Form 1: Proposal for a new field of technical activity

Circulation date: 2015-12-18 Closing date for voting: 2016-03-18	Reference number (to be given by Central Secretariat)
Proposer: ANSI (United States)	**ISO/TS/P** 256

A proposal for a new field of technical activity shall be submitted to the Central Secretariat, which will assign it a reference number and process the proposal in accordance with the ISO/IEC Directives (part 1, subclause 1.5). The proposer may be a member body of ISO, a technical committee, subcommittee or project committee, the Technical Management Board or a General Assembly committee, the Secretary-General, a body responsible for managing a certification system operating under the auspices of ISO, or another international organization with national body membership. Guidelines for proposing and justifying a new field of technical activity are given in the ISO/IEC Directives (part 1, Annex C).

The proposal (to be completed by the proposer)

Title of the proposed new committee **(The title shall indicate clearly yet concisely the new field of technical activity which the proposal is intended to cover.)**
Healthcare Administration

Scope statement of the proposed new committee (The scope shall precisely define the limits of the field of activity. Scopes shall not repeat general aims and principles governing the work of the organization but shall indicate the specific area concerned.)

Standardization in the field of healthcare administration will include classification, terminology and nomenclature, management practices and metrics that comprise the "business" operations among healthcare entities. Covered subjects would include healthcare supply chain, capital (financial) management, patient admission and discharge approaches, human resource management specific to healthcare management, facilities management specific to healthcare facilities", and all other non-clinical organizational support functions. These practices and metrics will be limited to staff and operational management of healthcare entities. For the purposes of this committee's work, this proposal identifies healthcare entities as those organizations "whose principal operations consist of agreeing to provide health care services and entities whose primary activities are the planning, organization, and oversight of such entities, such as parent or holding companies of healthcare providers."[1] This proposal adopts seven broad categories of healthcare entities for the purpose of this area of technical inquiry.[2] (SEE ATTACHED Appendix). The scope of this standard will principally be in the Health System and Related Sectors column in the chart below.

Standards that directly affect patient care and medical research are outside the scope of this standards effort. Test methods and specifications that are applicable to materials, appliances, instruments, and equipment that are in the practice of traditional and modern medicine are not within the scope of this standards effort. Clinical performance in patient safety and satisfaction standards will not be pursued by this standards setting body. These standards will not address water supply, sanitation, food relief and related services that have a healthcare benefit but are not exclusive responsibilities of healthcare entities. These standards will also not address 1) the management or administration of organizations that practice dentistry, 2) the production and use of medical devices or instruments, and 3) the capture and analysis of clinical medical information or procedures.

Determinants of Health Outcomes
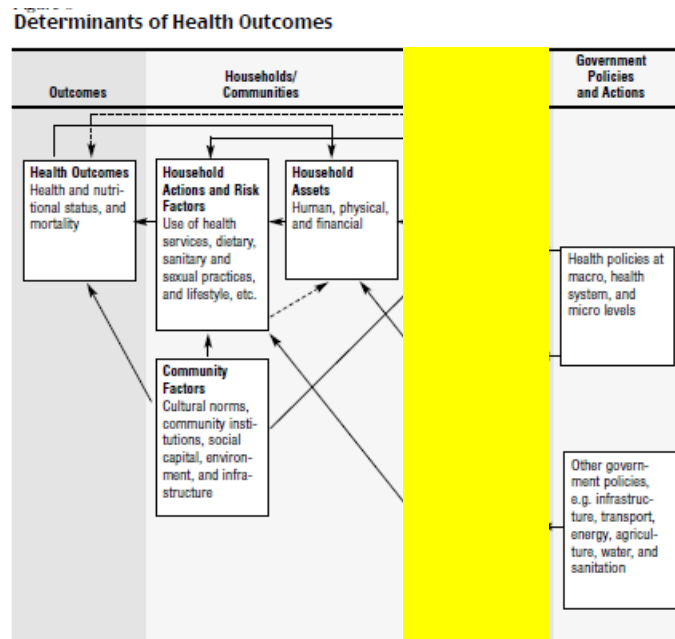
Source: A. Wagstaff, "Poverty and Health Sector Inequalities," *Bulletin of the World Health Organization* 80, no. 2 (2002): 99.

