcare organizations should consider when choosing an automated informed consent solution.

W1-17 **q&a: Anamarie Di Nunzio Rayburn on Pediatric Healthcare Quality and Constant Readiness**

Joann Genovich-Richards

Anamarie Di Nunzio Rayburn is the director of quality improvement services for Columbus Children's Hospital, Columbus, OH. In that role she has developed an infrastructure for constant survey readiness for external reviews, implemented an automated incident reporting system based on the principles of a nonpunitive safety culture, and facilitated many activities related to root cause analyses, healthcare failure modes and effects analysis, and hazard vulnerability analysis.

DEPARTMENTS

W1-20 **Media Reviews**

W1-23 **Quality NETWORK**

W1-25 **Quality Resources**



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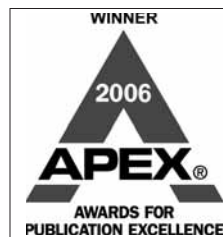
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Do Patients Differentiate Between Aspects of Healthcare Quality?

Tanja P. Mathiesen, Morten Freil, Ingrid Willaing, Torben Jørgensen, Anne H. Andreasen, Steen Ladelund, Henrik Harling

In the Western world patient satisfaction surveys and surveys measuring patients' perception of their experiences are widespread and are often used as an instrument in quality assessment of healthcare services (Bowling, 2002; Veenstra & Hofoss, 2003; Young, Meterko, & Desai, 2000).

According to the theoretical framework of Donabedian, the delivery of healthcare can be divided into three parts: a *technical* part, which includes diagnosis, treatment, care, and rehabilitation; an *interpersonal* part, which includes the psychosocial interplay between the healthcare staff and the patient; and, finally, a part dealing with the *organization* of the hospital admission, including continuity and coordination of care (Donabedian, 1988, 1992; Palmer, Donabedian, & Povar, 1991). Most patient surveys ask questions concerning quality assessment relating to interpersonal and organizational aspects of care. By contrast, questions asking patients to assess technical aspects of treatment and care are rare (Jackson, 1997).

In the literature it is common to find a perception of patients as incapable of assessing technical aspects of healthcare service because of their lack of knowledge or understanding of this aspect of treatment and care (Chapple, Campbell, Rogers, & Roland, 2002; De Man, Gemmel, Vlerick, Van Rijk, & Dierckx, 2002; Oberst, 1984). In addition, a common hypothesis states that patients tend to confuse technical quality of care with interpersonal or organizational quality of care (Oberst; Roter, Hall, & Katz, 1987). A problem with these explanations for the absence in patient surveys of questions concerning technical care is that the hypotheses have been more debated than studied.

Aims

In a previous study we examined the first hypothesis on patients' misunderstandings and lack of knowledge by comparing agreement between professionals and patients undergoing surgery for colorectal cancer on

Abstract: Although patient satisfaction surveys are widespread and are often used in healthcare quality assessment, it is commonly believed that patients are incapable of assessing technical aspects of care and furthermore tend to confuse technical quality with interpersonal or organizational quality. This study analyzed whether patients' assessment of technical quality of care was associated with their assessment of interpersonal and organizational quality in a hospital setting. The findings indicate that it was. When patients are asked to evaluate technical aspects of care, their evaluations seem to be affected by other aspects of the service they receive in a given healthcare institution.

questions relating to technical aspects of care (Mathiesen et al., in press). Results from that study revealed a more sophisticated view of the matter because cases of moderate to almost perfect agreement were reported—as well as significant differences in perceptions. In the present study we examined the second hypothesis—on patients' confusion of different aspects of treatment and care. The aim of this study was to evaluate whether patients' assessments of technical quality of care were associated with their assessments of the interpersonal and organizational quality of care.

Methods

In January 2003 an invitation to participate in the study was sent to all 45 Danish hospital departments that perform surgery for colorectal cancer. The hospital departments were asked to include all patients who had been discharged after surgery for a first-time colorectal cancer and who were able to understand Danish and capable of participating in the study. Twenty-one departments participated in the study from March 2003 through May 2004.

In order to describe the study population, the researchers obtained from the Danish Colorectal Cancer Group (DCCG) register information

Key Words

patient satisfaction
professional-patient
relations
quality of healthcare

on all colorectal cancer patients from the participating departments during the inclusion period. This register covers nearly 90% of all patients with colorectal cancer in Denmark (Nickelsen, Jørgensen, & Kronborg, 2005b). It contains patient-specific data on diagnosis, American Society of Anesthesiologists (ASA) score, stage of cancer, type of surgery, postoperative complications, and type of admission (planned versus emergency).

Data from the register showed that during the relevant period 527 patients met the inclusion criteria. All patients received a questionnaire at the time of their discharge from the hospital department and were encouraged by the healthcare professionals to complete it as soon as possible, but no formal registration of the length of time between surgery and the return of the questionnaires was made. A relevant questionnaire and information from the DCCG register were obtained for 336 patients (64%).

The questionnaire contained items on technical, interpersonal, and organizational aspects of care so that the patients' potential confusion of these aspects could be studied (see **Figure 1**). Because all Danish citizens are registered by a unique 10-digit number in the Civil Registration System, it was possible to match each questionnaire with data from the register. All necessary permissions were obtained from the Danish Data Protection Agency. The Danish local ethical committees do not, however, wish to answer inquiries based on questionnaires. Because of the linkage between the questionnaire and the register, immediate anonymity for the patients was not provided, but in the process of data analysis all patients were anonymous to the research group, and no hospital department was allowed to see the questionnaires after completion. The patients were informed about this procedure before they made their decision to participate.

In the process of choosing items for the questionnaire, the researchers conducted a qualitative analysis of three focus groups. Three hospital departments were each asked to recruit 10 patients who had undergone surgery for colorectal cancer within the last year. The participants' wishes and expectations relating to their hospital stay were explored during interviews that lasted 2½ hours. The interviewers used an open and relatively unstructured approach. A literature review of patient

perspectives together with previously validated questions from Danish and international patient surveys also served as resources in the development of the questionnaire.

So that the comprehensibility and the content of the developed questionnaire could be tested, five individual patient interviews were performed (McKinley, Manku-Scott, Hastings, French, & Baker, 1997). These pilot tests resulted in a number of comments and suggestions, and appropriate corrections of the questionnaire were subsequently made.

Potential association between patients' assessment of technical, interpersonal, and organizational aspects of care was analyzed by means of multiple logistic regression. Questions on technical quality of care were analyzed as dependent variables, and interpersonal and organizational aspects of care entered the models as predictor variables. Interactions between the predictor variables were analyzed when appropriate. None of the tested interactions turned out to be significantly associated with the dependent variables. Test results are given as an odds ratio with 95% confidence interval; $p < .05$ was considered statistically significant.

In accordance with recommendations in a study by Collins and O' Cathain (2003), the answers to both the dependent and predictor variables were dichotomized (*very good/not very good* or *to a high extent/not to a high extent*) wherever possible. All calculations were accomplished by means of the statistical packages SAS and R.

The following five dependent variables were selected: assessment of surgery (**Table 1**), pain management (**Table 2**), wound care (**Table 3**), overall medical performance (**Table 4**), and overall nursing care (**Table 5**). Because of the limited scale of research in this field, the approach was exploratory, and no assumptions were made regarding which interpersonal or organizational predictor variables would be primary or secondary.

So that eventual changes in the estimates could be evaluated, a construction with a stepwise regression of predictor variables was employed. For two of the five models, however, only a single multiple model was constructed for each dependent variable (**Table 6**). This deviation was caused by a reduced number of predictor variables due to a skewed distribution of answers on the two dependent variables, resulting in considerable limitations

in the degrees of freedom available for analysis. For the three models with the stepwise inclusion of variables, a uniform structure was applied (see Table 6).

Model 1 included variables concerning postoperative complications and patients' perception of whether 1–2 doctors or nurses had a special responsibility for the patient. Model 2 added variables on patients' assessment of the extent of the doctors' and nurses' time spent answering questions. Finally, model 3 added the patients' perception of cooperation between professionals. All three models were adjusted for sex, age, and stage of cancer, which means that the variables were also included in the models.

The variable on postoperative complications was tested for interaction with the patients' assessment of the extent of doctors' and nurses' time spent answering questions. It was decided not to reject a questionnaire completely if a few questions had been left unanswered, which explains the reduced data in Tables 1–5.

On the basis of the DCCG register a non-response analysis was applied in order to compare patients who returned their questionnaire with those who did not. The analysis was performed by means of multiple logistic regression.

