

Staying Prepared for the Joint Commission:
Restructuring for Continuous Accreditation,
Reynolds Army Community Hospital
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Abstract

As with all other facets of the healthcare arena the accepted measurement of quality is constantly evolving. The Joint Commission on the Accreditation of Healthcare Organizations and consequently, the U.S. Army Medical Department are measuring a great deal of a hospital's effectiveness and quality of services based on Performance Improvement. Performance Improvement is grounded in using the collection and analysis of quantitative data to be able to allow the hospital leadership the information that is required to make informed and intelligent decisions concerning the functioning of the hospital. In order to collect, analyze, interpret, and communicate that data, an efficient and streamlined committee structure is essential. The existing committee structure should be reengineered to ensure that the required committees and functions, outlined in the Joint Commission on the Accreditation of Healthcare Organizations and U.S. Army Medical Department rules and regulations, are integrated into the new structure. This is just the first step that is needed to allow Reynolds Army Community Hospital to evolve along with the changing standards. This will change the mindset of the hospital employees and help them understand that business practices of the 1990's are no longer sufficient in today's healthcare environment. We must constantly strive to improve the quality of services that are provided by our facility.

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**Staying Prepared for the Joint Commission:
Restructuring for Continuous Accreditation**

“For an enduring organization, there is no finite end state,
only a journey-always becoming, never being.”

- GEN (R) Gordon R. Sullivan (former Army Chief of Staff)

Imagine picking up the New York Times or the Dallas Morning Star and seeing the headline in bold letters “U.S. Army Hospital Fails Inspection” or “Military Hospital Provides Inferior Care.” What would you think?

“How could this happen?”

“This must be a mistake.”

“I’m never going to a military hospital again.”

Then imagine what type of investigations and fact-finding missions that Congress would initiate. “Impossible”, you say. Well, it is not impossible. In fact, unless U.S. Army Medical Treatment Facilities recognize the fact that the Joint Commission on Accreditation of Healthcare Organizations (known hereafter as the Joint Commission or JCAHO) is constantly evolving and amending its standards and the way it believes healthcare organizations should be operating, then this scenario could happen in the very near future. The U.S. Army Medical Department must develop their rules and regulations around the Joint Commission standards. The Joint Commission standards are to healthcare, what the Generally Accepted Accounting Principles, GAAP, are to accounting and finance.

Introduction

The United States Army Medical Department Activity (MEDDAC), Fort Sill, Oklahoma is the integrated delivery system for the United States Army in Oklahoma and Arkansas. The

mission of the MEDDAC is to deliver quality health care services while maintaining a high state of readiness in a workplace of excellence (U.S. Army, 2000). The MEDDAC's vision is to be Southwest Oklahoma's integrated health care system of choice for all eligible beneficiaries (Reynolds, 2000). There are approximately 54,000 eligible beneficiaries in southwest Oklahoma. This figure includes over 35,000 active duty soldiers, marines, airmen, and sailors and their family members, 16,000 retirees, as well as several thousand students, trainees and prisoners (Reynolds, 2000).

At the heart of this system is Reynolds Army Community Hospital (known hereafter as "Reynolds"), an 86-bed facility with a full range of inpatient and outpatient services. Reynolds was constructed in two phases, Phase II being completed in 1994 and was designed to accommodate 157 inpatient beds. The hospital has a staff of 900, including military, civilian, and contract employees (Reynolds, 2000). Reynolds is an integral player in the Department of Defense's (DoD) managed care organization, known as TRICARE and even has the Regional TRICARE Service Center as a tenet within the hospital. Additionally, Reynolds serves as one of the test sites for the TRICARE Senior Prime demonstration project; thereby making the facility responsible to abide by guidelines established by the Health Care Financing Administration as well as the normal DoD guidelines (TRICARE, 2000).

Conditions Which Prompted the Study

In 1951 the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) was established by the American College of Physicians, the American College of Surgeons, the American Hospital Association, the American Medical Association, and the Canadian Medical Association. An independent, not-for-profit organization, the Joint Commission is the nation's predominant standards setting and accrediting body in health care.

Since 1951, the Joint Commission has developed and updated numerous state-of-the-art, professionally based standards and has evaluated the compliance of health care organizations against these benchmarks. The Joint Commission evaluates and accredits nearly 20,000 health care organizations and programs in the United States. The Department of Defense, in the desire to maintain the highest possible care for its beneficiaries, mandates that all military medical treatment facilities participate in the accreditation process.

The mission of the Joint Commission on Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations. (Joint Website, 2000)

In 1997, the Joint Commission on the Accreditation of Healthcare Organizations adopted the philosophy of Performance Improvement mentioned above. The concept behind Performance Improvement is “to provide patients with the best possible care, you need to consistently monitor, analyze, and, if necessary, improve all of the processes in your hospital that directly or indirectly affect patient care” (Barnard & Eisenberg, 2000). Essentially, the health care organization needs to constantly be focused on improving all services that are even remotely associated with patient care.

This is a radical change from the current mentality here at Reynolds and a number of other health care organizations. The current practice throughout the health care community is to operate as usual and then 12 – 18 months from the scheduled Joint Commission survey date appoint a JCAHO committee or team. This team then begins the preparations that are needed to have a successful survey. “Upon the completion of the survey, the organization may return to ‘business as usual’ and may reduce its focus on performance improvement efforts” (Joint

Commission, 2000). This is a very expensive practice and is not the intent of the Joint Commission.

Performance Improvement is meant to be used everyday and to be “ingrained into the fabric” of the organization. The Joint Commission expects organizations to practice continuous accreditation. This means they are monitoring and improving their performance year-round. When the triennial survey occurs, the organization already knows where they stand and whether their performance improvements efforts are having the desired affect (Joint Commission, 2000). This will also prevent the organization from having to use a great deal of time and resources to make the last minute preparations and “gear-up” for the survey. The bottom-line is that “continuous improvement efforts help hospitals maintain the highest possible quality of patient care and services” (Joint Commission, 2000). In an attempt to ensure that the health care organizations are actually integrating Performance Improvement into the organizations, the Joint Commission has begun to conduct random unannounced survey’s that can occur from 9 – 30 months from the last full survey completed on the facility.

During the preparation for Reynolds October 2000 JCAHO survey, it was identified that Reynolds was not practicing continuous accreditation and that Performance Improvement was not an integral part of the organizational structure. Mr. Terryl Miller, one of the JCAHO surveyors, even made comments about the fact that it was evident that Reynolds had just started to prepare and also that it was apparent that our organization did not know what the philosophy of Performance Improvement was (Interview, 2000). The amount of time and resources that were used by the organization were excessive and the efforts by these individuals were still not able to make up for areas that were not being followed and tracked over the entire three year period from the last survey (1997) and the October 2000 survey.

The final JCAHO score for Reynolds was 86. This is quite a bit lower than the 1997 score of 97. Reynolds was not the only facility that had trouble with their JCAHO survey. Two medical centers, that are staffed much better, also scored in the 70's and 80's. Reynolds' leadership and the U.S. Army Medical Department, realizes that an in-depth analysis of each organization needs to occur to align the hospital closer to the JCAHO standards.

An obvious first attempt would be to start from scratch and redesign the functioning of the entire system. Instead of making a number of small alterations and adding a number of new committees that will require some of the same people to sit on numerous committees, we can overhaul the entire system and develop a new hospital framework and structure. As stated by Swain and Associates Consulting, we "need a more formalized, structured approach to JCAHO/regulatory standards" (Swain, 2000).

One of the most important steps in the Performance Improvement philosophy is the development of a Performance Improvement Plan. According to Performance Improvement: Winning Strategies... an ideal comprehensive PI plan:

1. Is consistent with the mission and vision of the hospital and individual departments.
2. Includes a mechanism to receive input from external and internal customers.
3. Requires the use of performance measurement tools.
4. Encourages collaboration among all departments and disciplines within the hospital.
5. Assures disciplined assessment, development of solutions, and maintenance of improvements.
6. Provides flexibility to meet changing priorities.

7. Suggests how to determine improvement priorities.
8. Describes the improvement process in consistent use throughout the organization. (Barnard, et al, 2000)

In addition to these eight elements, surveyors consider it critical to see how the hospitals reporting structure for monitoring PI is completed. This boils down to one thing; a well-functioning committee structure is critical to a PI plan (Ball, Counts, Jones, Vinci, and Winn, 1998).

There currently is no defined accountability for compliance with standards, and JCAHO functions are only loosely managed through various committees and individuals (Swain, 2000). This loose management of the critical JCAHO functions allows for confusion and a lack of clear and efficient communication. This includes communication horizontally, between committees and departments, as well as vertically from the executive committee down to the lowest level in the organization and vice versa.

Statement of the Problem or Question

Given that a successful Joint Commission survey is essential in today's healthcare arena, the following question is posed: What would be a more accurate and efficient committee/reporting structure, that can clearly focus on the JCAHO functions and at the same time allow for the highest quality care and smoothest operation of Reynolds Army Community Hospital.

Literature Review

Related literature was explored to determine whether there were any information published on the restructuring of committees and reporting system due to the transition of the

Joint Commission to the latest quality philosophy. The literature search included performance improvement, communication, structural change, and change theory.

Performance Improvement

Performance Improvement or Quality Improvement is a good example of how difficult it is to put theory into practice. Florence Nightingale first developed quality initiatives in health care in Great Britain between 1854 and 1870. She conducted studies that described how awful the quality of hospital care was during the Crimean War. She then used the results of these studies to develop early process standards for nursing care (Meisenheimer, 1997).

