The unpredictable nature of JCAHO’s tracer process is a challenge for even the most experienced survey coordinator. Prepare your entire staff to face the unknown with the new edition of this bestselling book. Completely updated and expanded, *Tracer Methodology*, Second Edition, takes the mystery out of the method and prepares your entire facility for the arrival of JCAHO surveyors—wherever and whenever they decide to launch a tracer.

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CHAPTER ONE

Tracer methodology: An evolution
Newcomers to healthcare often ask, “What were the JCAHO surveys like before the tracer methodology?” Since the implementation of the JCAHO’s Shared Visions–New Pathways™ in 2002, the survey process has changed in a multitude of ways. These changes were introduced in several phases, and they will continue to develop and change during the next several years.

The JCAHO states that healthcare organizations asked for these changes. It is also known that the old survey process was criticized by regulatory agencies. Additionally, many of these changes were prompted by media attention and public concern over patient safety. In response, the JCAHO developed its new accreditation process and carefully pilot tested the effectiveness of its methods in several healthcare organizations prior to implementation. This sounds good, but take a closer before-and-after look at this evolution in Figure 1.1.

The world of surveys in the era of Shared Visions–New Pathways sounds wonderful, and most of the healthcare organizations involved in this process will agree that it has been a positive change. But is there anything that continues to plague this new methodology? Contemplate the issues that continue to challenge healthcare professionals in Figure 1.2.
Before Shared Visions–New Pathways,

- surveys were announced every three years
- survey results were hardcopy and required filing/maintenance at the organization
- surveys were scored and competitive
- preparation for survey activities occurred as a “ramp-up,” “let’s-get-ready” approach
- surveys lacked follow-up for compliance (i.e., periodic performance review [PPR])
- surveys lacked self-assessment activities
- surveys focused on leadership interviews
- surveyors were inconsistent in interpretation of standards
- assessments of care processes consisted of closed record review and review of multiple notebooks filled with policies and procedures
- surveyors toured units for environmental issues but rarely engaged staff
- all units and departments were surveyed
- “dog-and-pony show” presentations were expected
- surveyors rarely interviewed patients
- inability to follow up on issues identified during the survey (i.e., the surveyor simply moved on to the next department)
- survey applications were hardcopy
- survey focus was often driven by surveyor background and experience (his or her comfort zone)
- surveys lacked individual organization focus (i.e., cookie-cutter surveys)
- postsurvey response consisted of an action plan to be implemented at a later date

After Shared Visions–New Pathways,

- surveys are unannounced.
- the application process has been made easier with the introduction of the online Jayco™ secure extranet application.
- surveys are scored, but the scores are not shared with the organization. The acceptable range of requirements for improvements (RFI) is a floating average that changes with each surveyed organization.
- preparation for surveys, at this point, should be ongoing and continuous.
Before and After (cont.)

- Survey activities require an annual review or self-assessment activity called a periodic performance review (PPR), to assess for standard compliance.
- Surveys are less focused on leadership and discourage an entourage or “cast of thousands” during survey activities.
- Surveys are more focused on staff and their application of standard compliance and provision of safe care processes.
- Surveyors review active patient records but will sometimes request closed records to look for trends.
- Although this is not an official guideline, not all units may end up being visited by surveyors. They are still required to visit all units with moderate sedation or anesthesia, but the rest of the visits are driven by the tracer activities.
- Surveyors often interview patients about the care they receive.
- Surveyors may elect to follow up on identified issues or revisit departments during special issue resolution times as indicated on the agenda.
- Surveyors may select one or more tracer patients during the tracer activity sessions indicated on the agenda, so they can spend as much or as little time as needed to assess an area/process thoroughly.
- Previous survey results and application information are maintained and available on the Jayco Web site.
- Surveyors are required to pass standard competency testing to raise the level of consistency in standard compliance assessment.
- Priority focus processes (PFP) are implemented to address individual needs of each organization.
- Post-survey response includes a detailed description of what actions have been taken to achieve standards compliance; designated elements of performance require measurement data to be submitted subsequently as evidence of compliance.
CHALLENGES