Figure 1. Wording of Questions in the Questionnaire for 336 Colorectal Cancer Patients

Assessments of the Technical Aspect of Care	Assessments of the Interpersonal Aspect of Care	Assessments of the Organizational Aspect of Care
<ul style="list-style-type: none"> • How would you describe the overall quality of the pain management during your hospital stay? • How would you describe the quality of the postoperative wound care? • To what extent did the overall medical performance fulfill your needs? • To what extent did the overall nursing care fulfill your needs? • How would you assess the effect of the surgery? 	<ul style="list-style-type: none"> • To what extent did the surgeon allocate enough time to answer questions? • To what extent did the nurses allocate enough time to answer questions? 	<ul style="list-style-type: none"> • Did 1–2 surgeons have a special responsibility for you? • Did 1–2 nurses have a special responsibility for your care? • How was the professional cooperation during your stay in the hospital department?

Note. The figure presents an extract of the questionnaire. Only questions finally used in the multiple regression models are shown.

Table 1. Associations Between Assessment of the Surgery as “Very Good” and Interpersonal and Organizational Aspects of Care (N = 336 Colorectal Cancer Patients)

Explanatory Variables	Reference Value	Model 1, n = 262 OR (95% CI)	Model 2, n = 250 OR (95% CI)	Model 3, n = 244 OR (95% CI)
Postoperative complications (according to the DCCG register)	No	0.40 (0.22; 0.72)*	0.36 (0.19; 0.69)*	0.40 (0.20; 0.79)*
1–2 surgeons had a special responsibility for the patient (patient assessment)	No	1.44 (0.70; 2.98)	1.53 (0.68; 3.46)	1.25 (0.52; 2.99)
1–2 nurses had a special responsibility for the patient (patient assessment)	No	1.04 (0.57; 1.92)	0.72 (0.36; 1.46)	0.73 (0.35; 1.53)
Extent of surgeons' time spent answering questions (patient assessment)	Not to a high extent		3.60 (1.42; 9.13)*	3.08 (1.12; 8.52)*
Extent of nurses' time spent answering questions (patient assessment)	Not to a high extent		2.84 (1.11; 7.25)*	1.42 (0.50; 4.00)
Cooperation between professionals during the patient's stay in the hospital department (patient assessment)	Not very good			4.44 (2.38; 8.29)*

Note. OR = odds ratio; CI = confidence interval; DCCG = Danish Colorectal Cancer Group. All analyses were adjusted for patients' sex, age, and stage of cancer. These variables were thus included in the models above. There were, however, no significant associations between these variables and patients' assessment of the surgery. Missing data are a result of questions that were left unanswered.

*p < .05.

Table 2. Associations Between Assessment of Pain Management as “Very Good” and Interpersonal and Organizational Aspects of Care (*N* = 336 colorectal cancer patients)

Explanatory Variables	Reference Value	Model 1, <i>n</i> = 260 OR (95% CI)	Model 2, <i>n</i> = 248 OR (95% CI)	Model 3, <i>n</i> = 242 OR (95% CI)
Postoperative complications (according to the DCCG register)	No	0.55 (0.30; 1.01)	0.53 (0.28; 0.99)*	0.56 (0.29; 1.11)
1–2 surgeons had a special responsibility for the patient (patient assessment)	No	1.26 (0.61; 2.59)	1.08 (0.49; 2.38)	0.87 (0.37; 2.05)
1–2 nurses had a special responsibility for the patient (patient assessment)	No	1.24 (0.68; 2.27)	1.21 (0.62; 2.34)	1.16 (0.57; 2.37)
Extent of surgeons' time spent answering questions (patient assessment)	Not to a high extent		4.88 (1.80; 13.22)*	4.19 (1.41; 12.45)*
Extent of nurses' time spent answering questions (patient assessment)	Not to a high extent		0.75 (0.29; 1.93)	0.33 (0.11; 0.97)*
Cooperation between professionals during the patient's stay in the hospital department (patient assessment)	Not very good			4.95 (2.60; 9.40)*

Note. OR = odds ratio; CI = confidence interval; DCCG = Danish Colorectal Cancer Group. All analyses were adjusted for patients' sex, age, and stage of cancer. These variables were thus included in the models above. There were, however, no significant associations between these variables and patients' assessment of pain management. Missing data are a result of questions that were left unanswered.

**p* < .05.

Table 3. Associations Between Assessment of the Wound Care as “Very Good” and Interpersonal and Organizational Aspects of Care (*N* = 336 Colorectal Cancer Patients)

Explanatory Variables	Reference Value	Model 1, <i>n</i> = 230 OR (95% CI)	Model 2, <i>n</i> = 221 OR (95% CI)	Model 3, <i>n</i> = 216 OR (95% CI)
Postoperative complications (according to the DCCG register)	No	0.70 (0.30; 1.64)	0.68 (0.28; 1.65)	0.95 (0.37; 2.44)
1–2 surgeons had a special responsibility for the patient (patient assessment)	No	1.89 (0.83; 4.31)	1.70 (0.72; 4.04)	1.75 (0.67; 4.57)
1–2 nurses had a special responsibility for the patient (patient assessment)	No	1.27 (0.66; 2.46)	0.98 (0.48; 2.00)	1.09 (0.50; 2.37)
Extent of surgeons' time spent answering questions (patient assessment)	Not to a high extent		2.45 (0.93; 6.45)	1.87 (0.58; 5.97)
Extent of nurses' time spent answering questions (patient assessment)	Not to a high extent		1.92 (0.74; 5.00)	1.25 (0.38; 4.08)
Cooperation between professionals during the patient's stay in the hospital department (patient assessment)	Not very good			5.18 (2.59; 10.39)*

Note. OR = odds ratio; CI = confidence interval; DCCG = Danish Colorectal Cancer Group. All analyses were adjusted for patients' sex, age, and stage of cancer. These variables were thus included in the models above. There were, however, no significant associations between these variables and patients' assessment of the wound care. Missing data are a result of questions that were left unanswered.

**p* < .05.

Results

No statistically significant difference between patients who returned their questionnaire and those who did not was found regarding age, sex, tumor stage, curative surgery, ASA score, or type of admission.

Patients with complications after surgery had a significantly lower response rate (53%) than did patients without complications (72%). Furthermore, a significant difference was seen in response rate between the hospital departments, but this difference was distributed

evenly along geographical lines and department sizes.

The presence of postoperative complications was negatively associated with patients' assessment of surgery, whereas the extent of surgeons' time spent answering questions and the perceived cooperation between professionals were positively associated with the assessment of surgery (Table 1). The positive association between assessment of surgery and the nurses' time spent answering questions was explained by the assessment of cooperation between professionals.

The extent of surgeons' time spent answering questions and the cooperation between professionals was positively associated with patients' assessment of pain management. The extent of nurses' time spent answering questions was, however, negatively associated with the assessment of pain management (Table 2). In the multivariate model examining associations between different covariates and patients' assessment of wound care, only the perceived cooperation between professionals was significantly—and positively—associated with the dependent variable (Table 3). The extent of surgeons' time spent answering questions and the perception that 1–2 surgeons had a special responsibility for the patient were positively associated with patients' assessment of the overall medical performance (Table 4). Similarly, the extent of nurses' time spent answering questions and the perception that 1–2 nurses had a special responsibility for the patient was positively associated with the assessment of overall nursing care (Table 5).

Discussion

The patients' perception of the surgeons' and nurses' time spent answering questions and the perception of cooperation among the staff had significant impact on the patients' assessment of technical quality, whereas perceptions about the assignment of a specific surgeon or nurse had little or at least not any significant effect.

All of the five dependent variables reflecting patients' perception of technical quality of care were significant and were positively associated with either an interpersonal or an organizational experience, and in four out of five analyses the perception of technical quality was associated with both.

Table 4. Associations Between Assessments of the Overall Medical Performance Fulfilling the Patient's Needs to a "High Extent" and Interpersonal and Organizational Aspects of Care (N = 336 Colorectal Cancer Patients)

Explanatory Variables	Reference Value	n = 281 OR (95% CI)
Postoperative complications (according to the DCCG register)	No	0.41 (0.17; 1.03)
Extent of surgeons' time spent answering questions (patient assessment)	Not to a high extent	11.20 (4.54; 27.62)*
1–2 surgeons had a special responsibility for the patient (patient assessment)	No	2.80 (1.06; 7.44)*

Note. OR = odds ratio; CI = confidence interval; DCCG = Danish Colorectal Cancer Group. Analysis was adjusted for patients' sex and age. These variables were thus included in the model above. There were, however, no significant associations between these variables and patients' assessment of the overall medical performance. Missing data are a result of questions that were left unanswered.