In the United States the desire to improve the quality of healthcare began in 1910, with the publishing of the Flexner Report. This report condemned many medical schools as substandard facilities and recommended a new set of medical education standards. Then in 1914 Dr. Ernest Codman, a surgeon at Massachusetts General Hospital began "...a patient follow-up system that emphasized outcome-oriented medical audits" (Meisenheimer, 1997, p.5). In 1918, thanks to Dr. Codman's efforts, the American College of Surgeons' created the Hospital Standardization Program. This program included the use of standards, hospital evaluations, and granting of accreditation for complying with the published standards (Meisenheimer, 1997).

In 1966, Avanis Donabedian developed the Structure, Process, and Outcomes Theory. Until then the medical system concentrated on assessing the processes but little else. This new structure, process, and outcome approach was a key lesson that continued to influence quality initiatives into the following decades (Kongstvedt, 1997; Meisenheimer, 1997).

In 1981, the Joint Commission for the Accreditation of Hospitals (the Joint Commission) implemented new standards that required the integration and coordination of quality assurance activities into hospital wide programs. By the end of the decade the Joint Commission had

begun compiling national averages on the number of health care organizations that were actually meeting the standards of measuring the quality of medical care. The numbers were very disappointing (Meisenheimer, 1997).

The 1980's also brought about a new interest in quality within the general business sectors. Such intellectuals as P. Crosby, Dr. W.E. Deming, and Dr. J. Juran espoused this quality philosophy. Each of these business leaders, although differing slightly in approach, "agreed that a management systems approach to quality improvement was essential in creating a culture of quality" (Meisenheimer, 1997). The federal government was also becoming aware of the importance of product and process quality and to help stimulate quality awareness, Congress passed Public Law 100-107 – The Malcolm Baldrige National Quality Improvement Act of 1987 (Jensen, 1996, p.51; Health Care Criteria for Performance Excellence, 2000).

Entering the 1990's, the U.S. health care system was concentrating on quality. The Joint Commission began the decade by introducing the ten-step model for monitoring and evaluating, which emphasized the concept of continuous quality improvement. The new standard also focused on total quality management (TQM). TQM was first developed by Deming and used by Japan in the 1960's and 1970's. TQM is just one type of quality management program. It attempts to bring together all the techniques of continuous quality improvement under one program and name, which is supported and administered by management (Meisenheimer, 1997). Some of the key dimensions of a true quality management program are leadership that empowers people to perform, knowledge of customer expectations, provision of satisfied customers, use of strategic planning with follow up assessments, development and management of human resources, achievement of world class results, use of valid statistical procedures, application of

benchmarking, enhanced supplier relationships and the integration of quality assessment, utilization management, and risk management (Jensen, 1996; Meisenheimer, 1997).

Both Deming's and Crosby's strategies for quality improvement were based on the premise that an organization's quality problems were due to its processes, not its people. In order to correct this problem, they recommended that the quality management program necessitated an organizational culture committed to quality. Today Performance Improvement is just one type of quality management program, along with total quality management, quality improvement, and total quality environment (Barry, 1994; Meisenheimer, 1997). Bottom line is that Performance Improvement is the industry benchmark and an essential aspect of PI is communication of the standards and the data collected.

Communication

Effective communication is essential to a well-functioning healthcare organization. Communication is defined as "the transference and understanding of meaning" (Robbins, 1998). The "transference" can take place by a number of different mediums. These include oral, written, or signs. The "understanding" of the message is essential because if the message is not understood then communication never really effectively occurred.

The communication process model (Figure 1) identifies the elements that need to occur to have a message passed. Between each step in the process, there is the possibility that the person responsible for that part may distort the message. If the message is distorted, then the communication did not actually take place, or worse, a miscommunication occurs and a different message is passed and carried out. The most important element of this model is the feedback. This feedback from the receiver to the sender/source of the original message alleviates any doubts that the message was received and properly understood. A study by the

Picker/Commonwealth Program for Patient Centered Care, “communication and coordination breakdowns make for needless duplications of effort and the delay or omission of important procedures and tasks” (Sultz & Young, 1999).

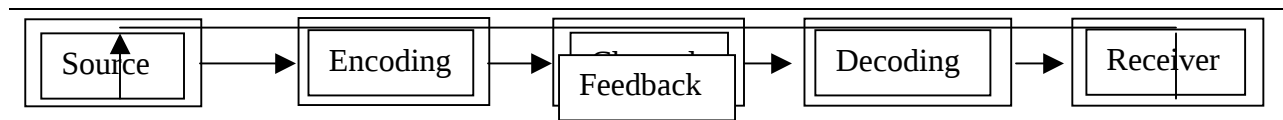


Figure 1. The Communication Process Model. Each arrow represents the message being sent.

This indicates that there is the possibility for miscommunication at five points where the message is passed (Robbins, 1998).

Hospitals are very complicated organizations and it is essential that they have very thorough interorganizational and intraorganizational communications processes. The interorganizational communications are critical in healthcare because of the vast number of external stakeholders that can effect the functioning of the organization.

The intraorganizational communications process is the communications that occurs within the hospital. Communications within an organization can occur by downward flow, upward flow, horizontal flow, and diagonal flow. Downward flow is typically the supervisor or other boss sending information down to their subordinates. Upward flow is the same idea but it is when the subordinates are using the chain to send information up to their supervisors.

While these flows are important, they are not sufficient for effective organizational communication. Horizontal flow occurs when one department sends information to another department that needs the information quickly. It usually occurs between staff of equal status

within the organization. Diagonal flow is similar to horizontal but it occurs when the communicators are at different levels of the organization. For example, if the chief of the pharmacy discovers that there is the potential for an adverse reaction between two medications ordered for a patient. The chief then calls directly to the ward nurse who would be administering the medications to inform them of the danger (Shortell & Kaluzny, 1994). Horizontal and diagonal flows are essential in complex healthcare organizations as the timing of the information flow can play an important part in the quality of care that is delivered to the patients.

Committees and process action teams, composed of staff members from different levels and specialties within the hospital, serve as an important mechanism of horizontal and diagonal communication flows (Shortell & Kaluzny, 1994). Committees and the organizational structure also compose one of the three elements in the communication of the organization's performance improvement activities (Meisenheimer, 1997).

Structural Change

An organization has many structures that “represent need satisfying interaction patterns” and reflect lines of communication and authority (Mackenzie, 1986 and Meisenheimer, 1997). In the healthcare arena, the committee structure is essential to having an efficient and quality run organization. The committees allow for a multidisciplinary membership and encourage interaction across clinical and non-clinical specialties, which are vital (Ball, et al, 1998).

As relationships and responsibilities change, the corresponding structures that were developed to help satisfy these relationships and responsibilities also need to change. Kenneth D. Mackenzie, an expert with more than 20 years of research on group/organizational structures, describes ten “Views on Organizational Structure” and the first view is that structures can and will change (1986). The key is that the structure and the strategy of the organization need to

help compliment each other (Thompson, 1994). In healthcare the committee structure should be designed to facilitate the collection, reporting and analysis of data that is based on the Joint Commission categorized standards and functions (Meisenheimer, 1997). As these Joint Commission standards change, the individual healthcare organizations need to reassess their structure and determine whether they need to change along with the standards because changing conditions demand structural changes (Robbins, 1998).

Change Theory

Once the decision is made that some changes need to occur in an organization, the changes need to be managed. Change as defined by Webster's College Dictionary is "to become altered or modified; to change from one form to another" (Costello, 1992). Planned change is defined as "change activities that are intentional and goal oriented" (Robbins, 1998). Planned change has two main goals. The first is to improve the organizations ability to adapt to changes in its environment and the second is that it seeks to change the behavior of employees (Robbins, 1998). Essentially, the success or failure of the planned change hinges on the support of the employees.

When you implement planned change it helps to identify how severe the change will be. Robbins divides change into two categories, called first-order change and second-order change. First order change is "linear and continuous" and it implies no fundamental shifts in the assumptions that organization members make and how the organization can improve. Second-order change is multidimensional, multilevel and involves radical change in how the organization operates and improves (Robbins, 1998).

Two other professors break change down into three types; adaptive, innovative, and radically innovative change. Adaptive change has a lower degree of complexity, cost,

uncertainty, and potential for resistance to change. Radically innovative change has the highest degree of complexity, cost, uncertainty, and potential for resistance to change. Innovative change falls someplace in between the other two (Kreitner & Kinicki, 1995).

When change occurs, especially second-order or radically innovative change, there is the potential for individual and organizational resistance to that change (Davidson, 2000). This resistance to change is not necessarily bad. In a positive side, it provides constancy and predictability. If resistance were nonexistent, then “organizational behavior would take on characteristics of chaotic randomness” (Robbins, 1998). However, resistance definitely does have its downsides.

If individuals or even the whole organization resists a change, then the very success of the change is in question. Therefore the organization must identify the sources of resistance to change and then identify ways to overcome this resistance (Robbins, 1998, Kreitner, et al, 1995, Levesque, 1998).

Each organizational behavior author has compiled a different list of individual sources of change but they all can generally be grouped into the following categories: habit, security, and fear of the unknown. The organizational resistance to change can be grouped into threat to group relationships, threat to expertise, and threat to current allocation of resources (Robbins, 1998, Kreitner, et al, 1995, Levesque, 1998).