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[1] Prince PhD, Thomas R. 1998. *Strategic Management for Healthcare Entities*. Chicago. American Hospital Association. p.4.

[2] Ibid.

Proposed initial programme of work (The proposed programme of work shall correspond to and clearly reflect the aims of the standardization activities and shall, therefore, show the relationship between the subject proposed. Each item on the programme of work shall be defined by both the subject aspect(s) to be standardized (for products, for example, the items would be the types of products, characteristics, other requirements, data to be supplied, test methods, etc.). Supplementary justification may be combined with particular items in the programme of work. The proposed programme of work shall also suggest priorities and target dates.

The proposed program of work for the standardization of healthcare administration:

1) Primary management standards
   a. Terminology
   b. A standard that describes and defines a classification system
   c. A standard that defines effective healthcare administration
        i. Cost and productivity management (e.g. Admission and continuation of services, materials management, food service management, complaint management) (in liaison with ISO/TC 267 Facilities management)
       ii. Financial management (e.g. revenue/patient served, budget planning process, capital expenditure planning, revenue cycle operations, payroll and vendor disbursements)
      iii. Human resource/labor management (e.g. engagement, exit interview process, vacancy reporting, separation rates, volunteer management, conflict management, turnover) (in liaison with ISO/TC 260 Human resource management)
2) Secondary support standards
   a. Supply chain management (in liaison with ISO/PC 277 Sustainable procurement)
   b. Health related disaster relief administration
   c. Pharmacy management
   d. Risk management (in liaison with ISO/TC 262 Risk management)
   e. Internal controls systems
   f. Asset management (in liaison with ISO/TC 251 Asset management)
   g. Maintenance management
   h. Transportation management

The priority of work will be establishing terminology, classification, cost and productivity standards that will resonate with the market place and provide immediate value to consumers, patients and end users.

Indication(s) of the preferred type or types of deliverable(s) to be produced under the proposal (This may be combined with the "Proposed initial programme of work" if more convenient.)

Preferred deliverables from this work would include ISO Standards and technical specifications on the effective administration of healthcare entities.

A listing of relevant existing documents at the international, regional and national levels. (Any known relevant document (such as standards and regulations) shall be listed, regardless of their source and should be accompanied by an indication of their significance.)

PAHO: Establishment of Technical Competency Standards for Emergency Response. Professionals Providing Care in a Mass Casualty Event.

PAHO: International Public Sector Accounting Standards. Pan American Health Organization (Washington, D.C, PAHO, 2007-10)

WHO: Hospital standards for Accreditation - examples from Afghanistan *2006, Ministry of Health Afghanistan and USAID: Management of Human Resource (Section 5); Pharmacy Management (Section 4)*

ISO 31000 - Risk management

ISO Guide 73:2009, *Risk management - Vocabulary* complements ISO 31000 by providing a collection of terms and definitions relating to the management of risk.

ISO/IEC 31010:2009, *Risk management – Risk assessment techniques* focuses on risk assessment.

ISO 9000 - Quality management

ISO 9001:2008 - sets out the requirements of a quality management system

ISO 9000:2005 - covers the basic concepts and language

ISO 9004:2009 - focuses on how to make a quality management system more efficient and effective

ISO 19011:2011 - sets out guidance on internal and external audits of quality management systems.
ISO 45001 - Occupational health and safety

ISO 26000:2010 - Social responsibility

Guidelines on occupational safety and health management systems, ILO-OSH 2001

C150 - Labour Administration Convention, 1978 (No. 150) Convention concerning Labour Administration: Role, Functions and Organisation (Entry into force: 11 Oct 1980)