*p < .05.

Table 5. Associations Between Assessments of the Nursing Care Fulfilling the Patient's Needs to a "High Extent" and Interpersonal and Organizational Aspects of Care (N = 336 Colorectal Cancer Patients)

Explanatory Variables	Reference Value	n = 283 OR (95% CI)
Postoperative complications (according to the DCCG register)	No	0.66 (0.27; 1.58)
Extent of nurses' time spent answering questions (patient assessment)	Not to a high extent	12.36 (5.26; 29.05)*
1–2 nurses had a special responsibility for the patient (patient assessment)	No	3.01 (1.36; 6.64)*

Note. OR = odds ratio; CI = confidence interval; DCCG = Danish Colorectal Cancer Group. Analysis was adjusted for patients' sex and age. These variables were thus included in the model above. There were, however, no significant associations between these variables and patients' assessment of the nursing care. Missing data are a result of questions that were left unanswered.

*p < .05.

Although Roter, Hall, and Katz (1987) refer to eight previous studies revealing significant associations between patient assessment of physicians' technical competence and physicians' affective behavior, few empirical studies of patients' potential confusion of technical quality with good interpersonal or organizational care are available. Because most of the dependent variables in the present study were significantly associated with both

Table 6. Overview of the Five Multivariate Regression Models Analyzing Potential Association Between Patients' Assessment of Technical, Interpersonal, and Organizational Aspects of Care

	Dependent Variables				
	Patient Assessment of Surgery	Patient Assessment of Pain Management	Patient Assessment of Wound Care	Patient Assessment of Overall Medical Performance	Patient Assessment of Overall Nursing Care
Explanatory Variables (Model 1)	<ul style="list-style-type: none"> • Presence of post-operative complications • 1-2 doctors with special responsibility for the patient • 1-2 nurses with special responsibility for the patient 	<ul style="list-style-type: none"> • Presence of post-operative complications • 1-2 doctors with special responsibility for the patient • 1-2 nurses with special responsibility for the patient 	<ul style="list-style-type: none"> • Presence of post-operative complications • 1-2 doctors with special responsibility for the patient • 1-2 nurses with special responsibility for the patient 	<ul style="list-style-type: none"> • Presence of postoperative complications • Extent of the doctors' time spent answering questions • 1-2 doctors with special responsibility for the patient 	<ul style="list-style-type: none"> • Presence of postoperative complications • Extent of the nurses' time spent answering questions • 1-2 nurses with special responsibility for the patient
Explanatory Variables (Model 2)	<ul style="list-style-type: none"> • Extent of the doctors' time spent answering questions • Extent of the nurses' time spent answering questions 	<ul style="list-style-type: none"> • Extent of the doctors' time spent answering questions • Extent of the nurses' time spent answering questions 	<ul style="list-style-type: none"> • Extent of the doctors' time spent answering questions • Extent of the nurses' time spent answering questions 		
Explanatory Variables (Model 3)	<ul style="list-style-type: none"> • Patient perceived cooperation between the professionals 	<ul style="list-style-type: none"> • Patient perceived cooperation between the professionals 	<ul style="list-style-type: none"> • Patient perceived cooperation between the professionals 		

interpersonal and organizational experiences, the results support these previous findings. Notably, however, there was a significantly reduced tendency for patients to assess the surgery as *very good* if they had a complication after surgery (Table 1). This result is important because it indicates a more complex construction of patients' technical assessments than the common hypothesis states. Thus, the patients' evaluations of the surgery were associated not only with interpersonal and organizational experiences but also with an experience of a more technical character. On one hand, this result suggests that patients are actually able to employ technical experiences in their evaluation of technical quality of treatment and care. On the other hand, no simple connection exists between the quality of surgery and post-operative complications, because the latter also

depends on patient- and disease-related characteristics (Nickelsen, Jørgensen, & Kronborg, 2005a). Therefore, it cannot be concluded that the reported association between complications and patients' assessment of surgery is a knowledge-based linkage.

Another remarkable result in the study was the reported inverse association between patients' experience of the nursing time spent answering questions and the assessment of the quality of pain management. No comparable studies of this subject are available, but it is unlikely that having nurses spend considerable time answering questions would decrease satisfaction with the pain management. A more likely explanation would be that patients' lack of satisfaction with their pain treatment induced the nurses to prioritize their communication with these patients. In addition, this association underlines

the uncertainty attached to the interpretation of the rest of the results because it is often difficult to determine which variable is actually the cause and which the effect. The nature of data does not allow the unambiguous conclusion that patients' interpersonal and organizational evaluations predict their evaluation of technical quality of care. In principle a reverse causal relation could be the case. Furthermore, Roter, Hall, and Katz (1987) noticed that these kind of data cannot establish whether the different aspects of treatment and care in fact are distinct (and the patients just not able to distinguish them), or whether interpersonal, organizational, and technical quality actually are related.

A strength of the present study was the combined use of a well-established national register and a separately developed patient questionnaire. The use of this register both ensured a validated source of disease-related information and formed the basis for a non-response analysis. However, the quantitative approach was not able to provide the basis for appropriate interpretation of all results. A qualitative approach to supplement the quantitative analyses would be advantageous.

Because of the linkage between the questionnaire and the register, immediate anonymity for the patient was not provided. This fact may have provoked unintended consequences in relation to the answers given. Nevertheless, in the later process of analysis the data were anonymous to the research group, and no hospital department was allowed to see the questionnaires after completion. All the patients were informed about this procedure.

Another reservation concerning the interpretation of the results is the possible presence of recall bias. As mentioned in the methods section, all patients were encouraged to complete their questionnaire in connection with the hospital discharge. A certain amount of recall bias is possible, especially because no systematic registration of the length of time between surgery and return of the questionnaire was made. The problem with recall bias in this study differs little from the problem of recall bias in most other patient satisfaction surveys.

A further limitation of the study was the selected population of elderly, severely ill, and solely surgical patients. Additional research in other medical specialties must be done before any conclusions about the generalizability of the results can be reached.

Finally, when researchers analyze patients from the same hospital departments, the assumption of independent observations in ordinary regression analysis may not be fulfilled because the patients may be influenced by the same things. We did not investigate this limitation further because of the lack of variation within departments.

Conclusions and Implications for Practice

With few exceptions, the results in this study support the widespread hypothesis that patients confuse various aspects of care. Our findings suggest the reasonable conclusion that if or when patients are asked to evaluate the technical quality of healthcare, their evaluations may be affected by other aspects of their treatment and care. This conclusion underlines the importance of both patient and professional evaluations in constructing a complete picture of quality of care. Further research in this field is needed in order to clarify both the relations between multiple variables and the generalization of the reported results.

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New CMS Guidelines Provide Incentive to Adopt Automated Informed Consent

James E. Gottesman

The informed consent process ideally serves as a way to educate patients about their conditions, treatment alternatives, and the benefits and risks of a procedure and is typically packaged as a generic form coupled with a conversation between patient and physician. However, shortcomings in this process can lead to significant patient safety, legal, and quality of care issues such as lack of informed consent, the selection of inappropriate or undesired therapies, dissatisfaction with potential outcomes, increased patient anxiety, and poor compliance with preprocedure and postoperative instructions.

Centers for Medicare & Medicaid Services (CMS) has clearly recognized the need for practitioners to disclose adequate information to patients, allowing them to make informed decisions about their care, and the need for comprehensive documentation of the informed consent process. To that end, CMS released new guidelines in 2004 that expand the breadth of information that must be disclosed to patients.

Redefining Informed Consent

In order for healthcare organizations—such as hospitals, ambulatory surgery centers, and physician practices that perform in-office procedures—to receive full reimbursement for medical procedures, they must comply with all regulations and guidelines set forth by payer organizations such as CMS, accreditation organizations such as the Joint Commission on Accreditation of Healthcare Organizations (now simply the Joint Commission [JC]), and individual state statutes. These guidelines and regulations may be adjusted, and new requirements may be added to them at any time.

The primary objective of these guidelines and regulations is to ensure that patients are given sufficient information to allow them to make informed decisions about procedures to be done and alternative treatments that might be employed to address underlying conditions

Abstract: This article explores how technology can assist healthcare facilities in meeting the new Centers for Medicare & Medicaid Services guidelines for informed consent. Issues addressed include shortcomings in the traditional informed consent process, ways that technology can facilitate meeting these new guidelines, other compliance benefits—such as achieving compliance with Joint Commission requirements—and last, criteria that healthcare organizations should consider when choosing an automated informed consent solution.

or illnesses. Both CMS and JC instruct healthcare organizations to establish their own policies for determining procedures that require informed consent and to identify emergent circumstances where informed consent could be implied to have been obtained. Basic guidelines for informed consent include communicating general information on the disease state, describing the planned procedure, outlining the diagnosis, identifying risks and benefits, specifying alternative treatments, and noting the time of consent. Because healthcare organizations must comply with the requirement to provide consent in an easily understandable format, they must develop a system for creating and managing the informed consent documentation, as well as making sure that those forms are updated with changes to procedures and guidelines as they arise. For examples of CMS and JC requirements for the informed consent process and the consent form, see **Figure 1**.