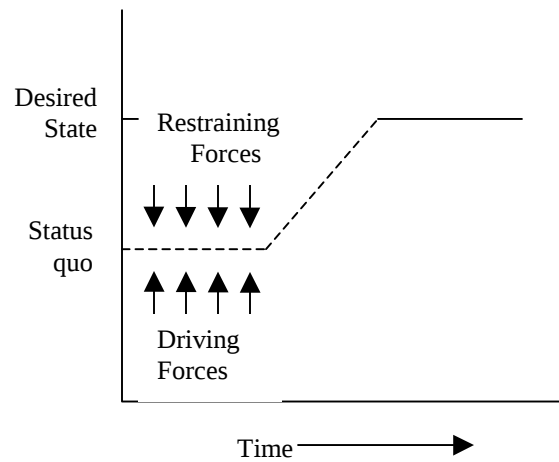
To overcome the resistance to change the organizational behavior scholars all agree that there are six strategies for overcoming resistance to change. The six strategies are education and communication; participation and involvement; facilitation and support; negotiation and agreement; manipulation and cooptation; and coercion, both explicit and implicit (see Figure 2) (Kotter & Schlesinger, 1979, Robbins, 1998, Kreitner, et al, 1995).

Figure 2. Six Strategies for Overcoming Resistance to Change (Kotter & Schlesinger, 1979)

Approach	Commonly Used in Situations	Advantages	Drawbacks
Education & Communication	Where there is a lack of information or inaccurate information and analysis.	Once persuaded, people will often help with the implementation of the change.	Can be very time consuming if lots of people are involved
Participation & Involvement	Where the initiators do not have all the information they need to design the change and where others have considerable power to resist	People who participate will be committed to implementing change, and any relevant information they have will be integrated into the change plan.	Can be very time consuming if participators design an inappropriate change.
Facilitation & Support	Where people are resisting because of adjustment problems.	No other approach works as well with adjustment problems.	Can be time consuming, expensive, and still fail.
Negotiation & Agreement	Where someone or some group will clearly lose out in a change and where that group has considerable power to resist.	Sometimes it is a relatively easy way to avoid major resistance.	Can be too expensive in many cases if it alerts others to negotiate for compliance.
Manipulation & Co-optation	Where other tactics will not work or are too expensive.	It can be a relatively quick and inexpensive solution to resistance problems.	Can lead to future problems if people feel manipulated.
Explicit & Implicit coercion	Where speed is essential and where the change initiators possess considerable power.	It is speedy and can overcome any kind of resistance.	Can be risky if it leaves people mad at the initiators.

The key to avoiding resistance and overcoming it, if it cannot be avoided is to develop a detailed and well thought out plan to help guide the organization through the changes to the current structure. Two popular approaches to managing change are Lewin's Three-Step Model and the Action Research Model.

Figure 3. Unfreezing the Status Quo (Robbins, 1998).



The restraining forces need to be decreased or the driving forces need to be increased in order for the system to move from the status quo to the desired state.

Lewin's Three-Step Model, as the name implies, advocates that successful change occurs by using the following three steps: unfreezing the status quo, movement to a new state, and refreezing the new change to make it permanent (Robbins, 1998). The status quo is usually held there by driving forces and restraining forces that create a stable state. The driving forces are those that are trying to change the organization. The restraining forces are those that are trying to hold the organization in that status quo. In order to move the organization to the new state, the status quo needs to be unfreezed by causing either the driving forces to increase or by causing the restraining forces to decrease. Once the change has occurred and the organization has reached the desired point, the whole system needs to be refrozen (see Figure 3). This will ensure that the organization will retain the change and will not revert back to the status quo.

The second method is the Action Research Method. This method refers to a process of change based on the systematic collection of pertinent data and then selection of a change action

based on the analysis of the data (Robbins, 1998 and Kreitner, et al, 1995). There are five steps in this process: diagnosis, analysis, feedback, action, and evaluation. The use of this methodology creates a more structured plan and will gain more support.

The first step, diagnosis, is the collection of information about the problems, concerns, and needed changes. The second step, analysis, involves taking all of the information that was collected and prioritizing this information into primary concerns, problem areas and possible actions. The third step, feedback, is sharing the information that has been collected and the corresponding analysis with the organizational elements that will be affected by the change. The fourth step, action, consists of the implementation of the actual change to correct the problems that were identified in steps one and two. The final stage, evaluation, is to evaluate how effective the change was. The data that was collected in the diagnosis and analysis stages is used as a benchmark to see if the changes helped improve the organization.

The literature review provides some very important insights into improving healthcare organizations. All four of the areas covered demonstrate the importance of the organizations committee structure, from its part in the hospitals communications model to the need of the organization to continuously evolve to stay abreast of the current changes in the healthcare arena.

Purpose

The purpose of this graduate management project is to conduct a qualitative study to develop a plan for organizing the most efficient and effective committee structure and reporting system to align the organization with functions outlined in the Joint Commission 2001 Hospital Accreditation Standards. The objectives are to analyze the hospital's existing committee structure, review the requirements that direct the establishment of each committee, and develop a new committee/reporting structure.

Methods and Procedures

This restructuring plan will be conducted utilizing a modified Action Research Model that consists of the following sections: diagnosis, analysis, feedback, and an action plan.

The qualitative method used to analyze the current structure is a combined method utilizing in-depth open-ended interviews, direct observation, and written documents (Patton, 1987). The following questions were explored: Is the current structure, the most optimal structure for effective functioning of the organization? Does the current structure contain all of the required committee's, according to regulations and established industry standards? If not, what would be more effective program design. The outline of the new system will be accomplished based on the qualitative analysis conducted by the researcher.

Diagnosis

As stated earlier, the problem is that the current JCAHO standards are becoming more detailed. The standards can no longer be met by providing the surveyors with a policy or regulation. They are much more interested in seeing data, analysis, and charts. They also want to be able to talk to employees within the hospital and ensure that they know the importance of Performance Improvement and what actions they are taking on a daily basis to meet these standards.

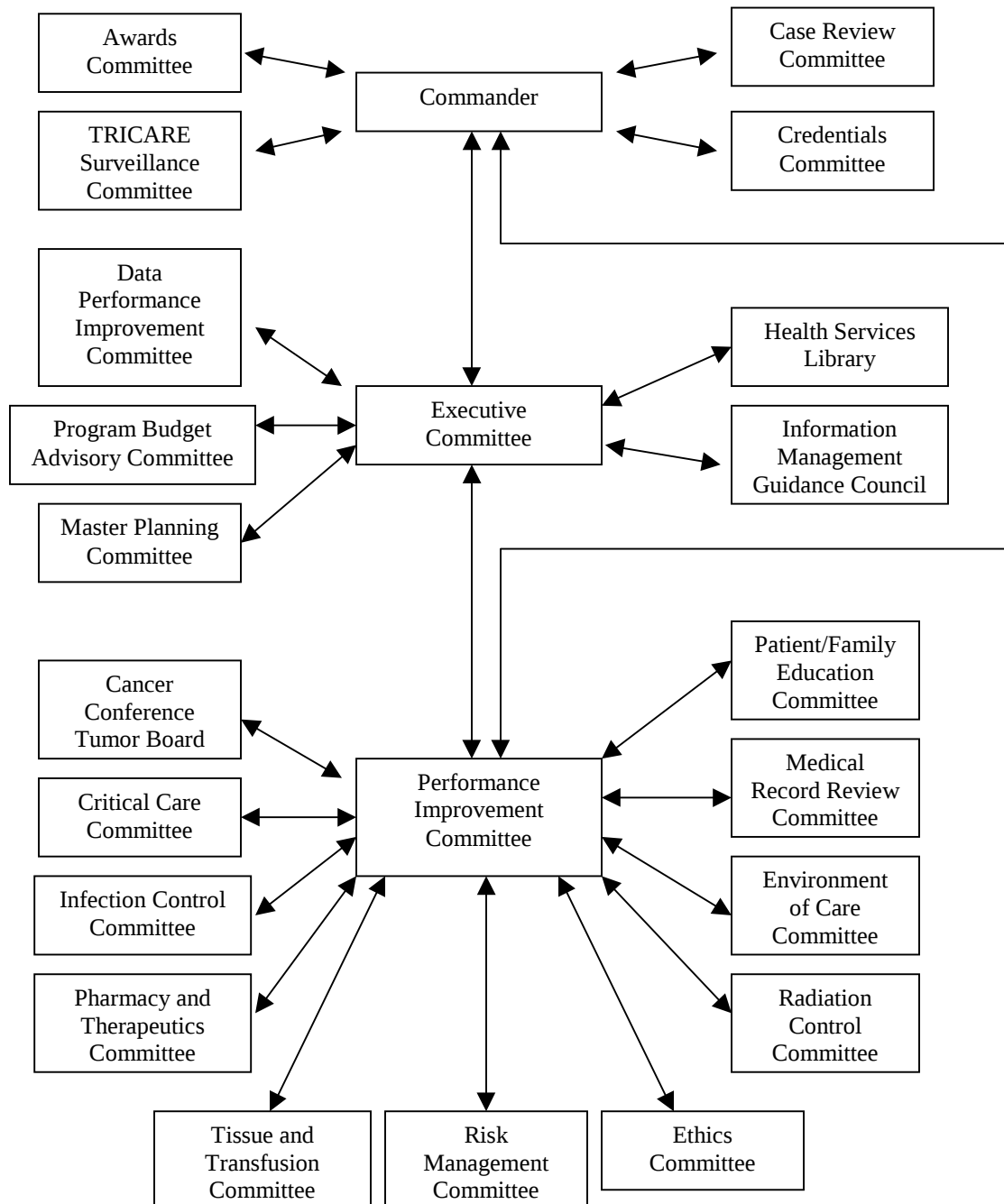
Analysis

Is the current structure, depicted in Figure 4, the most optimal for the most efficient functioning of the organization? The current committee system is a result of new taskings and problems that have developed over the years and then a committee is established to deal with it. This has resulted in a committee system that is a monster with no organization and clear-cut lines of supervision and reporting.