ISO 55000:2014 Asset management -- Overview, principles and terminology
ISO 55001:2014 Asset management -- Management systems -- Requirements
ISO 55002:2014 Asset management -- Management systems -- Guidelines for the application of ISO 55001
ISO Guide 73:2009 Risk management -- Vocabulary
ISO 31000:2009 Risk management -- Principles and guidelines
ISO/TR 31004:2013 Risk management -- Guidance for the implementation of ISO 31000
IEC 31010:2009 Risk management -- Risk assessment techniques
Association of periOperative Registered Nurses' ANSI standard: *AORN Guidance Statement: Perioperative Staffing*, AORN MAN-833-2013
Joint Commission standards(US)
American Nursing Credentialing Center Magnet Certification Program Standards (US)
National Safety and Quality Health Service Standards: Standard 1: Governance for Safety and Quality in Healthcare Organizations (Australian Commission on Safety and Quality in Health Care)
Community Health Accreditation Program Standards (US)

A statement from the proposer as to how the proposed work may relate to or impact on existing work, especially existing ISO and IEC deliverables. (The proposer should explain how the work differs from apparently similar work, or explain how duplication and conflict will be minimized. If seemingly similar or related work is already in the scope of other committees of the organization or in other organizations, the proposed scope shall distinguish between the proposed work and the other work. The proposer shall indicate whether his or her proposal could be dealt with by widening the scope of an existing committee or by establishing a new committee.)

The singular and prominent role that healthcare has in society calls for its own expression of proper management in medical environments. Meanwhile, the TC will learn from and likely normatively reference the relevant ISO and IEC deliverables that were developed in other committees. The new TC will also develop fresh commentary standards that best serve the interest of the medical market place. The new TC offers existing medical devices, medical testing, informatics, and other related standards developers a management environment where healthcare entities more effectively implement their standards. Finally, the healthcare sector more readily embraces conformity assessment schemas and management systems. Healthcare entities see organizational credentialing as a positive indicator and differentiator of value to its customer base. Stemming from the educational and professional foundations of medicine, the new TC anticipates strong interest in a conformity assessment solution that could arise from these healthcare administration standards.

A listing of relevant countries where the subject of the proposal is important to their national commercial interests.

All countries and regions of the world have healthcare entities that would fall under the scope of this standard. Their Ministries of Health and equivalent organizations have a paramount interest in providing the highest quality healthcare and the best possible cost. Developing countries and rural communities, which do not have the resources to experiment with management practices or to hire consultants to advise them on effective practices would directly benefit from the access of effective management practices and tools for more developed countries.

A listing of relevant external international organizations or internal parties (other ISO and/or IEC committees) to be engaged as liaisons in the development of the deliverable(s). (In order to avoid conflict with, or duplication of efforts of, other bodies, it is important to indicate all points of possible conflict or overlap. The result of any communication with other interested bodies shall also be included.)

The new Technical Committee (TC) will actively seek opportunities to coordinate and liaison with all of the international organizations below. Some of these international organizations have self-described management standards. These standards are small in number and mostly focus on leadership effectiveness, accounting, safety, quality, and performance management practices. These standards frequently support an existing conformity assessment schema. Instead of standards, some organizations below provide checklists, guidelines and other tools to help improve healthcare entity management.

Multilateral Organizations:

    United Nations (UN)

        World Health Organization (WHO)

        Pan American Health Organization (PAHO)

        UN Economic and Social Council (UNESCO)

          The United Nation Children's Fund (UNICEF)

          United Nations Development Program (UNDP)

    World Bank and WHO Special Program for Research and Training in Tropical Diseases

    International Labor Organization (ILO) has a standard for labor management which will not conflict with the work of this committee.

Bilateral Agencies:

    United States Agency for International Development (USAID)

Non-Governmental Organizations:

    Project Hope (USA)

    Oxfam International (UK)

Refugee and Disaster Relief Organizations:

    International Red Cross Red Crescent Movement

    Medecins san Frontieres (MSF)

The new Technical Committee will actively seek opportunities to coordinate and liaison with all of the internal parties below. The new TC's scope prohibits standards development for clinical care or medical devices. Therefore the new standards will be complementary, mutually reinforcing documents. The TC will have an opportunity to normatively reference standards from committees with existing relevant content: human resources, asset, facilities, risk and quality management.