Historically, healthcare organizations have struggled to meet the most basic of these guidelines. A study in the *Archives of Surgery* found that only 26% of informed consent forms included the four key elements of informed consent—benefits, risks, alternatives, and purpose of the planned procedure (Bottrell, Alpert, Fischbach, & Emanuel, 2000).

Now, with more stringent CMS guidelines, inadequacies are significantly magnified. In the *Interpretative Guidelines* set forth in the *State*

Key Words

CMS guidelines
informed consent
Joint Commission requirements

Figure 1. Informed Consent Assessment Tool for Directors of Quality Management and Hospital Compliance

Required Element	Requiring Organization	Evaluation
Consent Process		
Policy describing the process used to obtain informed consent	JC	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Policy describing how informed consent is documented in the patient record	JC	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Discussion of the potential benefits of the procedure	JC	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Consent Form		
Name of procedure	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Name of practitioner performing the procedure	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Names of other practitioners assisting with the procedure	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Specific surgical tasks that will be conducted by each practitioner	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Risks: potentially exact procedure-specific risks	CMS, Texas and Louisiana	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Alternative procedures and treatments	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Date	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Time of day	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Name and signature of person obtaining the patient's consent	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Signature of patient or legal guardian	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply
Signature of witness	CMS	<input type="checkbox"/> Comply <input type="checkbox"/> Do not comply

Note. This checklist may not include all required elements for a given practice or organization. Please have your compliance officer confirm that your process and forms comply with all state, federal, and accreditation requirements.

Operations Manual (SOM)—the federal publication employed by state survey agencies charged with determining whether facilities are in compliance with federal health and safety standards—required informed consent documentation has been expanded for those procedures that require the active participation of multiple practitioners (U.S. Department of Health and Human Services [DHHS], 2004). CMS now requires that the patient be informed when practitioners other than the primary surgeon will perform important parts of the surgical procedures, even when they are working under the primary surgeon's supervision. According to the *Interpretive Guidelines* (U.S. DHHS, 2004), a properly executed consent form must include the name of the practitioner(s) performing

the procedure(s) or important aspects of the procedure(s), as well as the name(s) of the specific surgical task(s) they will conduct during the procedure(s). As guidelines continue to be updated, healthcare organizations face a tremendous challenge in creating and managing these forms accurately and precisely in order to receive reimbursement from federal healthcare programs.

Many healthcare stakeholders, including the American College of Surgeons, have expressed concern about the challenges presented by these new guidelines. Because physicians have not been required to provide this level of detail on informed consent forms in the past, the guidelines present both a documentation and a compliance burden for healthcare organizations.

Teaching organizations that perform significant numbers of procedures involving multiple practitioners have an even greater burden to overcome.

The CMS *Interpretive Guidelines* (U.S. DHHS, 2004) also instruct practitioners to take into account a patient's capacity to understand what is being communicated by the practitioner. Those guidelines further note that the information provided during the informed consent process must be supplied in a language that the patient understands. The National Quality Forum addressed these specific requirements in *Improving Patient Safety Through Informed Consent for Patients with Limited Health Literacy—An Implementation Report* (National Quality Forum, 2005). The report provided a number of recommendations, including improving the quality of written consent forms and asking patients to "teach back" what they had been told to confirm their comprehension.

Using Technology to Meet Guidelines

Today, most healthcare organizations rely on either generic, one-size-fits-all consent-to-treat forms that are not specific to the proposed treatment or generic fill-in-the-blank forms. These fill-in-the-blank forms require providers to create a form from scratch for each patient. Preparing a procedure-specific form for each new patient often results in forms that are inconsistent, incomplete, and sometimes inaccurate because their creation is dependent upon both an individual provider's judgment and available time to document all aspects of the proposed procedure (including the key surgical tasks and identification of the practitioner who will perform those tasks). The amount of time a physician spends with a patient and the location where the informed consent discussion takes place are both very important. Informed consent obtained in the physician's office has been found to be associated with a decreased risk of indemnity payment, compared with informed consent obtained in the preoperative holding area (Bhattacharyya, Yeon, & Harris, 2005). Some practitioners and organizations have attempted to address this potential gap in information communicated to a patient by developing procedure-specific consents for only the most common or most litigious procedures. This unacceptable inconsistency in the consent process leads to varying standards of care

for patients depending on the procedure that those patients elect to undergo.

Automated informed consent applications standardize clinical communication and offer providers a comprehensive library of detailed, procedure-specific forms coupled with the ability to customize forms for each patient and procedure, if necessary. As a result, the inconsistencies and inadequacies of the traditional informed consent process are eliminated. When using an automated informed consent application, the provider can access an extensive database of relevant materials—such as customized educational information about the patient's disease process, procedure, and alternative treatment modalities. Educational materials are supplied at either an eighth-grade or a sixth-grade reading level to address the health literacy needs of a given patient. Supplemental information such as anatomical diagrams and pre- and postprocedure instructions is also available.

Procedure-specific informed consent forms, produced by automated informed consent applications, include explanations of risks, benefits, step-by-step descriptions of procedures, the prognosis if the patient elects not to undergo treatment, and other relevant information. All materials are written in a style that is patient-friendly and easy to understand—without complicated medical or legal jargon. Furthermore, all documents are available in the patient's native language.

With the flexibility to accommodate a variety of circumstances, an automated consent application can quickly and easily help healthcare organizations develop informed consent policies that comply with all necessary federal, state, and accrediting body regulations. For single-provider procedures, technology ensures that healthcare facilities consistently meet basic CMS guidelines so that healthcare organizations remain eligible to receive full reimbursement. In addition, an automated informed consent application allows providers to document a specific task assigned to a specific provider in multiple-provider procedures and also to achieve full compliance with the more stringent guidelines relating to complex procedures.

Considering Other Compliance Benefits

The use of an automated consent application also ensures that healthcare facilities are in compliance with other established regulations and guidelines. For example, JC requires providers

to disclose the nature of a procedure and the benefits of a procedure for every patient who is treated. JC requires that organizations develop a comprehensive policy on informed consent and that those policies specify all aspects of the informed consent process. Although the formal documentation requirements imposed by JC are less specific than those of CMS, the design of an organization's informed consent forms must consider the JC standards (Joint Commission Resources, 2005) and the organization's informed consent policy as well as the CMS requirements.

Informed consent requirements are spelled out in the statutes of all 50 states. Two states have taken steps to provide guidance on exactly what risks should be disclosed to patients undergoing specific procedures. Texas and Louisiana have medical disclosure panels (MDPs) that have established a minimum set of risks for various treatments. Providers in these states must ensure that informed consent forms specifically document the risks specified by the state's MDP for those selected procedures.

Finding the Right Solution

In order to fully leverage the benefits afforded by an automated consent application, healthcare organizations should look for the following when considering these applications:

Completeness—The application should provide consents that cover all aspects of the medical process. All procedures requiring informed consent, in all specialties (surgical and non-surgical), need to be addressed. The level of specificity and detail should be consistent throughout these documents.

Customization—The automated informed consent application should give providers the ability to customize forms for the individual patient and for a specific procedure.

Educational materials—A comprehensive library of educational materials is essential in helping providers explain complex procedures or treatments to a patient. Printable patient education materials, including anatomical illustrations, should be available in a format that supports various language requirements and meets the educational needs of patients who represent all levels of medical literacy.

Usability—For maximum efficiency, the application must be user-friendly for providers' convenience and must easily conform to

existing work flow. This will ensure maximum compliance with policy and maximize time-savings for providers.

Integration—Seamless connectivity with existing or planned electronic medical records (EMRs) and document management systems is a necessity for any healthcare organization. Compatibility with existing technology like tablet PCs and mobile computer carts in a wireless environment can streamline work flow, improve efficiency, and lower costs.

Expandability—The application should have the ability to generate other common patient forms such as the Health Insurance Portability and Accountability Act (HIPAA) authorization forms and medical history forms. Those documents may be digitally signed by the patient and automatically stored in the document management system.

