An empirical test of accreditation patient journey surveys: randomized trial

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Abstract

Objective. To evaluate the effectiveness of utilizing the patient journey survey (PJS) method in healthcare accreditation processes.


Setting. Acute healthcare organizations in Australia.

Participants. Seventeen organizations, 28 organizational staff, nine surveyors and 38 patients.

Main Outcome Measures. The results of each surveying method were compared. Participants provided feedback, via 18 interviews and 40 questionnaire surveys, about the benefits and disadvantages of a PJS compared to a CAS.

Results. The PJS method is not as comprehensive as the CAS method for accreditation assessment. In matched assessments the majority of items were rated lower by the PJS method than by the CAS. PJSs were shown to be appropriate for assessing mandatory clinical criteria, but were less effective for assessing corporate and support criteria. The two methods diverged in their final assessments of which organizations met the accreditation threshold. Participants endorsed the use of PJSs within accreditation processes.

Conclusions. The PJS methodology complements but is not a substitute for existing accreditation methods. There is significant stakeholder support for the inclusion of the PJS method within the current accreditation programme.

Keywords: Accreditation, patient journey, tracer method, healthcare, empirical research

Introduction

Patient-centred care has migrated from an idea to a strategy for organizing and delivering healthcare services. Governments, policy makers, managers and clinicians have, to greater or lesser degrees, embraced the notion and are examining how to deliver care with this focus. Similarly, for some time now accreditation agencies have turned their attention to how the idea of patient-centred care can be incorporated into decision-making. To this end, accreditation agencies in different parts of the world [1] have been using tracer methodologies, including the ‘patient journey survey’ (PJS) methodology, as one such strategy [2]. A PJS is an assessment, made by surveyors shadowing the sequential steps of a patient’s clinical care, of the processes in an organization that guide the quality and safety of care delivered [3]. PJSs may be useful for assessing the quality of care in healthcare systems [2] and identifying discrepancies between actual and expected levels of care [4–7]. Additionally, a PJS is considered to be one mechanism to increase the effectiveness of accreditation processes, to reduce the resources required for organizations to participate [2] and to fulfill the expectations of stakeholders for better accreditation designs [8, 9].

However, the optimism held for PJSs is not grounded in strong evidence. The problems are threefold. First, most of the support for the PJS is commentary rather than empirical. Second, most studies have limited generalizability as the patient journal methodology was evaluated with regard to specific diseases, medications or healthcare settings. For example, studies have examined emergency medicine [10] and primary care [4] systems, diagnosis of schizophrenia [11] and the treatment of Parkinson’s disease [12]. While

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restricted in settings and research scale, the findings suggest that the PJS is a useful strategy for assessing the quality of care and identifying discrepancies between the expected and actual levels of care [2]. A third problem is that previous research was conducted some time ago and delivery systems have altered over time. Current empirical studies into the PJS are required to evaluate its utility as an accreditation tool [13].

This paper reports an empirical study that evaluated the use and outcomes of the PJS method in comparison with the current accreditation survey (CAS) method employed within a prominent Australian healthcare accreditation program. In 2009, the Australian Council on Healthcare Standards (ACHS) and the Centre for Clinical Governance Research, University of New South Wales, were funded by the Australian Commission on Safety and Quality in Health Care (ACSQHC) to evaluate the use of the PJS methodology. The ACSQHC asked the partnership to investigate the viability and outcomes of the PJS method before considering its incorporation within Australian healthcare accreditation programs. The study objective was to examine the use of the PJS method and establish if it added value to the CAS method.

Methods

Study context

The Evaluation and Quality Improvement Program (EQuIP) of ACHS is an accreditation program in which ~1300 healthcare organizations in Australia and Hong Kong participate [14]. EQuIP provides a framework for health services to promote high-quality and safe care. The fourth version of EQuIP (EQuIP 4) is divided into clinical, support and corporate function areas, comprising 13 standards with 45 criteria, of which 14 are mandatory and 31 non-mandatory. Achievement is rated against a five-point scale (Little Achievement, Some Achievement, Moderate Achievement, Extensive Achievement and Outstanding Achievement) reflecting organizational quality and safety, and efforts to implement improvement strategies. Ratings of at least Moderate Achievement against the 14 mandatory criteria are necessary to obtain accreditation status.

EQuIP 4 has a 4-year cycle beginning with participating organizations self-assessing against the criteria. This enables organizations to evaluate their quality and safety practices, providing the foundation for two onsite surveys: the organization wide survey and the periodic review. Both surveys involve observations, interviews and document analysis by a trained team of peer surveyors in order to assess organizations’ quality and safety practices against the criteria [15, 16]. The organization wide survey involves a review of progress and achievement of the organization against all 45 criteria [17]. The periodic review surveys organizations against the 14 mandatory criteria and monitors progress towards implementation of the recommendations from the organization wide survey [17].