The current MEDDAC Regulation 15-1 is a large document of 56 pages that is not suited to today's healthcare environment. This creates a large amount of inefficiencies. First, it is the expectation that each committee create a large complex system of committee minutes. These minutes have to be typed by someone, which takes an enormous amount of time. After they are typed these minutes are then staffed through all of the executive committee. After receiving twenty-one sets of minutes, averaging approximately 9-11 pages, each of these individuals is spending an exceptional amount of time on reviewing these. Even more troubling is that after all this time is spent creating and reviewing these minutes, they still do not provide the statistical and analytical data that is required for Performance Improvement. The Joint Commission expects that certain statistical and analytical data be contained in the minutes that can reveal trends, either positive or negative. The executive committee would then be able to make informed decisions on areas that need to be improved or for areas that have attained the expected level of compliance and can then be held at that level. This is the essence of Performance Improvement.

Second, a review of the MEDDAC Regulation 15-1 reveals that each of these twenty-one committees has an average of 12.4 personnel who are required to attend. For those thirteen committees that have a clinical purpose, there are eight people that attend 80% of these meetings. Each meeting lasts at least one hour and a lot of them last two. So each month the hospital loses at least one day of work to committee meetings for each of these individuals. There are also seven people that have at least ten meetings that they are required to attend each month. These individuals are losing at least two full workdays. This does not include individual department or other separate meetings or working groups. While this may be acceptable to some of the administrative specialties, taking a provider or nurse away from their duties for that

Figure 4. Current Committee Structure.



This structure creates a very confusing system of reporting. This flowchart was developed from MEDDAC Regulation 15-1, dated 3 October 2000.

amount of time can produce a substantial loss of productivity for the facility. This is especially important when the military is downsizing and staffing is tied directly to the amount of workload that is being produced and documented. Discussions with the providers and nurses who are required to attend the most meetings reveals that they believe that a lot of the information that is discussed is repetitive at the various clinical committee meetings. They also believe that their time could be much better spent completing other administrative duties and performing clinical operations.

The analysis conducted clearly shows that the current structure is not the most effective. We then look at whether the current structure contains all of the required committee's? To determine what committee's are required we will have to look at both the industry standards and military regulations.

The Joint Commission Hospital Accreditation Standards manual dictates that there be six areas in which data is collected (Joint Commission, 2001). These areas include 1) ethics, 2) medical record review, 3) governing body, 4) medical staff, 5) surveillance, prevention and control of infections, and 6) performance improvement. However, it is not required that there be a separate committee for each of these areas. As long as the data is collected and reported in minutes where the Joint Commission is able to review them, then the intent of the requirement has been met (Joint Commission, 2001).

The U.S. Army Medical Department regulation concerning Quality Management and the structure of medical organizations is outdated and a draft proposal is currently being staffed. This author used the draft Army Regulation (AR) 40-68, Clinical Quality Management Program, dated 29 January 2001, to determine the committees required by the military. The draft AR 40-68 would require each facility to have the following committees: 1) Medical Treatment Facility

(MTF) Executive Committee, 2) Executive Committee of the Medical Staff (ECOMS), 3) Hospital Safety Committee, and 4) Health Care Consumer Committee.

The MTF Executive Committee would be composed of the Commander (chairperson), the Deputy Commander's for Administration (DCA), Clinical Services (DCCS), and Nursing (DCN), and any other staff designated by the commander. This committee would serve as the conduit for the channeling of PI information to the commander (Clinical, 2001).

The ECOMS would be composed of the DCCS (chairperson), the chiefs of each of the medical departments, the DCA, the DCN, the medical records administrator, the PI coordinator, and any other staff designated by the DCCS. Physicians must compose at least 51% of the voting members (Clinical, 2001).

The Hospital Safety Committee would be composed of the DCA (chairperson), the safety officer, the chief of logistics, the PI Coordinator, the risk manager, and any other staff members that the DCA designates. The Safety Committee is tasked with maintaining and improving the environment of care of the facility (Clinical, 2001). The environment of care, according to the Joint Commission, includes safety, security, life safety, control of hazardous materials and waste, emergency preparedness, medical equipment, and utility systems (Joint Commission, 2001).

The Health Care Consumer Committee would be composed of the Commander (chairperson), designated MTF leadership, and representation from the officer, enlisted, family member, and retiree beneficiaries. The purpose of this committee is to create a venue where communication can easily occur between the provider of care and services (the MTF) and the recipients (the beneficiaries) (Clinical, 2001).

The draft AR 40-68, dated 29 January 2001, also mandates that the following PI functions be performed, evaluated, and reported per the MTF PI plan: 1) medication use, 2)

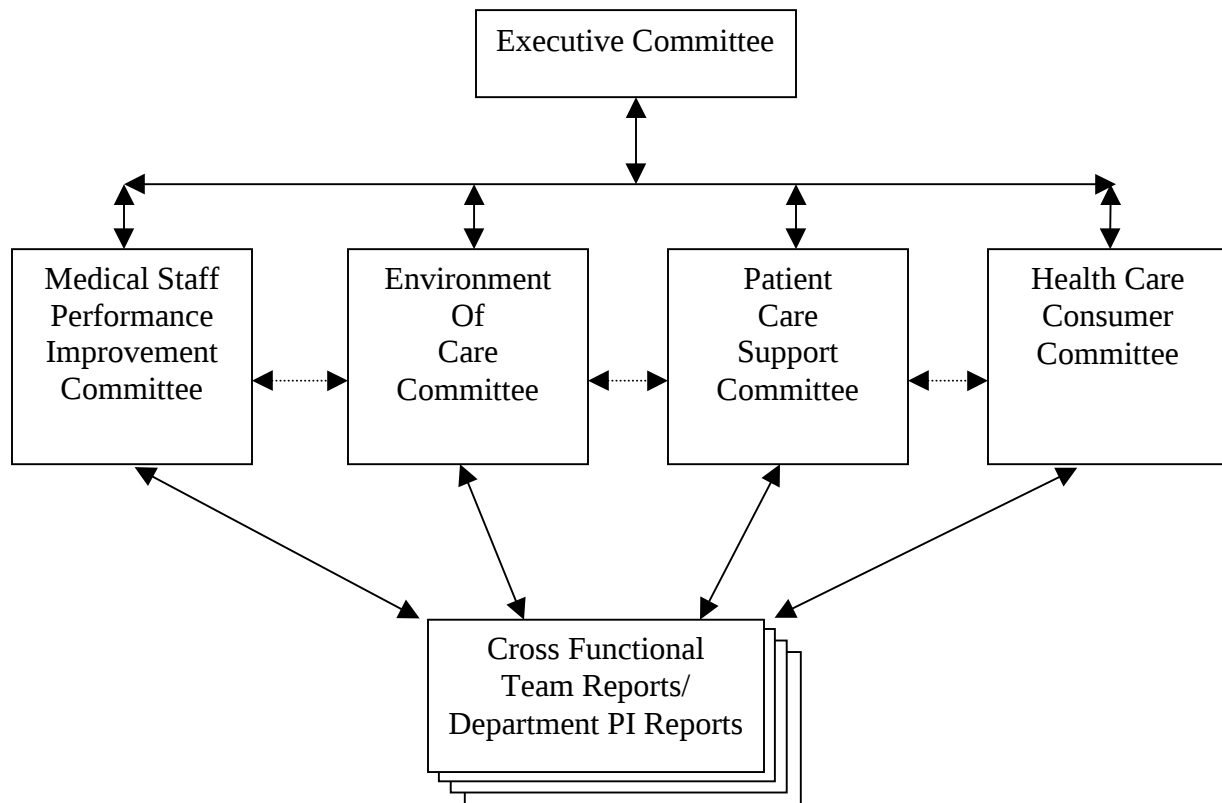
medical records, 3) blood and blood components, 4) operative and other invasive procedures, 5) credentials, 6) tumor board/cancer conference, 7) infection control, 8) deaths requiring autopsy, and 9) any other functions that are outlined in the MTF PI plan (2001). These functions and committees are very similar to the Joint Commission standards. The U.S. Army Medical Department is beginning to understand that it does not have to reinvent healthcare standards, all they have to do is adapt and implement the nationally accepted healthcare standards developed by the Joint Commission.

The review of the existing committee structure reveals that it does have all of the required committee and functions being performed. However, the way that the structure is constructed is very inefficient and does not allow for effective communications neither vertically up and down the chain of command, nor horizontally across departments and product lines. A simple restructuring of the committees will allow for a more efficient and effective system that is much less time intensive.

Based on the analysis of the current structure and the required committees and functions, a new simplified and efficient committee structure should be developed. This author proposes a system that includes five committees: Executive Committee, Medical Staff Performance Improvement Committee, Environment of Care, Patient Care Support Committee, and the Health Care Consumer Committee (Figure 5). A proposed Fort Sill MEDDAC Regulation 15-1, dated 18 March 2001, is at Appendix A.

The Executive Committee would consist of the Commander (chairperson), the DCA, the DCCS, the DCN, and the Hospital Command Sergeant Major (CSM). This group already meets on a daily basis but very informally. Under the new system this group would formally meet on a monthly basis. During this meeting, the new minutes (consisting of only the required data that

Figure 5. Proposed Committee Structure Reporting



The Committee's talk to and share information between them informally. The Committee's also collect information and task the different departments and functional teams within the hospital, either on a continuous report or as the need occurs. (Developed by LTC Tempsie Jones and CPT Richard Lindsay)

is needed) will be reviewed for each of the four other committees. The committee should be able to very easily identify any negative trends that need to be addressed. Guidance and directions can then be sent back down the system to be acted upon. This committee will also establish

policy, promote performance improvement, and provide for organization management and planning as outlined by the Joint Commission for the Governing Body.