Implementing an automated informed consent application creates a win-win situation for the patient, provider, and healthcare organization. Healthcare organizations can confidently supply patients with comprehensive and accurate information. As a result, patients are empowered to make knowledgeable decisions about their personal health and maintain realistic expectations about potential procedural outcomes. In addition, providers and healthcare organizations create a stronger relationship with patients through a more attentive, customized plan of care, resulting in improved quality of care and a likely reduction in medical malpractice risk.

Healthcare organizations may be subject to changes in guidelines or unannounced audits of their key processes at any time. An automated informed consent application provides facilities with the best chance of maintaining compliance with informed consent policies, thereby ensuring positive findings related to this critical process. These applications create consistency across the clinical care continuum, guaranteeing that all necessary and required information is being gathered, collected, and stored electronically for easy access by any appropriate provider. For a step-by-step guide to implementing an automated informed consent application, see **Figure 2**.

Leveraging Technology

Many healthcare organizations have made significant investments in automation—EMRs and computerized physician order entry systems

Figure 2. Sample Implementation of the Informed Consent Process Employing an Automated Informed Consent Application

Step 1

The application is launched through the provider or healthcare organization's electronic medical record (EMR) system, automatically populating the informed consent document with the patient's name, medical record number, date of birth, and other demographic information. The provider is prompted to enter information such as diagnoses, surgical site location, and other details. The patient- and procedure-specific informed consent documentation may be saved for rapid retrieval at a later point or the provider may continue the informed consent discussion with the patient.

Step 2

The patient meets with the provider to discuss his or her condition and possible treatment alternatives.

Step 3

The provider gives the patient an easy-to-understand written record of the informed consent discussion, along with education documents or annotated images that help the patient comprehend his or her condition, proposed treatment, and alternatives.

Step 4

When the provider and patient have reviewed all the data, both can sign the form electronically using a digital signature capture device such as a signature pad or a tablet PC. If required by the organization's informed consent policy, signatures of a witness or an interpreter may also be obtained. A progress note documenting the consent encounter is automatically saved to the healthcare organization's EMR system, and an electronic copy of the signed consent form—complete with time and date markers—is stored in the organization's document management system. A high-resolution paper copy of the signed consent form may be printed and presented to the patient. Either the note or the signed consent form can easily be accessed by appropriate admissions personnel, anesthesiology service staff, and clinical staff.

Step 5

On the day of the procedure, healthcare organization personnel can access the patient's consent form electronically to verify that the documentation is in place. If a provider listed on the consent form has changed from one originally listed, a progress note detailing that change is posted to the organization's EMR system. Again, a high-resolution paper copy can also be provided if necessary.

are notable examples—that improve patient safety and quality of care. In 2003, the Department of Veterans Affairs (VA) launched a pilot program to evaluate an automated informed consent application in five VA medical centers. That pilot program found a marked increase in compliance with informed consent policy in those medical centers that evaluated the application (Spotswood, 2005). Subsequently, the VA made the decision to implement the automated informed consent application in all 158 VA medical centers as part of an initiative called Electronic Support for Patient Decisions (VA, 2004).

The savings for an institution afforded by an automated informed consent application include both an annual savings in document scanning costs that may average \$80,000 per year and the potential for an annual savings in lost operating room time, due to lost or misplaced consent documents, that approaches

\$500,000 each year (Baum & Kelly, 2006). Furthermore, a small study of orthopedic malpractice claims alleging inadequate informed consent found that documentation of the informed consent discussion in an operative note resulted in combined legal expenses and indemnity payments that averaged \$450,000 less per incidence (Bhattacharyya et al., 2005). A computerized informed consent application may automatically generate a supplemental operative note detailing the informed consent discussion and thus may offer significant medical-legal liability protection to healthcare organizations.

It is estimated that the cost of an automated informed consent application for a 250-bed hospital is approximately \$250,000 for the first year followed by annual license and maintenance costs of approximately \$75,000 per year. This suggests that the payback period for an investment in an automated informed consent

tool may be very short. Implementation and adoption challenges with such an application may also be minimal. A study of the use of an automated informed consent application in the outpatient surgery area of a large teaching institution found clinician satisfaction, patient satisfaction, and clinician ease of learning to rank very high compared to traditional methods for obtaining informed consent (Ritenour, 2005).

As healthcare organizations evaluate traditional processes that may benefit from the application of technology, they must consider the traditional paper-based informed consent process, along with the challenges imposed by a complex compliance and regulatory environment, and consider an automated informed consent application as an effective solution.

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q&a: Anamarie Di Nunzio Rayburn on Pediatric Healthcare Quality and Constant Readiness

Joann Genovich-Richards, Interviewer



q Columbus Children's Hospital was one of the early adopters of a constant readiness culture, which involves mock patient tracer reviews, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) [now known simply as the Joint Commission] readiness rounds, and Environment of Care rounds. What organizational factors supported the development of your constant readiness culture and practices?

a In 2003, we became aware of the Joint Commission's unannounced rounds planned for 2006. JCAHO asked for volunteers to pilot the unannounced survey process. We were scheduled for a triennial survey in 2004, and we volunteered to participate in an unannounced survey in 2004. We were 1 of 35 hospitals and 2 children's hospitals that volunteered for the pilot. Our administrative strategy in 2003 was to be "prepared for the next patient" that entered our facility and to assume that the patient desired the clean environment and atmosphere that is observed during the announced JCAHO surveys. We developed our constant readiness tools and mock rounds in 2003 in order to change our organizational culture and practices.

q Please describe your approach to conducting tracer reviews. Who participates on the team? Did you need to add staff resources to accomplish them? How often are tracers conducted, and how frequently are various areas and activities reviewed? For example, does your team review personnel files of employees and credentials files of physicians every time you conduct a tracer? How much time is needed for the team to conduct a typical tracer review?

Anamarie Di Nunzio Rayburn is the director of quality improvement services for Columbus Children's Hospital, Columbus, OH. In that role she has developed an infrastructure for constant survey readiness for external reviews, implemented an automated incident reporting system based on the principles of a nonpunitive safety culture, and facilitated many activities related to root cause analyses, healthcare failure modes and effects analysis, and hazard vulnerability analysis. Her department includes physicians, quality improvement coordinators, a patient satisfaction coordinator, and a data analyst. She began her career in biology and later obtained a master of science degree in public health from the University of Miami, Miami, FL. She has extensive leadership experience in quality, case management, and risk management in acute care and rehabilitation hospitals. Columbus Children's Hospital operates 323 licensed beds on the central campus as well as home healthcare services and community-based urgent care, physician care, and behavioral health centers. More than 5,600 individuals are employed by the system, which is affiliated with Ohio State University. The hospital's mission includes research, education, and service. The largest pediatric referral center in Ohio, the hospital has achieved the American Nurses Credentialing Center's Magnet Status designation. In 2006 the hospital was recognized by the Leapfrog Group and *U.S. News and World Report* as one of the nation's top hospitals and was also listed as one of *Child* magazine's top 10 children's hospitals.

a Tracer reviews of patients are conducted monthly by senior leadership. A patient is identified either by diagnosis or by condition. The patient is traced through the organization, and each department that dealt with that patient is visited by members of the tracer review team. Staff members are asked specific questions regarding the patient's care, staff communication during handoffs, and other National Patient Safety

Goals. These rounds usually take at least 1 hour. The findings are presented at our monthly task force meetings.

We give the names of the employees and physicians whom the patient had contact with to the human resources (HR) department so that their HR files can be checked for deficiencies such as late appraisals or missing competencies. Most of our physicians are employed, and we include residents and fellows in the HR review process. We also use tracer rounds to validate the implementation of policies and procedures from sentinel event and root cause analysis reviews.

q You also have a vigorous approach to Joint Commission readiness rounds. Who participates in those rounds? How often is a specific area reviewed? How have you adapted the rounds for reviewing inpatient areas, support areas, and ambulatory clinics?

a We conduct unannounced Joint Commission survey readiness rounds in each department every quarter. A team consists of two hospital employees (at least one with a clinical background in doing chart reviews) from the quality department and administrative and medical staff leadership. Conducting the reviews usually takes 30–60 minutes. Names of four employees are given to the HR department, which then reviews the personnel files and provides feedback on deficiencies such as a late performance appraisal or missing competencies. We use three different tools to review the inpatient, ambulatory, and support areas. Most of the questions are similar, but the tools are customized to fit the area. For example, the inpatient tool reviews restraint usage, the ambulatory tool reviews follow-up on abnormal laboratory or test results, and the support areas tool reviews storage of medication in the pharmacy for separation of look-alike and sound-alike medications.

q How does your department manage all of the data that are obtained from the tracers and rounds? How is progress toward improvement and resolution monitored?