Organizational sample

During the study period in November and December 2008, ACHS had 39 member organizations, from its total membership within Australia, scheduled for an on-site EQuIP 4 accreditation survey. These organizations were classified as follows: public metropolitan teaching hospitals; public and private metropolitan hospitals; public and private regional health services; community settings, either public or private; and stand-alone day procedure centres. From this sample, 21 organizations were randomly selected for inclusion in the study, providing a stratified, representative sample of Australian healthcare organizations. Invitations to participate were accepted by 18 organizations. The PJS data from one organization were not returned by a surveyor within the scheduled timeframe for analysis and became lost to follow-up. The final sample contained 17 organizations.

Procedures

The PJS method was tested in parallel with the CAS method. Each survey was conducted simultaneously, but independently of each other, by different survey teams. Data from each survey were maintained separately and did not contaminate the other survey assessments, outcomes or reports produced. Survey teams conducting CASs were assigned to organizations as per existing ACHS policy and procedures. Surveyors conducting the PJS method were assigned to attend participating organizations for a single day. In total, 38 PJSs were conducted. Where a surveyor conducted more than one PJS in an organization, they summarized and combined the individual PJS findings to produce a single assessment for that site.

Staff of participating organizations nominated multiple patients who accessed multiple services and received complex treatment. From these lists, the PJS surveyors selected patient records that, in their assessment, best facilitated examination of diverse organizational departments and services. Once patients’ records were selected, the surveyors recorded the services involved in their treatment. For each service, the staff to be interviewed and EQuIP 4 criteria to address were noted. Surveyors required, on average, 3 hours to complete a PJS.

Surveyor selection and training

ACHS has a surveyor workforce totalling nearly 350 personnel. From this pool, ACHS staff selected nine highly experienced surveyors for the study. Prior to conducting a PJS, these surveyors received training via teleconferences or face-to-face discussions from ACHS staff about the PJS methodology and how to use this data-gathering tool.

PJS guidelines and assessment tool

PJS guidelines and an assessment tool, based on the EQuIP 4 criteria and rating scale, were developed for the study. These were intended to provide a standardized structure for surveyors to follow the course of care and services provided to enrolled patients, and assess relationships among
different organizational departments. The guidelines and tool
described the data requiring collection, provided examples of
documents requiring review and suggested questions that
could be used to gather information from patients and or-
ganizational staff. Participating organizations were provided
with the guidelines prior to the survey visit.

The PJS tool assessed organizations against 40 of the 45
EQuIP 4 criteria. The variation of criteria used was due to
three factors. First, criteria relating to access issues were
reduced into a single criterion and finding. Second, the four
information management systems criteria were reduced to a
single criterion. The simplification of the access and informa-
tion management systems criteria enabled surveyors to focus,
as per the purpose of the PJS methodology; on the clinical
aspects of care. Third, a criterion that examined governance
delegation practices was not assessed because it could not be
related to the patient journey. Therefore, the study tool pro-
duced a database containing 680 ratings, that is, 17 organiza-
tions across 40 criteria.

Feedback methodology
Following the completion of the two survey methods at each
site, feedback data were gathered from patients and staff of
participating organizations and PJS surveyors, via structured
interviews and a questionnaire. The 38 patients on whom the
PJS focused received a questionnaire. Surveyors and organ-
izational staff who helped coordinate or implement the study
received a questionnaire and an invitation to participate in
an interview. The feedback activities were designed to elicit
respondents’ experiences with and views about the major
benefits and disadvantages of PJSs within an accreditation
programme. Specific issues examined included: how sur-
veyors were received in departments, wards and units; the re-
action of organizational staff to PJSs; and how surveyors
linked PJSs to the EQuIP 4 criteria. The data were subjected
to thematic analysis to identify emergent issues [18].

Results
Two sets of results are presented. First, we provide a compar-
ison of surveyors’ assessments from the two survey
methods. Second, respondents’ views of the major benefits
and disadvantages of PJSs compared to CASs are reported.

Comparison of PJS and CAS findings
The breakdown of data items is presented in Fig. 1 and
Table 1. The study was expected to provide 680 items for
comparison. However, the CAS and PJS methods yielded
only 449 and 247 ratings, respectively. Unreported items and
items assessed by only one method reduced the data set to
180 matched data points, or 27% of the anticipated total. In
the set of matched items, there was agreement between the
two methods for nearly three quarters of the data \( n = 128 \).
Conversely, a sizable minority of items were in disagreement
\( n = 52 \). Of the items in dispute, 89% were assessed by the
PJS method as lower against the criteria.

As indicated in Table 2, there was considerable variability
between the two survey methods in their assessment of manda-
 toriy criteria in the three EQuIP 4 function areas. Across
the clinical, support and corporate function areas, CASs
reported against 99, 98 and 93% of the relevant criteria.
Conversely, PJSs assessment rates were 84, 29 and 31% for
the respective areas.

There was divergence between the two survey methods in
their assessments of which organizations met the accredit-
ation threshold – see Table 3. CASs assessed that the thresh-
old was met for 13 of the 17 organizations. There was
insufficient information collected by the PJSs to make a valid
comparison with the CASs for these 13 organizations. In
four cases, the PJSs assessed that an organization failed to
meet the threshold. CASs concluded that accreditation status
was achieved for three of these. In one instance, both the
CAS and PJS methods agreed that an organization did not
meet the threshold. There were three cases where CASs eval-
uated that organizations did not meet the threshold, but PJSs
failed to complete an assessment.