ISO/IEC Technical Committees:
    ISO/TC 106 Dentistry
    ISO/TC 168 Prosthetics and orthotics
    ISO/TC 170 Surgical instruments
    ISO/TC 176 Quality management and quality assurance
    ISO/TC 194 Biological and clinical evaluation of medical devices
    ISO/TC 198 Sterilization of health care products
    ISO/TC 210 Quality management and corresponding general aspects for medical devices
    ISO/TC 215 Health informatics
    ISO/TC 249 Traditional Chinese medicine
    ISO/TC 251 Asset management
    ISO/TC 260 Human resource management
    ISO/TC 262 Risk management
    ISO/TC 267 Facilities management
    ISO/TC 276 Biotechnology
    ISO/PC 277 Sustainable procurement
    ISO/PC 283 Occupational health and safety management systems

A simple and concise statement identifying and describing relevant affected stakeholder categories (including small and medium sized enterprises) and how they will each benefit from or be impacted by the proposed deliverable(s).

Patients and consumers of healthcare will benefit from slower increases in the cost of health care and the resulting access to care. UK and US research also shows that patients are more satisfied and are healthier when receiving services from better managed healthcare organizations.

Organizations that provide healthcare benefits will enjoy either a reduction in their benefits costs or more predictable, slower increase in the costs of coverage as efficiencies in healthcare management are transferred to the policy holders.

Insurance companies and nation Ministries of Health will more accurately monitor and compare the quality of management and assess cost control as they determine which healthcare entity provides the best value for their customers and populations.

Developing countries and rural healthcare providers will more easily access and adopt the most effective practices and metrics of more established and better resourced healthcare systems.

Healthcare entities will enjoy the sharing of effective management practices that will drive better outcomes for patients and will reduce the increase in spending of non-clinical services.

Society in general will be better informed about the effectiveness of their healthcare system and gain access to a better quality of care.

An expression of commitment from the proposer to provide the committee secretariat if the proposal succeeds.

ANSI is prepared to assume the secretariat of this ISO committee if formed. It is ANSI's intention to delegate administrative responsibility for the secretariat to the University of Texas Medical Branch (UTMB). The President of the UTMB fully supports the development of these ISO standards and has provided the Chief Human Resources Officer (CHRO) of UTMB the material support and the direction to staff and to support development of these standards. The UTMB CHRO will establish a standards development staff that will be dedicated to the proper administration of TC. At minimum this staff will have an organizational leader with primary responsibility for the administration of this effort with a direct reporting relationship to the CHRO. The Administrator will be permanent official management position at UTMB. If UTMB is granted the responsibility to administer the TC, that role will also be a permanent management position. UTMB also commits to sending this staff to all training and meetings that will sufficiently prepare them to accomplish these duties. UTMB will also participate in standards support activities to further the interest of standards development in general.
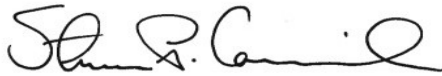
Purpose and justification for the proposal. (The purpose and justification for the creation of a new technical committee shall be made clear and the need for standardization in this fieldshall be justified. Clause C.4.13.3 of Annex C of the ISO/IEC Directives, Part 1 contains a menu of suggestions or ideas for possible documentation to support and purpose and justification of proposals. Proposers should consider these suggestions, but they are not limited to them, nor are they required to comply strictly with them. What is most important is that proposers develop and provide purpose and justification information that is most relevant to their proposals and that makes a substantial business case for the market relevance and the need for their proposals. Thorough, well-developed and robust purpose and justification documentation will lead to more informed consideration of proposals and ultimately their possible success in the ISO IEC system.)

Below are nine justifications that provide compelling support for the start of this new technical area. They are discussed in more detail in the attached Appendix.