a We use a Microsoft Access database for entering the data and generating division-specific and corporate-specific

reports. Quarterly results are shared with the nursing program managers, senior leadership, and quality improvement (QI) committees at their meetings. All department managers must present their scores on the Joint Commission readiness rounds and Environment of Care rounds to their peers twice a year. Best practices are also shared at these meetings.

q Your organizational structure is slightly unusual: you are administratively responsible for two part-time medical directors—one a practicing neonatologist and one a retired cardiac surgeon—as well as a part-time medical coordinator who is a retired pediatrician. What are the roles of the medical directors and coordinator? How did that structure evolve? What have been the advantages and challenges of having these physicians report to the organization's nonphysician quality leader?

a I am very fortunate to have such rich physician talent. The retired pediatrician has been with the department for 10 years. He is mainly responsible for overseeing morbidity and mortality reviews for the medical staff and conducting sentinel event and root cause analysis reviews. The medical director who is a neonatologist helped transform the medical staff structure after a problematic JCAHO survey in the early 1990s. He has been very instrumental in communicating QI issues to the medical staff and assisting in the mandatory review functions such as blood and sedation. He is a great facilitator and leads most healthcare failure modes and effects analyses and other projects such as medication reconciliation. It is a benefit for him to be practicing because he understands the medical staff viewpoint. We then identified a need for the same type of communication with the surgeons. Our surgeon in chief was contemplating retirement, and having him serve as a second part-time medical director seemed a perfect solution.

The two medical directors also investigate patient complaints, complete incident reports, and coordinate outcome activities for the surgery and medical departments. I am requesting additional physician resources for the emergency department and ambulatory clinics. We are implementing an electronic medical record and automating QI reviews.

Our quality leadership committee includes the three quality department physicians, the chief nursing officer, a medical director, and me. We all collaborate on strategic quality initiatives, and the reporting structure has never been an issue. We have found it advantageous for the medical staff to have someone to represent them and their concerns.

q You have had a very successful career in healthcare quality. What career advice would you give to healthcare quality professionals seeking to advance in their careers?

a The best advice I can give someone is to listen to your customers and not be afraid to take risks. I schedule feedback sessions with my department managers and QI leadership to evaluate current processes and determine what customers would like to see improved or changed. As certified professionals in healthcare quality, we need to be constantly improving ourselves by visiting quality and regulatory Web sites and implementing new ideas.

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Media Reviews

Lecia A. Albright

SMART Nursing: How to Create a Positive Work Environment That Empowers and Retains Nurses

June Fabre, Springer Publishing, www.SpringerPub.com, 2006, \$35, 208 pages, ISBN 0826125859

Audience: educators, managers, nursing administrators, nursing staff

Key Words: culture, nursing, work environment

SMART Nursing is one in a series of five books addressing the nursing environment, management, the nursing shortage, and advanced practice issues. New nurses and novice managers in particular will find this book most useful. The book offers a basic approach to creating a positive work environment for staff nurses as part of an effort to retain nurses in healthcare organizations. The nursing literature includes numerous studies supporting the importance of a positive work environment and identifying its characteristics (often called magnet forces). This book identifies some of the same characteristics (as well as some different ones) but addresses the research base only superficially.

The author presents a conceptual model for SMART Nursing, which is described as being based on systems theory. The model contains six elements or “building blocks”: respect, simplicity, flexibility, integrity, communication, and professional culture. Fabre then presents 10 assumptions to further explain the model, but she does not offer a strong rationale for the interrelatedness of the model elements or the basis for their development.

The first part of the book makes the case for using this model. Each of the six elements is then discussed, along with applications and future directions. Examples illustrate the importance of the six elements, and tips for clinical nurses, managers, and educators to use in incorporating the elements are given at the end of each chapter. These tips are general and conceptual (such as “use common sense”); more concrete

suggestions would be more helpful. The references and recommended readings relate more to topics in management and leadership than to research-based studies.

The author presents many examples for applying this model. Interestingly, the final chapter shifts the focus from nurses in the work environment to groups outside nursing. Because the intended audience is nurses, it is not very likely that this chapter will reach the other groups who have a role in influencing nurses’ work environment.

Reviewed by Susan V. White, PhD RN CPHQ FNAHQ, JHQ’s interviews editor and associate chief of nursing service and quality improvement at Veterans Health Administration James A. Haley Veterans’ Hospital, Tampa, FL

Doing More with Less: Lean Thinking and Patient Safety in Health Care

Joint Commission Resources, www.jcrinc.com, 2006, \$75, 131 pages, ISBN 0-86688-951-5

Audience: healthcare administrators, healthcare quality professionals, medical and nursing professionals, organizational performance improvement managers

Key Words: administration and management, evaluation, healthcare delivery, international quality, Joint Commission, patient safety, performance improvement, quality tools, redesign, reengineering

Doing More with Less: Lean Thinking and Patient Safety in Health Care, written under the auspices of Joint Commission Resources, was intended to give healthcare professionals a practical and focused explanation of how and why lean thinking applies to the crucial issue of patient safety. The foreword was written by Helen Zak, executive vice president and chief operating officer of Lean Enterprise Institute.

Chapter 1 provides an overview of lean thinking and brief comparisons to other quality systems. It presents the origins of lean

thinking and explains how the system began as a manufacturing model that is still used in industry. A brief description of lean terms is also given. Chapter 2 provides a description of lean steps. Chapters 3 and 4 demonstrate how the lean methodology is applied to the healthcare industry in specific situations with the end goal of patient safety and quality services. Chapter 5 presents case studies from organizations that have applied lean methodology and experienced successful outcomes. Finally, three appendixes offer references and short biographies and highlight applicable Joint Commission performance improvement standards.

This book is an excellent resource, not only in providing an explanation of the lean thinking methodology but also in demonstrating the application of lean thinking in healthcare. Case studies strengthen the understanding of how lean thinking can be implemented and how it can improve patient quality and safety outcomes. The Joint Commission Resources' stated goal of producing a practical book that can help strengthen an organization's approach to lean thinking was accomplished.

Reviewed by Toni Layer, MHCA RN CPHQ, performance improvement coordinator, South Central VA Healthcare Network, Jackson, MS

Core Curriculum for Medical Quality Management

American College of Medical Quality, Jones and Bartlett Publishers, www.jbpub.com, 2005, \$199, 213 pages, ISBN 0-7637-3061-0

Audience: physicians and other healthcare professionals who are new to quality improvement or who are looking for a broader overview of the field of healthcare quality

Key Words: information systems, quality assessment, utilization management

Core Curriculum for Medical Quality Management provides an excellent introduction to quality management, particularly for physicians, medical students, and other healthcare providers. It could easily be used as a textbook in a course on healthcare quality, utilization, and informatics. Each of the six chapters is written by a different expert in the respective fields of quality management, utilization management, organization design,

economics, medical informatics, and legal and ethical issues.

The most extensive material can be found in the chapter on quality management principles and practices. The book begins with a historical overview of the work of Ernest Codman, Avedis Donabedian, and Donald Berwick, moving from quality assurance through continuous quality improvement and total quality management. The chapter focuses on three primary aspects of quality management: a means of accountability, an effort to continuously develop and improve services, and a mechanism to improve clinical outcomes. Information about the PDCA (Plan, Do, Check, Act) process and the Clinical Value Compass is provided as an aid in accomplishing these goals. In addition, several statistical analysis tools are included, such as affinity diagrams, Pareto diagrams, and histograms.

The chapter on utilization management addresses, among other topics, demand management, case management, and discharge planning. Most important is the discussion of nine common tasks that the authors believe are fundamental to the study of utilization management. The relationship between the quality leader and the healthcare organization's design and management is the focus of another chapter, while the remaining chapters focus on such external factors as economics, finance, the legal environment, and ethics.

This book is an excellent reference for medical staff leaders and other healthcare professionals seeking current information about medical quality management, principles, methods, programs, systems, and experiences. This highly readable basic text provides a sound initial working knowledge of the field.

Reviewed by Pamela Scarrow, CPHQ, manager of quality improvement and patient safety, American College of Obstetricians and Gynecologists, Washington, DC

The Health Disparities Myth: Diagnosing the Treatment Gap

Jonathan Klick and Sally Satel, American Enterprise Institute for Public Policy Research, Veronique Rodman, vrodman@aei.org, 2006, \$15, 81 pages, ISBN 0844771929

Audience: healthcare policy makers and those in a position to influence them

Key Words: healthcare delivery, public policy, quality of care

The authors (one a legal scholar and health economist and the other a physician) allege that too many experts subscribe to what they call the *biased-doctor model* of treatment disparities to explain disparate care or health status of blacks and whites in the United States. They maintain that the 2002 Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* added unmerited weight to promotion of the biased-doctor explanation and that differences in treatment do indeed vary by race, but not because of race. The authors hypothesize that class and related geographic factors, not the biases of doctors, explain disparities in care. They express concern that bias is nearly impossible to detect and measure within a healthcare setting and that efforts to do so are diverting resources from more effective approaches to reducing inadequate care.