Discussion
The study results suggest that the PJS method, as compared
with the CAS method, may not be appropriate to assess all ac-
creditation standards. Evaluation of the matched assessments
made using the two methods revealed that the PJS method
rated a significant majority of items lower than did the CAS
method. While PJSs were shown to be capable of assessing
Figure 1 Breakdown of data items.

Table 1 Examination of criteria ratings for the organizations by the CAS⁸ and PJS⁹ method

<table>
<thead>
<tr>
<th>Organization number</th>
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<th>Criteria rated by PJS method assessment only</th>
<th>Criteria where neither survey method assessed</th>
<th>Criteria where same rating given by both survey methods</th>
<th>Criteria where different rating given by survey methods</th>
<th>PJS method assessment lower</th>
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Totals 269 67 151 128 52 46 6 13 680

CAS, current accreditation survey; PJS, patient journey survey.
mandatory criteria in the clinical function area, they were less effective assessing those in the corporate and support function areas. The two methods diverged in their final evaluations of which organizations would have met or not met the accreditation threshold. Insufficient assessments by the PJS method does not facilitate further investigation of the differences. These outcomes are consistent with the focus of PJSs which is to ‘follow the sequential steps of a patient’s clinical care’ [3]. PJS are not expected to observe the range of organizational facets of a health system, as represented by the criteria in the support and corporate functions of the accreditation programme investigated. However, on the basis of this trial, it seems clear that as the PJS method provides an additional perspective into, and further insights about, the clinical care provided by health organizations. It seems best considered an effective complement to the CAS method. Surveys, patients and organizational staff who participated in the study supported the inclusion of the PJS method in the accreditation process. The positive experiences of the PJS method are captured by the following statements:

You look at policies and procedures with both [PJSs and CASs], but this [PJS] is more specific, more focused. For example, with a stroke patient, I looked at clinical guidelines and compared them with what actually happened to the patient. This is a better way of looking at policies and procedures because it shows how they are actually followed.

ACHS Surveyor: feedback interview

Doing the patient journey was actually an interesting and valid way to be assessed. It was far tougher than [the] usual accreditation.

Organisational staff member: feedback interview

The endorsement of the PSJ method by participants provides further impetus for accrediting agencies to consider its inclusion within their repertoire of tools. Prior to doing so, however, the utility of PJSs needs to be carefully considered in the context of current concerns regarding the efficiency of accreditation programmes and the demands placed on clinical staff. The following comments represent the concerns participants noted:

However, the method can impinge on care and time needs to be set aside for interviews.

Organisational staff member: feedback questionnaire

We felt that there was insufficient time to prepare effectively for the visit; participation was confronting.

Organisational staff member: feedback interview

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**Table 2** Comparison of mandatory criteria of EQuIP 4 function areas reported using CAS and PJS methods

<table>
<thead>
<tr>
<th>Organization number</th>
<th>Clinical criteria (×/7)</th>
<th>Support criteria (×/3)</th>
<th>Corporate criteria (×/4)</th>
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Totals (%) 118 99 50 15 63 21

**Table 3** Comparison of accreditation threshold assessments reached using CAS and PJS methods

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Totals 13 4 0 4 13

CAS, current accreditation survey; PJS, patient journey survey.

bYes, accreditation threshold reached; No, accreditation threshold not reached.
The strategies suggested by study participants for improving the PJS method highlight some of the issues that need resolution. Accreditation agencies may incur additional costs in order to train surveyors in effective PJS techniques and include them in survey processes. The further development of standardized tools and guidelines to assist training and the implementation of PJS will doubtless drive improvements. This methodology will contribute to better judgements of participating organizations by accrediting agency, surveying and organizational staff.

Assistance is required from organizational staff to effectively prepare for and enable the conduct of PJSs. Hence healthcare organizations may need to make additional investments of time and resources, or accrediting agencies need to consider how the process could be made more efficient, if PJSs were to be implemented widely. Additionally, the sample of PJS participating patients required to ensure appropriate assessment of the quality and safety of an organization requires specification. This preliminary list of issues indicates that the costs and benefits of PJSs require further investigation in order to more fully consider their value and place within an accreditation programme.

**Limitations**

A limiting factor is the study sample size, including the numbers of participating organizations, PJSs conducted and completed and surveyors. The accrediting agency purposefully, rather than randomly, selected surveyors for participation. The guidelines and tools for the study were provisional and may need refinement, as does the PJS implementation process. Collectively, these issues necessitate caution and are the reason for not formulating strong conclusions from this study. To investigate the generalizability of the findings, studies with more power and representative organizational and survey samples, as well as validated protocols and tools, are necessary.

**Conclusion**

The study suggests that the PJS method is a useful tool that can complement existing accreditation survey processes. The PJS method provides complementary insights concerning the clinical care provided by a health organization. Additional research is required to calculate the benefits and costs of including PJSs within accreditation programmes.

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**Conflict of interest**

The authors have no conflict of interest to declare.

**References**