The second committee would be the Medical Staff Performance Improvement Committee. This committee would be chaired by the DCCS and will consist of the all of the Deputy Commanders, all clinical department chiefs, the PI Coordinator, the Risk Manager, the Credentials Coordinator, the Chief, Patient Administration Division, the Chief, Clinical Support Division, the Chief, Utilization Management, and the Librarian. This committee will meet monthly for approximately three hours.

The Medical Staff Performance Improvement Committee will be an amalgamation of twelve existing committees: Credentials, Performance Improvement, Critical Care, Pharmacy and Therapeutics, Tissue and Transfusion, Tumor Board/Cancer, Risk Management, Ethics, Radiation Control, Medical Records Review, Patient/Family Education, and the Library Committee's. All of these functions and data from the old committees will still be reported in the Medical Staff Performance Improvement Committee. If there is any more coordination or work that needs to be conducted that doesn't involve everyone then a working group or a Process Action Team (PAT) can be formed to handle that situation. This consolidation should save some members of this committee between 10-20 hours per month in meetings, as they will now be attending one meeting vice the twelve that they attended in the past.

This committee will satisfy the requirements by the Joint Commission to have an ethics forum, a medical records review group, a Medical Staff Executive Committee, and a Performance Improvement Committee. It will also satisfy the requirement in draft AR 40-68 to have an Executive Committee of the Medical Staff and to monitor all of the functions outlined

with the exception of the infection control function, which would be monitored by the Environment of Care Committee.

The third committee would be the Environment of Care (EOC) Committee. This committee will retain the same membership as currently exists and will add the Chiefs of the Department of Primary Care and Community Medicine (DPCCM) and Department of Specialty Care. This will not create an additional meeting that they have to attend because they will no longer have to attend the Infection Control or Master Planning Committees as those two committees will be consolidated with the EOC Committee. This will also alleviate two meetings for three people that used to attend all three meetings and alleviate one meeting for five other people that previously attended two of these committees. Bottom line is that consolidation will allow for a decrease in the time required to complete these functions.

This committee will satisfy the Joint Commission requirements to have minutes that will address the surveillance, prevention, and control of nosocomial infections. It will also satisfy the requirement by draft AR 40-68 to have a Hospital Safety Committee and to monitor, evaluate and report on the function of infection control.

The fourth committee would be the Patient Care Support Committee. This committee would be composed of DCN (chairperson), DCA, DCCS, the Chiefs of the clinical and administrative departments or their designees, and the assistant chiefs of the Managed Care and Business Analysis Directorate and the Information Management Division. This committee will combine the existing Program Budget Advisory Committee, the Data Performance Improvement Committee, and the Information Management Guidance Council. It will also incorporate the Human Resources function of the Joint Commission. This committee although not mandated by

any organization will consolidate those other administrative areas that are essential to the running of the organization but do not fit in the other categories.

The last committee is the Health Care Consumer Committee. There is currently a Health Care Consumer Council that meets quarterly. The current MEDDAC Regulation 15-1 outlines the correct purpose and function of the committee. The purpose is to provide a forum where the medical facility and beneficiaries can communicate openly with each other concerning services, entitlements, and benefits that are provided or they feel should be provided. In actuality, this committee functions more like a briefing. Topics will be identified ahead of the meetings and each subject matter expert from the hospital will get up and brief something. This is more of a one-way communication versus two-way communication as originally intended. The answer to this would be to structure the actual running of the meeting to reflect the original expectations.

Feedback

Feedback is the way that findings from the analysis get briefed back to the actual decision makers of the organization. In this particular case, the analysis results were consolidated and presented to the Executive Committee in a specially called meeting. The Executive Committee asked some questions and then agreed that this restructuring needs to be implemented.

Action Plan

The action plan is the actual implementation of the change to correct the problems that were identified during the diagnosis and analysis phases. The action plan consists of two phases.

The first phase is the notification phase. A briefing of the new structure would be given to the medical staff, the administrative supervisors, the nursing supervisors, and in the quarterly Commander's Call. The reason that each of these forums needs to be addressed is because they

are all impacted by these changes. Each of these forums may require a different strategy outlined in Figure 2.

The medical staff and the administrative and nursing supervisors will be the most effected by the changes. These three groups will also be the most resistant to change. The best strategies to use are education/communication and participation/involvement. The best chance to gain acceptance from these groups are to find one person from each of these groups and then have them “champion” your cause. When the restructuring is being briefed you can have that individual either help give the brief or have them sit up front and field any questions. If their peers respect this person then it will simplify the process of gaining acceptance by the rest of the group.

The briefing must also sell the restructuring in terms of time and effort saved. Each of these individuals has very hectic schedules and the healthcare providers despise the administrative workload in the first place. If you show them the time that will be saved because they will attend only 5 meetings per month instead of 15 then they will buy into the change with strong enthusiasm.

The briefing at the Commanders Call will allow the rest of the staff to be aware of the changes. It should not be as controversial for the hands on workers as they have less participation in these committee meetings. This will primarily be a strategy of education and communication. Those workers do need to be aware though because they will need to know to whom they report data, ideas, or problems.

The second phase would be the actual implementation of the new structure. This would be considered innovative change according to Kreitner and Kinicki (1995). The cost is relatively cheap, while the complexity and uncertainty are moderate.

The best way to implement the change would be to select an implementation date and notify the hospital of that date. On that date, the restructuring would take place. Prior coordination will have already occurred so that all committee members are aware of the committees on which they sit and they will already have them put into their schedules. The chairpersons and recorders will need to have sat down ahead of time and thought out the agendas for the meetings.

Evaluation

The final stage would be the evaluation phase. During this phase the same data that was collected and evaluated in the diagnosis and analysis phase will be collected and reanalyzed. The results should reflect the expectations when the change was originally designed.

For this restructuring the evaluation could consist of determining how much time has been saved from attending committee meetings and how much time is spent on writing and then staffing the committee minutes. Both of these should reflect a savings of time spent on administrative functions that could be better used to provide care to patients.

A survey can also be distributed to the members of the Health Care Consumer Committee to determine if the beneficiaries felt that they had more impact or at least a forum to discuss their concerns than existed prior to the restructuring. The final and most telling evaluation of the success in restructuring will occur in October 2003, when the Joint Commission returns for their next survey. This restructuring should form the framework for a better understanding and implementation of all of the Joint Commission standards.

Conclusion and Recommendations

Conclusion

Based on a review of the current structure and first hand knowledge of the problems that occur because of the system, this author believes that the existing structure can be dissolved and a more effective system established. Reynolds Army Community Hospital needs to totally re-engineer its committee and reporting structure to more properly align itself with the recommendations and functions of the Joint Commission.

The analysis of the structure and the requirements imposed by the Joint Commission and the U.S. Army Medical Department clearly show that this organization is not operating at the peak of efficiency. This is not only true of Reynolds but also of a number of other military treatment facilities within the U.S. Army. LTG Peake, the new Surgeon General of the U.S. Army, has recently raised this exact topic. The U.S. Army Medical Commands Quality Management staff has recently held several video-conference meetings concerning restructuring and developing new ideas to keep the military prepared for the Joint Commission surveys of the future.

Recommendations

Recommend that Reynolds institute the changes set forth in this paper. This restructuring will allow Reynolds to attain the highest efficiency in communications and will move the facility towards changing from the current mentality to an organization that is constantly striving to increase quality.

This is just the first small step. Everyone in the institution needs to buy into this philosophy of continuous accreditation. This will set the tone for the organization to review the status quo. It will allow Reynolds to become more familiar with the Joint Commission's functional areas and will allow the organization to take a closer look at the proper reporting of Performance Improvement measurements.

This study will serve at minimum, as the baseline and reflects the most current literature and thoughts about proper structure and reporting that are used in the healthcare community. It will also present the organization with some ideas as to the most effective ways to overcome resistance to these changes and make the organization keep continuous accreditation at the forefront for the future.

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Appendix

*MR 15-1

DRAFT

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY DEPARTMENT ACTIVITY
Fort Sill, Oklahoma 73503-6300

MEDDAC Regulation
No. 15-1

21 March 2001

Committee Management
BOARDS, COMMISSIONS, AND COMMITTEES

*This regulation supersedes MEDDAC Regulation 15-1, dated 3 October 2001.

MR 15-1, 21 Mar 01

Committee Management
BOARDS, COMMISSIONS, AND COMMITTEES

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CHAPTER 1

GENERAL

1-1. Purpose. This regulation:

- a. Establishes the administrative and professional meetings and committees required by command directives for the efficient operation of U.S. Army Medical Department Activity (MEDDAC), Fort Sill.
- b. Provides guidance to ensure that each meeting and committee constitutes an action-oriented body contributing and reporting to the Executive Committee and/or other body as appropriate.
- c. Prescribes the composition, purpose, objectives, functions, and administrative requirements for each meeting and committee.

1-2. Reference. AR 15-1 provides general regulatory guidance applicable to all committees. Specific reference, which apply to each committee, are included in the terms of reference for that committee.