- Justification 1: Establishing healthcare administrative standards will slow if not reduce the cost of providing healthcare through the widespread adoption of interoperable metrics and practices.

- Justification 2: Reducing the cost of healthcare will make these services more affordable and thereby provide an opportunity for greater access to society.

- Justification 3: Improving the administrative and managerial performance of healthcare entities results in better healthcare outcomes for patients.

- Justification 4: Although numerous standards exist for the laboratory protocols, clinical services and patient care functions of healthcare organizations, there are scant standards that address administrative functions or these standards are specific to a particular healthcare entity.

- Justification 5: Standardizing Healthcare administrative metrics will create apple-to-apple comparisons of organizations performance that will better educate consumers and drive process improvement activities.

- Justification 6: Rural communities and developing countries will have access to effective practices that offer a roadmap to improve their own quality of healthcare services they receive.

- Justification 7: Positive support has been received from other standards developers and members of the healthcare technical community.

- Justification 8: Standards will complement standards developing efforts of existing ISO standards developing committees.

- Justification 9: The healthcare community and its stakeholders are highly receptive to standardization and certification and will adopt approaches from these sources readily.

A proposed framework for these standards is presented on the attached scope (Appendix). This framework is based on the view that reducing cost while improving the quality of outcomes is a patient centered, value focused view of providing healthcare. In addition, improving the speed of services that customers receive during the patient care lifecycle multiplies the positive effects of this value centered approach.

Signature of the proposer

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Further information to assist with understanding the requirements for the items above can be found in the Directives, Part 1, Annex C.

Appendix

Categories of Healthcare Entities within Scope

- Clinics, medical group practices, individual practice associations, individual practitioners, emergency care facilities, laboratories, surgery centers, and other ambulatory care organizations
- Continuing care retirement communities
- Health maintenance organizations and similar prepaid care plans
- Home health agencies
- Hospitals
- Nursing homes that provide skied, intermediate, and less intensive levels of health care
- Drug and alcohol rehabilitation centers and other rehabilitation facilities.

Preliminary Framework for Standards Projects

Labor

Metrics	Practices
Vacancy (Rates and Costs)	Engagement
Cost of Vacancy	Performance Management
Healthcare Costs Per Employee	Exit Interview Process
Clinical and Classified Absence (Rate and Cost)	In-Service and Continuing Education
Clinical and Classified Turnover (Rate and Cost)	
1st Year Service Turnover Rate (Vol and Invol)	
Average Tenure for Each Job Category	
Clinical and Classified Diversity	
Separation Rates (Probationary and Annual)	
Training Costs per Employee	
Salary and Benefits Costs per Employee	
Classified and Clinical Operating Costs /FTE	
Defining Healthcare FTE	
Labor Costs per FTE	
Overtime Pay Percent for Job Categories	
Clinical and Classified Workforce ROI	
Percentage of Positions filled Internal/External	
Cost Per Hire	
Time to Accept	
HR Staff Costs Per Employee	
Time to Fill	
Recruiting Source Yield Ratios	
Training and Development \ FTE	
Workers Compensation Cost and Incident Rates	
Workers Compensation Severity Rate (days out)	

Finance

Metrics	Practices
Clinical and Classified Value Added	Budget Planning Process
Revenue / Clinical (or Classified)	Capital Expenditure Planning
Revenue / Patient Served	Billing and Reimbursement
	Payroll and Vendor Disbursements

Cost and Productivity

Metrics	Practices
Supply cost per patient-day	Patient Acceptance Criteria
Full-time staff equivalents (FTEs) per patient-day	Admission and Continuation of Services Processes
	Food Services Management
	Material Management
	Phlebotomy
	Pediatric patient experience
	Trauma Patient Experience
	Clinical Patient Experience

	Obstetric Patient Experience
	Clinical and Classified Employee
	Emergency and Disaster Preparedness
	Direct Contract Services and Products
	Accepted Administrative Terms and Abbreviation
	Public Disclosure of Information
	Complaint Management (Internal and External)
	Investigation and Research Management
	Safety Program for Administrative Areas
	Discharge Process
	Physical Facilities Evaluation