- Surveyor inconsistency in standard interpretation is still troublesome.
- Some surveyors grasp the new methodology, but some still struggle and are frustrated with the new process.
- Survey lacks “systems” approach to larger organizations.
- Departments not surveyed often feel left out of the process.
- Most organizations miss scoring, especially if used as a target for improvement or goals for the organization.
- Results of the survey are not negotiable with the surveyors. You have to wait for your survey results to be submitted by the surveyors and then complete a clarification request.
- Because the survey is not scored, it’s difficult to determine whether you’ve passed or failed the survey until days later, when you receive the final word back from the JCAHO (only the JCAHO knows that magic floating acceptable average of RFIs)
- Periodic performance review information is not evaluated thoroughly during the survey. One of our organization’s surveyors asked me one question: “Did you do it?” They never asked to look at it. I am sure some surveyors spend more time on the PPR, but ours did not.
- PFP areas selected by the JCAHO’s database often do not appear to be related to the organization
- Unannounced surveys seem to occur at the most inopportune times (e.g., when the CEO or CNO is on vacation).
- Ensuring proper identification of surveyors is a safety risk; with prior notification, at least organizations knew who to expect and when. Presurvey notification information is posted to your Jayco extranet site at 7:00 a.m. on the day of the survey and provides the surveyors’ names, biographical information, and pictures.
- Maintaining continuous survey readiness must be balanced with major projects, such as new construction, installation of electronic medical records, and initiation of new services.
Despite these remaining issues, overall the improvements have been well received. However, it is important to fully understand the importance of several of these issues (even though the JCAHO still needs to work on them) and fully understand how they relate to tracer activities. One of the processes to which I refer is the priority focus process (PFP).

**Priority focus process**

*Assessing your organization’s presurvey data*

Determining your priority focus areas (PFA) is an integral part of tracer methodology. The JCAHO defines PFAs as “processes, systems, or structures in a healthcare organization that significantly impact quality and safety of care. They guide the assessment of standards compliance in relation to the patient/resident/client tracer activities.” The JCAHO identifies PFAs specifically for your organization and then uses them to select patient tracers. Predicting your PFAs is therefore the first step in determining which patients to select for your mock patient tracers, discussed more in Chapter 4.

The JCAHO will not officially release your organization’s PFAs until the day of your survey, on or before 7:00 a.m. EST, but it is possible for you to predict what they will be. (PFP data is not available at this time for office-based surgery and critical access hospitals.) The key to such a prediction is understanding the JCAHO’s process for determining PFAs and then undergoing a mock PFA-selection process.

The JCAHO selects four PFAs from the following 14:

- Assessment and care
- Communication
- Credentialed practitioners
- Equipment use
- Infection control
- Information management
- Medication management
- Organizational structure
- Orientation and training
- Patient safety
- Physical environment
- Quality improvement
- Rights and ethics
- Staffing
The JCAHO also considers your organization's specific patient populations and services that you provide. The commission calls these clinical service groups (CSG). CSGs are program-specific and defined as categories of patients or services for which data are collected. These are derived from your accreditation application and other data used to select PFAs. This aids in consistency with the surveyors' selection for tracer activities.

To determine your organization's PFAs, the JCAHO uses an algorithm that looks at:

- nationally available outcomes data (e.g., Centers for Medicare & Medicaid Services [CMS], Leapfrog, etc.)
- ORYX
- past survey performance (e.g., prior RFIs or weak areas for your organization)
- patient-satisfaction data

Don't wait for the JCAHO to look at these areas for you. In my organization, we were able to predict accurately three out of four PFAs using the methods outlined in this book. Our PFAs were patient safety, communication, credentialed practitioners, and staffing. Patient safety was chosen by the JCAHO due to the nature of a previous RFI, and because the National Patient Safety Goals are a primary focus of the JCAHO. Credentialed practitioners was also identified as one of our PFAs due to a previous survey finding in the medical staff standards. The focus on staffing issues was derived from external data sources outcomes monitoring and from the fact that staffing is a JCAHO hot topic, with its focus on the HR staffing effectiveness standards and patient throughput issues (i.e., overcrowding).

The only PFA we did not identify and plan for prior to survey was communication. Although we did not predict it, our hospital was easily able to demonstrate effective communication processes, so this PFA was not a problem.