The authors provide 19 pages of supporting notes in this 81-page book. Their conclusions support the findings of some health plans that are laboring to respond to various public pressures to assess for evidence of disparities in the treatment of various populations.

Reviewed by Jane Miller, MSN CPHQ FNAHQ, disease management coordinator, HealthPlus of Michigan, Lansing, MI

The Social Medicine Reader (2nd ed.), Volume 3: Health Policy, Markets, and Medicine

Jonathan Oberlander, Larry Churchill, Sue Estroff, Nancy M. P. King, Ronald Strauss, editors, Duke University Press, www.dukeupress.edu, 2005, \$22.95, 304 pages, ISBN 0-8223-3569-7

Audience: consumers interested in healthcare policy, students of healthcare policy

Key Words: consumer/advocacy, ethics, government regulations, healthcare delivery, international quality, public health, public policy, quality of care, resource utilization

The Social Medicine Reader: Health Policy, Markets, and Medicine is the third volume of the Social Medicine Reader trilogy. This series was created for use in the first-year class at the University of North Carolina School of Medicine to introduce medical students to the idea that medicine has a profound influence on social, cultural, political, and economic

forces. This volume focuses on health policy and the economics of medical care. The essays are drawn from such diverse sources as international medical journals, law journals, book excerpts, correspondence, and personal stories. The intent is to provide a balanced view of how the American healthcare system has been shaped by economic pressures and how the system is responding to policy issues like quality of care and access to care.

The book is divided into sections on (1) the uninsured, healthcare costs, and public programs, (2) managed care, markets, and rationing, and (3) international perspectives and emerging issues.

Of particular interest in the first section are readings outlining the history of healthcare payments in the United States. Donald L. Madison's "From Bismarck to Medicare—A Brief History of Medical Care Payment in America" gives an excellent overview of how the American system of healthcare financing has evolved.

The second section specifically addresses how managed care and limited resources have shaped the rationing of healthcare. Probably the most controversial section deals with the ethics of rationing and the decision-making process that determines who receives care. Of particular interest in this section was a very personal article from the popular literature: "Defending My Life" by Geov Parrish, in which he chronicles his fight through the healthcare system to get treatment for kidney and pancreatic failure.

The third section addresses the international dimension of the problem and the issues that are continuing to emerge, including age-based and economics-based rationing. Of primary interest to healthcare quality professionals is the article "Keeping Quality on the Policy Agenda," by Elizabeth A. McGlynn and Robert H. Brook.

This book whets the appetite for the other two volumes in the series. The series would provide an excellent basis for discussion in any group of healthcare professionals or consumers regarding the effect of social, political, and economic considerations on healthcare policy and payments.

Reviewed by Eileen Johnson, MSN RN BC CPHQ, clinical consultant on quality reporting and measurement, HCA Information Technology and Services, Nashville, TN

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Quality NETWORK

Robert J. Rosati and Daniel van Leeuwen, Quality NETWORK Editors

“Quality NETWORK” offers reviews of selected Web sites relevant to healthcare quality professionals. The editors welcome comments and feedback on the column as well as suggestions for future reviews. To read previous reviews that have appeared in the journal, visit www.nahqplus.org, the exclusive Web site for NAHQ members.

The Health Care Blog

www.thehealthcareblog.com/

Key Words: consumer/advocacy, education, healthcare settings/delivery systems, public policy issues

The Health Care Blog (with the tagline “Everything you always wanted to know about the Health Care system. But were afraid to ask”) began in 2003 and is hosted by Matthew Holt, who has more than 14 years’ experience as a researcher and forecaster in the healthcare industry. His current position is senior consultant with Professional Services Solutions, Inc., and he posts opinions daily on this Web site. The blog features a variety of topics aimed at informing consumers about policy issues and information technology. Although Holt is the primary author, guests offer comments on current issues. Archived topics include health plans, policy and politics, technology, pharmacy benefits, and physicians.

The Web site is intended to create a forum for opinions on healthcare issues. The title of this blog may lead one to expect more discussion of clinical or condition-driven information than discussion of policy topics. The site contains several links to other sites, but the vendors identified through these links appear to be paid advertisers, so consumers would be wise to evaluate the content of the material and reputation of the sponsor.

It is easy to navigate this site and enter a comment or read the recent posts, but the site is not designed to present valid and reliable consumer education on specific healthcare topics. Those interested in an online discussion of

topics will be more likely to find this site appealing than healthcare quality professionals, who are inclined to seek resource-driven sites. Most healthcare quality professionals are constrained by multiple demands and must use their time efficiently to access reliable data and information sources. A blog is not generally accessed during work time, and therefore this site will not be bookmarked in my favorites.

Reviewed by Susan V. White, PhD RN CPHQ FNAHQ, JHQ’s interviews editor and associate chief of nursing service and quality improvement at Veterans Health Administration James A. Haley Veterans’ Hospital, Tampa, FL

The HealthCentral Network

www.thehealthcentralnetwork.com

Key Words: mental health, prevention, primary care, psychiatric/behavioral care, public health

This online commercial medical information site is updated daily. The primary goal of HealthCentral Network is to partner with companies to achieve their advertising goals. All links on the home page are commercial (dot-com) links. Six links appear under the heading Mind, 19 links under Body (with information on topics from acid reflux to sleep management), and 4 links under General Health. Each section has additional links in three subcategories: Find (get answers to questions, check symptoms, find resources), Manage (take action, achieve goals, resolve a problem), and Connect (find support, get advice, voice your opinion). This is a consumer-friendly site with links to a myriad of information, video clips, and blogs. Healthcare quality professionals should exercise caution, however, because the site may lead users to the products or resources paying the most to advertise. The site is available to all; there is no membership fee. I did not add the site to my list of favorites but may suggest it to friends or family members looking for consumer-friendly health-related information.

Reviewed by Deborah Dowling, MPH BSN CPHQ, senior director for quality management, Randolph Hospital, Asheboro, NC

The White House

www.whitehouse.gov/infocus/healthcare

Key Words: consumer, empowerment, information, technology

The White House Web site provides an array of information regarding President Bush's initiative to strengthen healthcare.

The intent of the site is to expand consumers' understanding of the healthcare system and encourage their active involvement in the decision-making process. Healthcare quality professionals may appreciate reviewing the president's executive order that directs federal agencies to share the following information with consumers: the prices paid to healthcare providers; information on the quality of services rendered to consumers; the ways that improved information technology can facilitate healthcare information; and ways to ensure high-quality and efficient care.

The site also provides information on the president's agenda for making healthcare more affordable by allowing civic and small groups or businesses to form association health plans, passing legislation to bring about medical liability reforms, expanding health information technology regarding electronic health records, and expanding health savings accounts. Visitors can click on other links to issues related to healthcare in the president's 2006 State of the Union

Address, such as reforming healthcare for the 21st century, carrying out a national strategy for dealing with pandemic influenza, and making healthcare affordable and accessible.

Visitors to the site are given ways to contact the White House by e-mail, fax, or telephone and to submit questions. Although the Web site is easy to navigate and free of charge, I would not consider this site a favorite because so much of the information can be easily obtained from local radio stations, newspapers, and cable television.

Reviewed by Sandra E. Ward, MA MS RN CPUR CPHQ, risk management coordinator, HIP Health Plan of New York, New York, NY

Help Identify and Review Sites

The JHQ team invites you to help identify and review Web sites. A review consists of the name of the site or sponsoring organization, a URL reference, key words, the intent of the site, and comments about ease of navigation, value, pertinence to the healthcare quality professional, timeliness, and cost, if any.

Please forward—via e-mail—questions, sites for review, or, better yet, sites with reviews, to Quality NETWORK coeditor Robert Rosati at robert.rosati@vnsny.org.

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Quality Resources

Luc R. Pelletier

QUALITY RESOURCES

This *JHQ* feature provides members with interesting up-to-the-minute resources that will help them navigate through the constant flood of healthcare quality information. Brief descriptions of recently released media are provided, as well as ordering and Internet access information.