1-3. Objectives: The broad objectives of this regulation are to:

- a. Assure sound management and administrative practices in the conduct of committee activities.
- b. Eliminate duplication of effort and overlap between committees.
- c. Maintain complete and current records of committee activities.
- d. Ensure that all action is confined to the parameters of authority under which the committee is organized.
- e. Ensure that committee action does not replace normal staffing action, except in cases where the committee arrangement is clearly superior to normal actions.

1-4. Scope. This regulation is applicable to all activities within U.S. Army Medical Department Activity (USAMEDDAC), Fort Sill.

1-5. Explanation of Terms. The following terms are defined for the purpose of this publication.

- a. Committee. A body of persons with collective responsibility, appointed to consider, investigate, advise,

or take action, and usually to report. The term "committee" applies to a council, board, commission, panel, subcommittee, task force, or other group with collective responsibility formally established by written terms of reference.

b. Terms of Reference. The written authority which directs or authorizes the establishment of a committee. Terms of reference may be in the form of a regulation, directive, statute, or other recognized written authority.

c. Excused/Unexcused Absences.

(1) Excused absence is when committee member is absent due to leave, 'IDY, or medical emergency.

(2) Unexcused absence is when a committee is otherwise not present for a meeting.

1-6. Special Categories and Exclusions. Boards of officers concerned with specific investigations, e.g., report of survey and line of duty investigation boards, being governed by applicable Army Regulations and other Department of the Army regulatory publications, are excluded from this regulation, except that, in all cases, committees will operate in consonance with the objectives outlined in paragraph 1-3.

1-7. Policy. The following general policies pertain to the establishment, use, operation, and termination of all committees within MEDDAC.

a. This regulation establishes and provides terms of reference for all permanent MEDDAC committees. Temporary committees serving a single short-term purpose may be established.

b. The use of a committee to perform a given specialized function will be authorized only when it can clearly be shown that its use will afford a more effective, expeditious, or economical means of accomplishing the objective. The committee device is considered most effective for fact finding, research, special studies, review, audit, and survey activities. When properly organized for such purposes, a committee may provide a source of objectivity and reinforcement to the decision making process.

c. Occasional meetings among or between members of MEDDAC activities for the purpose of exchange of information, advice, and ideas, or for providing coordination among the various activities will not be construed as requiring the establishment of a committee. Working relationships of such nature are encouraged instead of the creating of a committee which would require written terms of reference in order to reflect its purpose, functions, and objectives.

d. When it can be determined that a committee has completed the task for which it was created or that a valid operational requirement no longer exists, the committee will be terminated.

e. The Commander may designate alternate members for any committee within this regulation as required.

1-8. Responsibilities: The following responsibilities are assigned within MEDDAC:

a. Commander: The Commander constitutes the final approving authority for the establishment and termination of all committees, acting upon the recommendations of his or her immediate advisory staff.

b. Chiefs of divisions, departments, and separate services will be responsible for monitoring the activities of committees for which their activity is the proponent in order to ensure that:

(1) No unnecessary committees are established.

(2) All active committees under their jurisdiction are supported by written terms of reference, are fully justified, and that all appropriate approvals have been obtained.

(3) Required committee records and reports are maintained within the activity.

(4) Committees are promptly terminated upon completion of the task if there is no longer an existing, valid operational requirement.

1-9. Channels of Communication. Proposals concerning establishment, membership utilization, or termination of a committee will be forwarded through channels to the Commander for consideration and approval. Proposals will be fully documented. Chiefs of appropriate activities will originate proposals concerning establishment or termination.

CHAPTER 2 COMMITTEE ORGANIZATION AND ADMINISTRATION

2-1. Composition.

a. Committee Chairperson. Each established committee will have an appointed chairperson. Duties of the chairperson include, but are not limited to:

- (1) Announcing both formal and informal meetings to include notification of all members.
- (2) Establishing time and place for all meetings.
- (3) Assembling items to be placed on the agenda for presentation at the meetings.
- (4) Presiding over the meetings.
- (5) Reviewing minutes of meetings as prepared by the recorder or secretary.
- (6) Ensuring correct disposition of minutes, reports, and other committee records.

b. Recorder. Each committee will have a designated recorder whose duties will include:

(1) Serve as the action officer for the committee. Such duties will include: the preparation of the agenda as directed by the chairperson; preparation and disposition of minutes, reports, and other records; maintenance of committee files; announcement of the meetings to those involved; and the preparation of follow-up reports to the committee on action taken by the committee. The recorder may be assisted in this by clerical personnel as necessary.

(2) Serve as the chairperson's assistant to maintain ongoing surveillance of the responsibilities assigned to the committee. Such responsibilities will include advising the chairperson routinely of developments in the committee's area of responsibility which occur between meetings.

c. Committee Members. Committee members may perform the following duties:

- (1) Research and present topics for discussion.
- (2) Conduct special projects or studies for presentation as directed by the chairperson.

2-2. Subcommittee. Subcommittees comprised of regular committee members may be appointed by the chairperson to pursue or investigate special projects not requiring the attention of the entire committee. Subcommittees will be governed by the principles of purpose, function, and objective described elsewhere in this regulation and will report directly to their parent committee.

2-3. Minutes, Reports, and Other Committee Records.

a. The recorder of each committee will be responsible to the chairperson of the committee for the maintenance of accurate written records of the committee activities. The chairperson will ensure that the minutes of the previous meeting are reviewed by the committee to substantiate their accuracy as published. Minutes will be prepared in the format prescribed in appendix E and F of this regulation. Official letterhead stationery will be used only for those minutes which are forwarded outside this command (i.e., to MEDCOM or DA). Those minutes that remain at MEDDAC will be typed on plain bond paper with the appropriate heading.

b. All committee minutes and records will be authenticated with the signatures of the recorder and chairperson and will be forwarded to the Executive Committee and the Performance Improvement Coordinator for review and approval within ten working days from the date that the committee met. A file copy of the minutes will be retained in the office of record. Files of minutes and committee records will be maintained in accordance with the Modern Army Record Keeping System (MARKS) as outlined in AR 25-400-2.

c. Reports originated by committee action will be those required by the committee terms of reference. Reports prepared for dispatch to activities outside this command will be forwarded to Administrative Officer, Headquarters, for concurrence and signature.

d. Confidentiality of Medical Information is governed by AR 40-66 and AR 40-68, chapter 2, paragraph 2-2b. Committee minutes will not contain patient or provider identification with the exception of Medical Staff Performance Improvement Committee (which will give the name of the practitioners considered before the committee and the determination of their respected clinical privileges). The Risk Management Committee minutes will follow the guidelines outlined in AR 40-68, chapter 3, paragraph 3-5d.

2-4. Voting. It is desirable that all action taken or recommended by a committee be concurred by all committee members; however, the voting process is considered essential to committee action. Unless otherwise specified by committee terms of reference, only appointed committee members may be allowed to vote on issues. The recorder is a voting member unless otherwise stated. In all committees comprised of less than 10 members, a quorum will guide the voting process (the minimum number of officers and members, usually a simple majority, who must be present for the valid transaction of business).

2-5. Schedule. The time and place of committee meetings will be announced via electronic mail and the public address system. The chairperson of each committee is responsible for informing members of any changes to the schedule.

CHAPTER 3 EXECUTIVE COMMITTEE

3-1. Purpose. The purpose of the Executive Committee is to assist the Commander in the maintenance of high quality patient care and effective utilization of available resources.

3-2. Composition. Voting Members:

- a. Commander -(Chairperson).
- b. Deputy Commander for Nursing.
- c. Deputy Commander for Clinical Services.
- d. Deputy Commander for Administration.
- e. Command Sergeant Major.

3-3. References:

- a. AR 40-2
- b. AR 40-68
- c. AR 40-400
- d. Accreditation Manual for Hospitals, JCAHO.

3-4. Function: The functions of the Executive Committee are to:

- a. Review and approve hospital goals, policies, procedures, and programs related to all patient care, treatment and safety.
- b. Develop and maintain a mechanism that provides for the systematic review of the quantity and quality of care provided by the hospital.
- c. Ensure that effective communication is maintained between the Commander, clinical staff, and administrative staff on matters related to patient care and treatment.
- d. Ensure that the medical staff is provided with the administrative assistance to facilitate the regular comprehensive peer review of clinical practice and to facilitate utilization review activities within the hospital.
- e. Determine the hospitals accreditation status and take actions to ensure accreditation standards are maintained.

f. Request, receive, and evaluate reports from other standing committees and from other staff members with respect to the hospital's accreditation status in specific areas.

g. Supervise the conduct of the interim JCAHO self-survey and preparations for the actual accreditation survey.

3-5. Meetings: The Executive Committee will meet monthly and whenever else deemed necessary. The Commander's Secretary (recorder) maintains the calendar for the Executive Committee.

3-6. Administration: Executive Committee Logs with enclosures will be maintained by the Commander's Secretary in Headquarters. The log will be reviewed by the Executive Committee on a quarterly basis.

CHAPTER 4

MEDICAL STAFF PERFORMANCE IMPROVEMENT COMMITTEE

4-1 Purpose. The purpose of the Medical Staff Performance Improvement Committee is to promote an environment that is conducive to continuing quality improvement of patient care throughout the entire spectrum of services provided. To assure high quality medical care within available resources through continuous monitoring and evaluation of the quality and appropriateness of patient care. This will be done through continued assessment of patient care, utilization review and analysis, and supervision

4-2. Composition:

a. Permanent Members:

- (1) Deputy Commander for Clinical Services - (Chairman).
- (2) Deputy Commander for Nursing
- (3) Deputy Commander for Administration
- (4) Chief, Department of Primary Care and Community Medicine
- (5) Chief, Department of Speciality Care
- (6) Chief, Department of Behavioral Health.
- (7) Chief, Department of Pathology.
- (8) Chief, Department of Radiology.
- (9) Chief, Pediatric Service.
- (10) Chief, Internal Medicine Service
- (11) Chief, Department of Preventive Medicine
- (12) Chief, Directorate of Managed Care and Business Analysis
- (13) Chief, Patient Administration Division
- (14) Chief, Clinical Support Division
- (15) Chief, Department of Pharmacy
- (16) Chief, Utilization Management

(17) Chief, Plans, Mobilization, Education, Training, and Security

(18) Chief, Logistics Division

(19) Infection Control Nurse

(20) Safety Officer

(21) Performance Improvement Coordinator

(22) Chief, Emergency Medicine Service.