Let's look at some of these PFA criteria more closely.

**Outcomes Data**

To determine your organization's priority focus areas, the JCAHO uses several types of outcomes data. With each of these data sources, look for spikes or outliers in data information. Also pay close attention to trends in data over time (e.g., increased lengths of stay for particular diagnoses or patient populations, readmission rates, and less than desirable outcomes of patient care). Using a rules-based system,
the JCAHO evaluates the following organizational information:

- Accreditation application information
- Federal and state entities (e.g., MedPAR)
- CMS Nursing Home Compare
- CMS Home Health Compare
- Outcomes Assessment and Information Set (OASIS)
- The Leapfrog Group
- Healthgrades
- ORYX core measure data (now publicly available)
- Complaints received by the JCAHO Quality Monitoring System (QMS)
- Lab proficiency testing failures

It is critical to monitor these outcomes on an ongoing basis to determine potential system- and patient-tracer focus areas. Federal and state acute-care outcomes data include information such as:

- hospital demographics
- admission rates
- readmission rates
- observation status
- average daily census
- volumes
- complication rates
- lengths of stay
- cost reports
- expenses
- inpatient days
- diagnostic related group (DRG)
- revenue

These data are extracted from Uniform Billing 92 formats. From this data extraction, CMS produces a Web-based analytical severity-adjusted data file called Medicare Provider Analysis and Review (MedPAR). The MedPAR data reflect hospital utilization of all Medicare beneficiaries and are updated every federal fiscal year (12 months, ending in October).
The patient-outcomes and quality-improvement data collected by state agencies vary from state to state. For example, in Florida, the Medicare Quality Improvement Organization (QIO) is called Florida Medical Quality Assurance, Inc. (FMQAI). FMQAI is federally funded and contracts services with CMS through the U.S. Department of Health and Human Services. If you are unsure of what data are available from your state QIO, contact your utilization or quality management staff for assistance.

If MedPAR and state quality data are used in the acute-care setting, what data are available to long-term care settings and home healthcare? Long-term care settings (e.g., skilled nursing facilities) became the forerunners of data collection and submission requirements in June 1998 with the Minimum Data Sheet (MDS). The OASIS is a similar requirement for home healthcare. Both MDS and OASIS databases provide a rich array of clinical information, including diagnoses, assessments of cognitive and functional status, treatment, signs and symptoms of decline or exacerbation of illness, and types of medication administered to patients.

Although used primarily for prospective payment purposes, these data are also useful to determine PFAs of concern. For example, if you note a concern with assessment skills in your OASIS or MDS data, that area might be identified as a priority focus area.

The Leapfrog Group

Federal and state agencies provide clinical-outcomes data, but there are also Web-based organizations that provide this information to the public. One of these organizations is called The Leapfrog Group. The Leapfrog Group is a partnership of more than 170 public and private organizations that provide healthcare benefits. Participation in this program is voluntary. The group was created to inform consumers and purchasers about patient safety and quality services. Information and data provided by The Leapfrog Group are available on its Web site, www.leapfroggroup.org.

The type of information available depends on the organization’s use of computerized drug-order entry, ICU staffing ratios, volume, and outcomes ratings for high-risk procedures or conditions such as:

- coronary artery bypass graft (CABG)
- percutaneous coronary intervention
- abdominal aortic aneurysm repair
- esophagectomy
- pancreatic resection
- high-risk deliveries and neonatal ICUs
The site displays data results alphabetically by facility in pie charts:

- **Full pie**: The organization has fully implemented Leapfrog’s recommended safety practice.
- **Three-quarter pie**: The organization has made good progress in implementing Leapfrog’s recommended safety practice.
- **Half pie**: The organization has made a good early-stage effort in implementing Leapfrog’s recommended safety practice.
- **Quarter pie**: The organization is willing to report publicly but does not yet meet Leapfrog’s criteria for a good early-stage effort.
- **Empty pie**: The organization did not disclose this information.
  
  **N/A**: Not applicable.

**Healthgrades**

Another publicly available source of data that the JCAHO crunches into its priority-focus database is Healthgrades. Healthgrades is a technology partner of The Leapfrog Group and supports hospital data reports. The Healthgrades Web site (www.healthgrades.com) links to Leapfrog hospital survey results as part of the information it provides to the public. All of the information collected is arranged in a report card format.