Resources

Advertised Job Vacancies Dip in November, the Conference Board Reports

Total online job advertisements declined by 119,800 (3%) to 3,711,300 in November, according to the Conference Board Help-Wanted OnLine Data Series (HWOL) released December 2006. There were 2.4 advertised vacancies online for every 100 persons in the labor force in November. The monthly decrease in advertised job vacancies was reflected in 39 of the 50 states and was widespread across most major metropolitan areas. Over the year, online advertised vacancies increased 15% for the nation as a whole.

The 3,711,000 unduplicated online advertised vacancies in November include 2,396,000 new ads that did not appear in October, as well as reposted ads from the previous month. During November, total ads dipped 3%, and new ads declined 5%. Over the course of the year (November 2005–November 2006) total ads and new ads rose 15% and 16%, respectively.

The occupations with the most advertised online vacancies nationally in November were management (410,300) and business and financial operations (305,300), followed by office and administrative support (297,200). There were also 335,600 online advertised vacancies for healthcare jobs, including 295,300 for healthcare practitioners and technical occupations and 40,300 for health support occupations. In terms of the sheer volume of healthcare ads, California (53,000), Florida (31,700), and Texas (25,300) were the top states. Metropolitan areas with the

largest demand included Los Angeles (15,700), New York City (14,200), and Boston (12,200), followed by Miami, Phoenix and San Francisco—all of which had more than 10,000 ads posted in November for healthcare positions.

The Conference Board introduced its newly redesigned HWOL with the release of the October 2006 data. The HWOL program is now one of the earliest released economic indicators for the previous month. Geographic coverage has been expanded and currently provides detailed monthly data on labor demand (vacancies) for the United States, the 9 census regions, the 50 states, and 52 of the largest metropolitan areas.

Information on total ads has been introduced along with the already existing data on new ads. Economic analysis in the release has been broadened to include both labor supply (unemployment) and labor demand (vacancies). In addition, the program has been expanded to include geographic occupational detail on labor demand along with occupational pay levels. Detailed information on this series is available in the technical notes to this series on the Conference Board Web site at www.conference-board.org/economics/helpwantedOnline.cfm. The upcoming schedule of monthly releases is listed in this release as well as the technical notes on the Web site.

The underlying data for the Conference Board HWOL are provided by Wanted Technologies, Inc. Financial support for this series is provided by CareerBuilder.com. As a nonpartisan and not-for-profit organization, the Conference Board is one of the world's leading business membership and research organizations. The Conference Board produces the Consumer Confidence Index and the leading economic indicators for the United States and other nations. These barometers can have a significant impact on the financial markets. The Conference Board also produces a wide range of authoritative reports on corporate governance and ethics, human resources and diversity, executive compensation, and corporate citizenship. Its conference and council programs bring together more

than 10,000 senior executives each year to share insights and learn from each other.

For more information, go to www.conferenceboard.org.

SAMHSA and Ad Council Unveil National Mental Health Anti-Stigma Campaign

The Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the Ad Council, launched a national awareness public service advertising (PSA) campaign in December 2006 designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems.

“We took a new approach to de-stigmatizing mental illness with this campaign,” said Assistant Surgeon General Eric B. Broderick, SAMHSA acting deputy administrator. “Instead of telling people why they shouldn’t discriminate against people with mental illnesses, we are showing how friends can be supportive of those who have disclosed they are having a mental health problem and the critical role that friendship plays in recovery.”

Despite the fact that an overwhelming majority of Americans (85%) believe that people with mental illnesses are not to blame for their conditions, only about one in four (26%) agrees that people are generally caring and sympathetic toward individuals with mental illnesses, according to a HealthStyles Survey released in December 2006. The survey data, licensed from Porter Novelli by SAMHSA and the Centers for Disease Control and Prevention (CDC), also found that only one-quarter of young adults believe that a person with a mental illness can eventually recover and slightly more than one-half (54%) who know someone with a mental illness believe that treatment can help people with mental illnesses lead normal lives.

“The advances made in treatments and services for mental illnesses offer the hope of recovery for all,” said Acting Surgeon General Kenneth Moritsugu, MD MPH, who helped kick off the campaign. “Mental illness is not something to be ashamed of. It is an illness that should be treated with the same urgency and compassion as any other illness. And just like any other illness, the support of friends and family members is key to recovery.”

According to SAMHSA, in 2005 an estimated 24.6 million adults aged 18 or older experienced serious psychological distress

(SPD), which is highly correlated with serious mental illness. Among 18- to 25-year-olds, the prevalence of SPD is high (18.6% for adults 18–25 versus 11.3% for all adults 18 and older). But this age group exhibits the lowest rate of help-seeking behaviors. In addition, those with mental health conditions in this age segment have a high potential to minimize future disability if social acceptance is broadened and they receive the right support and services early on.

In addition to collaborating with the CDC, SAMHSA’s National Mental Health Anti-Stigma Campaign has partnered with other federal agencies, including the National Institute of Mental Health (NIMH), state mental health agencies, leading researchers on stigma, and a broad coalition of stakeholders, including organizations that represent provider organizations and consumer and family member groups. The campaign held a series of regional meetings to develop a grassroots network that would gain support and provide assistance with antistigma efforts to states and local communities.

A resource guide titled *Developing a Stigma Reduction Initiative* was also recently released and is based on the evaluation and lessons learned from the Elimination of Barriers Initiative. The guide provides information on how to mount a statewide antistigma campaign, examples of outreach materials, reports on the best practices for stigma reduction, and important resources for technical assistance.

The PSAs were distributed to more than 28,000 media outlets nationwide in December and will air in advertising time that will be donated by the media.

For more information, visit www.whatadifference.samhsa.gov. Copies of the guide can be obtained by calling SAMHSA’s National Mental Health Information Clearinghouse at 800/789-2647.

It Takes a Region: Creating a Framework to Improve Chronic Disease Care

In the absence of a concerted national effort to improve the affordability and quality of healthcare—particularly for chronic diseases—many communities and regions across the country are taking steps to collaboratively improve healthcare for local populations. This California HealthCare Foundation (CHCF)-funded report explores how to develop an effective collaboration to improve healthcare and reduce costs for patients and providers. It

examines the strategies of regional efforts and their potential for success, including analyses from nine prominent initiatives, in an effort to identify actions and structures that maximize improvement across a geographic area.

The result is a framework for creating a regional healthcare system. This practical model identifies four essential strategies: sharing data to measure performance, engaging customers, supporting delivery system improvement, and aligning benefits and finances. It also discusses employing multiple strategies for regional transformation and offers a road map for getting started.

The report concludes that although a significant amount of qualitative information about regional improvement activities exists, we have relatively little quantitative information about program impact. In order to build a stronger foundation for future regional efforts, we need better evidence about successes and failures, along with more sharing of experience among coalition leaders.

For more information, visit www.chcf.org/topics/chronicdisease/index.cfm?itemID=127575.

N-SSATS Survey Reveals That Nearly Half of All Patients Are in Treatment for Both Alcohol and Drug Abuse

The proportion of patients in treatment for drug and alcohol abuse constitutes nearly half of all clients (47%), according to the *National Survey of Substance Abuse Treatment Services (N-SSATS): 2005*, released in December 2006 by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The survey results showed that on March 31, 2005, 1.08 million people were enrolled

in substance abuse treatment, an 8% increase from 1 million in 2000. Of those people, 34% were in treatment for drug abuse, up from 29% in 2000. By contrast, clients enrolled in treatment only for alcohol abuse declined from 23% in 2000 to 19% in 2005.

N-SSATS: 2005 contains data on the location, characteristics, and use of alcoholism and drug abuse treatment facilities and services throughout the United States and its territories. A total of 14,047 facilities (95%) responded to the 2005 survey.

The 2005 national survey reported that the number and proportion of clients receiving methadone increased from 172,502 (17% of all clients) in 2000 to 235,836 in 2005 (22% of all clients). It also indicated that opioid treatment programs, which focus on treating addiction to heroin and prescription narcotic pain medications, were available in 8% of all substance abuse treatment programs.

N-SSATS, a snapshot of the substance abuse treatment delivery system, helps SAMHSA and state and local governments assess the nature and extent of services provided in state-supported and other treatment facilities and forecast treatment resource requirements. March 31 is used as a reference point because on that date survey participants report on the number of clients in treatment.

For more information, visit <http://findtreatment.samhsa.gov>. The locator service provides the phone numbers and locations of the nearest state-approved treatment facilities.

Luc R. Pelletier, MSN APRN BC CPHQ FNAHQ FAAN, is editor in chief of the Journal for Healthcare Quality. He is an administrative liaison with Sharp Mesa Vista Hospital and a healthcare consultant in San Diego, CA.