(23) Head Nurse, Emergency Room.

(24) Head Nurse, Intensive Care Unit.

(25) Chief, Obstetrics and Gynecology Service.

(26) Chief, Resource Management Division.

(27) Credentials Coordinator

(28) Librarian

(29) Performance Improvement Secretary (recorder/non-voting)

3. References:

a. AR 40-2

b. AR 40-3

c. AR 40-5

d. AR 40-14

e. AR 40-48

f. AR 40-66

g. AR 40-68

h. AR 385-11

i. DoD Directive 6025.13

- j. Title 10 CFR, Parts 19, 20, 21, 30, 31, and 35, Nuclear Regulatory Commission
 - k. MEDCOM Regulation 40-1
 - l. MEDDAC Regulation 40-68
 - m. JCAHO Accreditation Manual for Hospitals.
 - n. American College of Surgeons, Commission on Cancer, Cancer Program Standards
 - o. Oklahoma State Law
 - p. TB Med 521
 - q. TB Med 525
4. Objectives: The following directives are broken down into subject areas.
- a. Performance Improvement: to assure that the Administrative, Medical, Nursing and Support Staff in an interdisciplinary manner:
 - (1) Participate in staff education, training and implementation of CQI.
 - (2) Identify those Important Functions and Dimensions of Performance that are most important to the health and safety of the patients served. A tool to assist in identification and reporting is provided in Appendix C.
 - (3) Develop interdisciplinary clinical indicators and complete intra/interdepartmental measurement and assessment related to the important functions or services provided.
 - (4) Complete intensive evaluation for any clinical indicators (important single events or trends in care) that are at significant variance with predetermined process variation.
 - (5) Take appropriate action for any identified opportunity to improve care and monitor the effectiveness of that action. The model for undertaking performance improvement opportunities is FOCUS-PDCA.
 - (6) Document and report the plan, do, check, and action related to that opportunity.
 - (7) Demonstrate improvements in all patient care services.
 - (8) Reduce risk-creating incidents, adverse effects to patients and medical malpractice claims through a proactive approach to risk prevention.
 - (9) Improve customer-supplier communication and customer satisfaction.

(10) Participate in and improve healthcare provider screening, selection and accession processes.

(11) Objectively evaluate process performance through criteria based assessment and review of other QI/RM information as required.

(12) Consolidate quality improvement team activities into a comprehensive program that integrates both communication and issue resolution within and across departmental lines.

(13) Utilize resources efficiently to promote the highest quality in health care services and address any over-utilization, under-utilization or inefficient use of resources.

b. Medical Records Review

(1) To provide medical record review for clinical pertinence by ensuring each record reflects the timeliness, clarity, completeness, and accuracy of medical entries addressing the diagnoses, results of diagnostic tests, therapy rendered, and condition of the patient at the end of hospitalization, 23-hour Observation, or Ambulatory Procedure Visit.

(2) To initiate concurrent and/or process reviews when medical record reviews and analyses reveal deficiency trends. To recommend corrective actions specific to problems identified and evaluate the effectiveness of actions taken.

(3) To analyze and discuss inpatients, 23-hour Observation Patients, and Ambulatory Procedure Visits delinquency rates at hospital, ward, and clinic levels. Provide positive enforcement action as appropriate to correct problem areas.

c. Credentials

(1) To delineate in writing the clinical privileges of all health care providers identified in AR 40-66 and AR 40-48.

(2) To reinforce the internal controls in credentialing of health care providers and maintain acceptable standards of care in this MEDDAC.

(3) To review each health care provider's credentials file for current evaluation and performance assessment, verification of previous clinical privileges, training, experience, demonstrated competency, required technical skills, current licensure, CME, proper ethical and professional conduct and health status, all of which affect the individual's ability to provide quality patient care.

(4) To evaluate requests for additional privileges.

(5) To evaluate the credentials of new health care providers.

(6) To reevaluate health care providers who are in probationary or restrictive categories of professional activity.

(7) To consider or make recommendations concern limitations, suspension, or revocation of provider's clinical privileges.

(8) To evaluate the quality of care provided by any health care provider at the request of the Commander.

d. Risk Management

(1) To identify patterns of negligent behavior.

(2) To determine the seriousness of risk and make recommendations to minimize either the risk or the governments liability.

(3) To detect improper record keeping.

(4) To ensure that all pertinent information is properly documented and safe guarded.

(5) To investigate all identified problems.

e. Critical Care

(1) Define and enforce the policies and procedures specified for the intensive care and recovery areas.

(2) To continually review unit operations, facilities, policies, and procedures to ensure that quality care is provided to all patients.

f. Pharmacy and Therapeutic

(1) To advise the Commander and professional staff in all matters pertaining to the use of therapeutic and diagnostic agents.

(2) Advise the Commander, Chief of Pharmacy Service, and professional staff in the selection or choice of therapeutic agents which are the most efficacious and cost effective.

(3) Evaluate objectively clinical data regarding new pharmaceuticals proposed for use in the hospital.

(4) Develop a formulary for use in the hospital and to provide for its continual review or revision.

(5) Propose educational programs for the professional staff on matters related to pharmaceuticals to include their usage.

(6) Recommend to the Office of the Surgeon General nonstandard pharmaceuticals considered worthy and desirable for standard classifications.

(7) Review of appropriate supply bulletins and disseminate pertinent information to members of the professional staff.

(8) Supervise the conduct of Antibiotic and Drug Utilization Review studies and act on study recommendations.

(9) Review all reported adverse drug reactions and forward appropriate reports as required.

(10) Review all medication errors submitted to the committee by pharmacy, nursing or other healthcare providers.

g. Tissue and Transfusion

(1) To provide for preoperative and postoperative diagnostic agreement, and to determine acceptability of procedures by comparing results with pathological reports.

(2) To serve as the medical staff Blood Utilization Review Committee.

(3) To review all autopsies on in-hospital deaths and to provide clinical-pathologic correlation.

h. Tumor Board/Cancer Conference. To enter all diagnosed cases of malignant neoplasm into the tumor registry, and to evaluate the recommended treatment and disposition of such cases, to include patient management, prevention, screening, diagnosis, treatment, follow-up, rehabilitation, and continuing care.

i. Ethics

(1) To provide support, counsel, and information in determining the appropriate use of medical technology.

(2) To help resolve doubt concerning the propriety of a Do Not Resuscitate (DNR) order when there is a lack of concurrence by the treating physicians or of the family among themselves or with the treating physicians.

(3) To provide consultation for a staff member who has a cultural, ethical or religious conflict in delivering specific patient care.

(4) Educate hospital personnel, patients and family members about resources available to assist them in making decisions concerning the treatment of critically ill patients.

(5) Develop hospital guidelines and policies pertaining to decision making in the care of patients. Review existing policies and treatment procedures to determine appropriateness and compliance.

j. Radiation Control

(1) Recommend approval or disapproval of each type of radiation source from the standpoint of radiological health and safety of patients, working personnel, and the public.

(2) Recommend individual users for each type of procedure with each specific radionuclide and ensure that any physician authorized to use radioactive material on humans meets the criteria specified in Title 10, part 35, Code of Federal Regulations. Recommendations will be consistent with the limits and conditions of the NRC license and DARA.

(3) Prescribe, if required, special conditions permitted in the work area and special procedures for use of radiation sources.

(4) Formulate and review the radiation protection training program.

(5) Monitor radiation exposures within the command and recommend actions to keep exposures as low as reasonably achievable (ALARA). As a minimum, the collective dose to all radiation workers, average dose and highest individual dose will be reviewed at quarterly meetings.

(6) Formally review, at least annually, the policies and procedures established to maintain low exposure.

(7) Review records and reports from the Radiation Protection Office to include any overexposure investigation or incident involving radioactive material or ionizing radiation. Recommend appropriate corrective actions.

5. . Meetings: The Medical Staff Performance Improvement Committee will meet formally once a month, however, additional sessions can be called as needed. The committee will attend to all business that is required for the general members before releasing the administrative and non-credentialed providers. At that time the committee will perform the credentials subcommittee. This subcommittee will vote by secret ballot to recommend either approval, renewal, modification, limitation, suspension, or revocation on each request or case. All members must vote yes or no. No abstention votes will be permitted. The recommendations will be submitted in the minutes to the Commander.

6. Administration: Formal minutes of the meetings will be recorded and authenticated by both the chairperson and the recorder. IAW AR 40-68, the minutes will specify the number of yes and no votes on each request or case considered. The minutes will be dated and will identify each committee member by rank, full name, and title. Also each health care provider will be identified by rank, full name, area in which privileges are being requested, and recommendation with specified vote. All patient's cases will be identified by Family Prefix (FMP) and last four

digits of SSN. The minutes will be prepared in original only and submitted directly to the Commander for review and approval; after which, the original minutes will be maintained on file in the Performance Improvement Office.