Healthgrades purchases data from MedPAR and primarily focuses on mortality rates for defined inpatient procedures or disease groupings, which include the following:

- Appendectomy (new)
- Atrial fibrillation
- Back and neck surgery (except spinal fusion)
- Back and neck surgery (spinal fusion)
- Bowel obstruction
- Carotid endarterectomy
- Cholecystectomy
- Chronic obstructive pulmonary disease
Chapter one

- Community-acquired pneumonia
- Coronary bypass surgery
- Coronary interventional procedures, angioplasty/stent (renamed)
- Diabetic acidosis and coma (new)
- Gastrointestinal bleed
- Gastrointestinal procedures and surgeries (new)
- Heart attack
- Heart failure
- Hip-fracture repair (ORIF)
- Maternity care (renamed)
- Pancreatitis (new)
- Partial hip replacement
- Peripheral vascular bypass
- Prostatectomy
- Pulmonary embolism (new)
- Resection/replacement of abdominal aorta
- Respiratory failure (renamed)
- Sepsis
- Stroke
- Total hip replacement
- Total knee replacement
- Valve replacement surgery
- Women’s health

In hospital report cards, Healthgrades assigns a number of stars to each hospital’s performance. Using a star grading system, five stars indicates best outcomes, three stars indicates as-expected outcomes, and one star indicates poor patient outcomes. If a hospital does not meet the required volume of data for scoring, the hospital is not rated.
Throughout the year, your organization should receive quarterly data graphs and information from your ORYX vendor to use in analysis. The JCAHO expects organizations to develop performance improvement initiatives based on your analysis of ORYX data. At the time of your survey, JCAHO surveyors will review the ORYX summary report and request information about analysis and improvements made as a result of ORYX findings. It will also use the report to select PFAs.

Your organization will receive an ORYX summary report from the JCAHO prior to your survey date. To determine the report’s effect on your PFAs, look for spikes or outliers in performance throughout the year. They will weigh into the PFAs chosen for your organization.

For example, if the ORYX indicator for pregnancy-related conditions shows a higher-than-expected benchmark range for third- and fourth-degree lacerations, the surveyor is likely to choose a vaginal labor and delivery patient to trace.

Healthgrades, The Leapfrog Group data, and ORYX data are currently available to the public. ORYX public information appears on the JCAHO Web site at www.jcaho.org under the “Quality Reports” section.

**Priority focus process summary report**

The JCAHO will compile and process via algorithm the outcomes data from the sources mentioned above, along with data from patient-experience surveys and previous accreditation results, to create an individualized priority focus process summary report.

Information about this report is available on your organization’s JAYCO Web site the morning of your survey. However, using the tracer-patient selection worksheet in Figure 1.3, you can predict your organization’s priority focus areas well in advance of your survey. This will allow you ample time to identify areas of focus and to prepare your staff by conducting internal tracers.

**Warning:** Do not wait for notification from the JCAHO that your Priority Focus Process Summary is available. Check your own data on a quarterly basis and estimate your PFAs.
CHAPTER ONE

USING PRIORITY FOCUS AREAS IN THE SURVEY PROCESS

Before the surveyors arrive at your organization, they will already have access to your PFA information. The surveyors assigned to your organization are the only survey staff with viewing rights to your PFA information. They will use it as a survey guide during the survey team planning meeting.

Just after the opening conference of the survey, the surveyors will discuss PFAs with your organization. The surveyors might ask you or your leaders whether you received the PFA information via the JAYCO site and whether you have any questions about how the PFA is derived. They will confirm with your organization that the PFAs are used

- to convert presurvey data into focused organizational information
- to aid in focusing the survey activities
- in tracer selection criteria during the initial stages of the survey
- to improve consistency in survey activities for organizations with similar presurvey data
- to individualize the survey activities to suit the needs of each organization

Once tracer patients are selected, your PFAs will initially drive the focus of the surveyors’ assessment. Questions directed at leadership and staff will center around the PFAs. As the survey progresses, the surveyors may be satisfied that the PFAs identified are no longer problematic or they may confirm that the PFAs are true issues for your organization.

In addition to PFAs, understand how the JCAHO now scores elements of performance and, subsequently, standards based on findings from tracer activities. In my experience, even though the JCAHO states that “surveys are no longer scored,” this simply means that it does not share the score with your organization.

SCORING GUIDELINES

One of the most challenging aspects of the entire survey process is not really knowing how you are doing on your survey. Sometimes surveyors will respond as if you are doing well with the survey or they may state that some of their findings might turn out to be insignificant. But when the surveyors compile their findings, you could end up with multiple RFIs that you did not anticipate, particularly
with Category C elements of performance. When the surveyors hand us our survey results, I always
note the size of the report. If it is pretty thick, I know we have work to do to bring our organization
into compliance with standards.

The best way to combat this confusion is to have a good grasp of the scoring guidelines. Use this infor-
mation to aid you with mock tracer assessments and periodic performance review requirements.

**Scoring Guidelines Update**

To understand the approach to scoring, first understand how the standards are formatted.

Each standard now has the following three basic components:

- The **standard** itself, which is a statement of the objective.
- The **rationale**, which explains why this is a reasonable objective.
- The **elements of performance** (EP), which is a list of the elements that must be demonstrated by
  the organization to be deemed in compliance. They used to be buried in the intent statements
  or, worse yet, surveyors’ laptops.

**Scoring starts with an assessment of how well you comply with each EP and is done on a scale of 0–2.**

- 2 = satisfactory compliance
- 1 = partial compliance
- 0 = insufficient compliance
- NA = element that does not apply to your organization

**Each EP is categorized as an A, B, or C, and is scored separately.**

- **A**—These are all-or-nothing elements: Either you have them or you don’t (e.g., a policy or a
  license). Also identified as As are elements that must be in full compliance (e.g., a National
  Patient Safety Goal or a CMS Condition of Participation). A elements are scored as 2 (sufficient
  compliance) or 0 (insufficient compliance). When A elements contain bullets, all bullets must
  be compliant to result in a score of 2.

- **B**—B elements generally can also be scored as present or absent. However, they can be scored
  as 2 (sufficient compliance), 1 (partial compliance), or 0 (insufficient compliance) when the EP
The principles of good process design include the following five criteria:

- Aligns with the organization’s mission, vision, and values
- Meets or exceeds the needs of its customers
- Demonstrates current standard of practice in the field
- Addresses current knowledge regarding risk and patient safety
- Uses information from the organization’s PI measurement and analysis activities

When all five tests are met, the score of 2 will stand. The presence of at least one will result in a score of 1, and the presence of none will result in a score of 0.

- C—These elements are based on performance in the sample reviewed by the survey team (e.g., documentation in a medical record or adherence to a policy on medication administration). A score of 2 is awarded if one or no occurrences of noncompliance are found. A score of 1 is given if there are two instances of noncompliance. Any more than two instances of noncompliance will result in a score of 0.

When C elements contain bullets, a score of 2 will be given if all bulleted items have fewer than two instances of noncompliance. When all bullets have three or more instances of noncompliance, the score will be 0. Any other pattern of noncompliance will be scored as 1. An easy way to remember this is to think, “three strikes and you are out” of compliance.

Note: The organization’s implementation track record is also important and can affect scoring in any category. Most of the standards are not new, so it is assumed that you will have at least a 12-month track record. A score of 2 will be given if the element for demonstration shows 12 months of compliance. A score of 1 will be given when six to 11 months of compliance is demonstrated. Less than a six-month track record will result in a score of 0.

- M—Some elements will also have Ms next to them. The M stands for measure of success (MOS). This comes into play if the standard is found to be out of compliance during an on-site
survey. Following acceptance of your action plan to demonstrate compliance, the results of four months’ data will have to be submitted to the JCAHO. Results will be scored as:

greater than 90% = compliance

80%–89% = partial compliance

less than 80% = noncompliance

Organizations should utilize this scoring mythology when performing their PPR. Data collection should be implemented for Category C elements of performance to confirm the organization’s compliance.