CHAPTER 5 ENVIRONMENT OF CARE COMMITTEE

1. Purpose. To establish a interdisciplinary forum to formulate procedures, policies, and guidelines for staff to follow to ensure a safe and healthful environment for patients, visitors, and staff members within MEDDAC and DENTAC.

2. Members of the committee represent administration, clinical services, and support services.
Composition:

- a. Deputy Commander for Administration (Chairperson)
- b. Chief, Logistics Division
- c. Chief, Nutrition Care Division
- d. Chief, Nursing Administration
- e. Infection Control Representative
- f. Chief, Personnel Division
- g. Chief, Plans, Training, Mobilization, and Security
- h. Chief, Equipment Management Branch, Logistics
- i. Chief, Facility management Branch, Logistics
- j. Chief, Department of Pathology
- k. Chief, Department of Radiology
- l. Chief, Department of Primary Care and Community Medicine
- m. Chief, Department of Specialty Care
- n. Chief, Resource Management Division
- o. Chief, Information Management Division
- p. Chief, Pharmacy Services
- q. Chief, Clinical Support Division

- r. Cdr, HQ and Medical Company
- s. Cdr, DENTAC
- t. Environmental Science Officer
- u. Occupational Health Nurse
- u. Risk management Coordinator
- v. Industrial Hygienist
- w. Safety Manager (Recorder)
- x. Non-voting Members:
- y. Housekeeping contract Supervisor
- z. Others as required

3. Objectives. Functions of the EOC Committee include:

- a. Develop and recommend safety, infection control, and EOC policies, procedures, and improvement initiatives to the Command Group. Communicate data and analysis to the Command Group.
- b. Maintain liaison with other RACH committees to ensure exchange of information of mutual concern.
- c. Determine and implement actions aimed at the continuous improvement of personal safety awareness of staff, on and off duty.
- d. Implement, promote, and monitor a systematic, continuous, and proactive hazard surveillance program.
- e. Implement, promote, and monitor an effective hazard abatement program.
- f. Provide safety-related information to be used in the orientation of new personnel and in the continuing education of staff.
- g. Review and approval of safety-related suggestions.
- h. Use of safety awards to recognize outstanding safety performance.
- i. Review and analysis of pertinent reports, and evaluation of the objectives, scope, implementation, and effectiveness of the following EOC programs:

- (1) Safety Management
- (2) Security Management
- (3) Hazardous Materials and Waste Management
- (4) Emergency Preparedness Management
- (5) Life Safety management
- (6) Medical Equipment Management
- (7) Utility Systems Management
- (8) Smoking Policies

4. Meetings. The Environment of Care (EOC) Committee meets at the discretion of the Chairperson, however, not less frequently than bimonthly (every other month).

5. Administration. Minutes of the meeting will be submitted by the Recorder to the Deputy Commander for Administration for signature and to the Commander for approval. Approved minutes will be maintained in a permanent file in the Performance Improvement (PI) office. Information copies will be furnished to all committee members. The format will be prescribed by PI.

6. Authority to Act in an Emergency (Empowerment). The multidisciplinary Environment of Care Committee has the authority through the Commander and the chairperson or Safety Manager to take immediate action when hazardous conditions exist that could result in personal injury to individuals or damage to equipment or property.

7. References.

- a. AR 385-10 The Army Safety Program
- b. MEDDAC Regulation 385-1 Safety Program
- c. JCAHO Accreditation Manual for Hospitals
- d. AR 40-5 Infection Control

CHAPTER 6
PATIENT CARE SUPPORT COMMITTEE

6-1. Purpose. To provide oversight and direction for data/information management, human resources, and other support functions.

6-2. Composition.

- a. Deputy Commander for Nursing – (Chairman)
- b. Deputy Commander for Administration
- c. Deputy Commander for Clinical Services
- d. Chief, Information Management Division
- e. Chief, Managed Care and Business Analysis Directorate
- f. Chief, Personnel Division
- g. Chief, Patient Administration Division
- h. Chief, Logistics Division
- i. Chief, Department of Pharmacy (or representative)
- j. Chief, Department of Primary Care and Community Medicine (or representative)
- k. Chief, Department of Specialty Care (or representative)
- l. Chief, Clinical Support Division
- m. Chief, Budget Division
- n. Chief, Managed Care Division
- o. Chief, Plans, Mobilization, Education, Training, and Security
- p. Chief, Systems Branch
- q. Chief, Equipment Management Branch

6-3. References:

- a. AR 25-1

- b. AR 25-30
- c. AR 37-2
- d. AR 37-21
- e. AR 37-100
- f. MEDCOM Regulation 15-5

6-4. Objectives:

- a. To identify user needs to the Information Management Officer in the following areas:
 - (1) Telecommunications.
 - (2) Visual Information.
 - (3) Records Management.
 - (4) Printing Publications.
 - (5) Automation.
- b. To provide input in establishing information management policies and plans.
- c. Assist in developing the annual MEDDAC Information Management Plan.
- d. To provide guidance to the command on the Human resource functions as outlined by the Joint Commission.
- e. To provide assistance in other Patient Care Support areas as directed.

6-5. Meetings: The Patient Care Support Committee will meet monthly.

6-6. Administration. Minutes of the meeting will be submitted by the Recorder to the Deputy Commander for Administration for signature and to the Commander for approval. Approved minutes will be maintained in a permanent file in the Performance Improvement (PI) office. Information copies will be furnished to all committee members. The format will be prescribed by PI.

MR REG 15-1
CHAPTER 7
HEALTH CARE CONSUMER COMMITTEE

1. Purpose:

- a. The Health Consumer Committee provides a communication for transmittal of information, suggestions and expressed concerns of the Army community regarding health services.
- b. Improve health consumer education and information services.
- c. Provide a means of conveying concern regarding health entitlements, benefits and changes thereto.
- d. Provide plans and recommendations for implementation of new or projected services to meet the needs of the health consumer.

2. Composition:

- a. MEDDAC Commander - (Chairperson).
- b. DENTAC Commander - (Co-Chairperson).
- c. Deputy Commander for Administration.
- d. Deputy Commander for Clinical Services.
- e. Deputy Commander for Nursing
- f. Command Sergeant Major
- g. Chief, Department of Preventive Medicine
- h. Chief, Department of Primary Care and Community Medicine.
- i. Chief, Clinical Support Division.
- j. Chief, Directorate of Managed Care and Business Analysis.
- k. Patient Representative Officer.
- l. Administrative Officer
- m. TRICARE Service Center Representative
- n. TRICARE Senior Prime Representative

- o. Representative, USAFATC.
- p. Representative, USAFAS.
- q. Representative, Personnel & Support Battalion.
- r. III Corps Artillery Surgeon
- s. Representative, III Corps Artillery.
- t. 17th FA Bde Representative
- u. 75th FA Bde Representative
- v. 212th FA Bde Representative
- w. 214th FA Bde Representative
- x. Army Community Service Representative.
- y. Others as required.
- z. MEDDAC Commander's Secretary (recorder without vote)

NOTE: Other dependents and retirees may be invited to present comments to the committee, but cannot serve as representatives and/or committee members.

3. References:

- a. AR 40-2.
- b. HSC Supplement 1 to AR 40-2.

4. Objectives:

a. To develop a program of obtaining information regarding the adequacy of care which includes ethics, aesthetics, timeliness, overall satisfaction and appropriate avenue of redress.

b. To provide the Health Care Consumer with a better understanding of the Army Health Care Delivery System, an opportunity to provide comments, and a method to have their views considered in the decision making process.

5. Meetings: The meeting will be conducted quarterly.

6. Administration: Minutes of all meetings will be recorded, authenticated, and submitted to the Commander for review and approval. A file copy will be maintained in headquarters.

MCUA-HQ

The proponent of this regulation is Headquarters. Users are invited to submit comments and/or suggestions to Reynolds Army Community Hospital, CDR USAMEDDAC, ATTN: MCUA-HQ, Fort Sill OK 73503-6300.

FOR THE COMMANDER:

OFFICIAL:

STEPHEN WILKINSON
LTC, MS
Deputy Commander for
Administration

CYNTHIA A. JONES
Administrative Officer

DISTRIBUTION:

A
MEDDAC Intranet

APPENDIX

MINUTES FORMAT FOR COMMITTEES

(Signature Page Format)

(Office Symbol)(15-1a)

(Date of Meeting)

MEMORANDUM FOR RACH Performance Improvement Committee

SUBJECT: Minutes of the (month) (Name of department/service) Committee Meeting

1. The (name of the department/service) Committee was convened at (time), on (date) in the (location) by the Chairperson.
2. Attendance. See enclosure 1.
3. Minutes Review. Minutes of the (date) meeting were reviewed, and approved as written (or with corrections noted) by committee census.
4. Old Business. See enclosure 2.
5. Monitoring and Evaluation Indicators. (See enclosure 3 (Annual Indicator Use Planning Guide & Summary of Performance Improvement Indicator forms.)
6. New Business. See enclosure 4.
7. The meeting was adjourned at (time). The next meeting is scheduled for (time), (date) in the (location).

(SIGNATURE BLOCK OF RECORDER)
(Title)
Recorder

(SIGNATURE BLOCK , CHAIRPERSON)
(Rank, Corps)
(Title)/ Chairperson

Encls
1. Attendance Roster
2. Old Business
3. Monitoring and Evaluation Indicators
4. New Business
5. (Any additional enclosures)

WILLIAM B. DAVIS
LTC, MC
DCCS

DISTRIBUTION:
1 cy - QM Coordinator (original)
1 cy - Each committee member
1 cy - Committee(s) to which recommendation(s) made