**Standards are scored only as compliant or noncompliant.** To determine which it’s going to be, the surveyors will enter the scores for the individual elements of performance (i.e., 0, 1, or 2), and if at least 65% of the elements for that particular standard are scored as a 2, the standard will be deemed compliant. However, if a single EP is scored as 0, the standard will be scored as noncompliant. Each standard stands alone—that is, there are no more grids or grid scores.

**Your number of noncompliant standards will be tallied** and you will be compared to the normal distribution of the hospitals surveyed in 2005. It’s expected that 97.5% of the population will fall within two standard deviations of the mean for expected performance. Organizations will have 45 days to submit evidence of standards compliance (ESC) and plans for subsequent measures of success that will be used to demonstrate attained compliance. Your organization will be considered accredited from the time of the exit conference through submission of MOS data. Accreditation will be continued as long as your organization submits an acceptable ESC and four months of data that demonstrates performance greater than 90%.

Organizations that do not submit a timely ESC or an acceptable ESC will be placed on provisional accreditation status. This is a new, temporary category that allows the organization an additional 30 days to submit a revised ESC. The JCAHO can take as many as 30 additional days to determine whether the ESC is acceptable. If the ESC is rejected, the organization drops to conditional accreditation. If it is accepted, the status remains at provisional status until the measures of success are accepted. Continued delays in submitting required data and information to the JCAHO can escalate and ultimately result in denial of accreditation.

If your number of noncompliant standards is greater than two standard deviations but less than three standard deviations from the expected mean (approximately 2% of hospitals will fall into this category),
you will be notified of conditional accreditation. Conditional accreditation status requires submission of an ESC but will be followed by a focused survey before moving to accredited status. At more than three standard deviations (approximately 0.5% of hospitals), you will receive preliminary denial of accreditation.

When in doubt, score your mock tracer and periodic performance review assessments more toward noncompliant or partially compliant, instead of giving your organization full credit. During our self-assessment activities, staff often present “evidence of standards compliance” to our accreditation committee when they are unsure about a borderline compliance issue. When in doubt, I tend to lean toward partial compliance or noncompliant, which leaves us plenty of room for improvement and ensures follow-up on identified issues. The bottom line is to be harder on your organization than you think the surveyors will be.

The next step is to apply the scoring guidelines to your mock tracer activities, the various types of tracers, and other survey activities.
**TRACER-PATIENT SELECTION WORKSHEET**

1. Identify priority focus areas (PFAs) for facility (using publicly available pre-survey data): (What indicators have been identified as opportunities for improvement?)

   a. ORYX data
      Core Measure:____________________________________________________________________
                      __________________________________________________________________________
      Core Measure:____________________________________________________________________
                      __________________________________________________________________________
      Core Measure:____________________________________________________________________
                      __________________________________________________________________________

   b. OASIS (homecare):________________________
      ______________________________________________________________________________
   d. Leapfrog (available at www.leapfroggroup.org): _________________________________
      ______________________________________________________________________________
   e. Healthgrades (available at www.healthgrades.com):_______________________________
   f. Patient experience survey:________________________________________________________
      ______________________________________________________________________________
   g. Previous survey results (Type I’s/supplementals): What were the issues?
      ______________________________________________________________________________
      ______________________________________________________________________________
      ______________________________________________________________________________
      ______________________________________________________________________________

2. Critical Focus Areas (CFA) to survey: Using findings from the above available data, identify areas of opportunity for improvement in the following PFAs. Underline those that apply.

   - Assessment and care
   - Credentialed practitioners
   - Infection control
   - Communication
   - Equipment use
   - Information management
3. Identify Clinical Service Groups (CSG) tracer information within the organization (e.g., pulmonary, cardiovascular, rehabilitative, emergency services, etc.). This information is derived from organization’s application for accreditation.

a. ____________________________ i. ____________________________
b. ____________________________ j. ____________________________
c. ____________________________ k. ____________________________
d. ____________________________ l. ____________________________
e. ____________________________ m. ____________________________
f. ____________________________ n. ____________________________
g. ____________________________ o. ____________________________
h. ____________________________ p. ____________________________

4. Obtain active patient list (including patient name, room number, diagnosis, and physician) and the daily surgical/special procedures schedule.

From PFA, CFA, and CSG information, select tracer patients. On average, select four to six tracer patients per 50 beds.

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CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787
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