Purpose and Justification for the Proposal

Background: Based on 2010 data from the World Health Organization, the total global expenditure on health was 6.5 trillion US dollars. Among the member countries of the Organisation for Economic Co-operation and Development, the United Spends the most on per person on health ($8,832) while the average for OECD members spends $4380. Since 1960 the cost of healthcare has shown steady increases in most OCED countries with the United States leading the way at 16.4% of GDP in 2012 dollars.
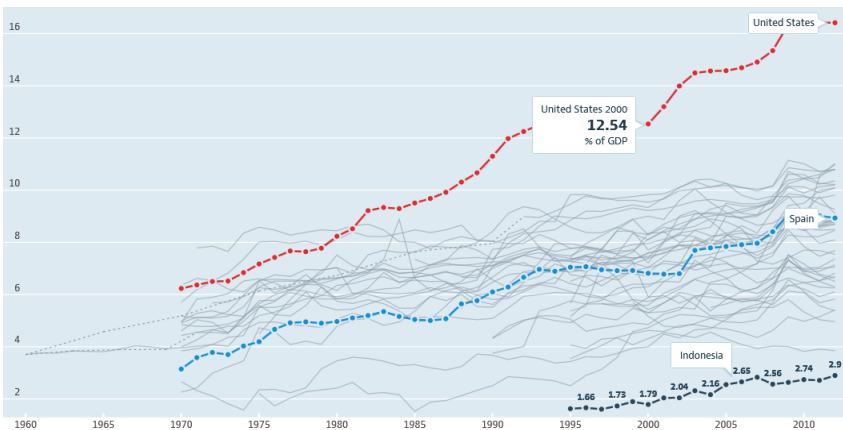

Chart 01 Health Spending Total % of GDP,1960 – 2012[3]
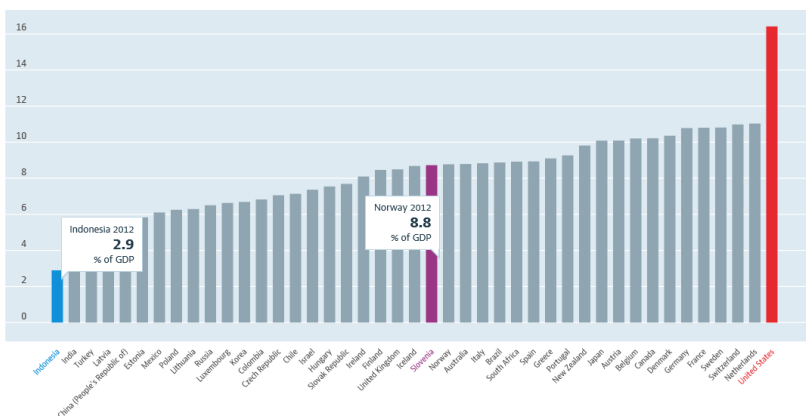**Source: Health expenditure and financing: Health expenditure indicators**

Chart 02 Health Spending Total % of GDP,1960 – 2012[4]
Source: Health expenditure and financing: Health expenditure indicators

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[3] Accessed from https://data.oecd.org/healthres/health-spending.htm on August 17, 2015
[4] Accessed from https://data.oecd.org/healthres/health-spending.htm on August 17, 2015

As a function of access to care, the number of people seeking doctor's consultations has stayed steady or increased, particularly in developing countries. Their stays in hospitals have dramatically decreased over time while discharge rates are continuing to increase. This data suggests that a higher number of patients are seeking care and are being moved through the stages of the healthcare system. This increasing rate of delivery of healthcare services is likely due to improved clinical services and greater illness prevention and wellness initiatives. However, this increase in the flow of patients within the healthcare system creates stress upon the patient care management system. Using redundant and antiquated management systems, healthcare providers must spend more money to keep ahead of the demand in services.
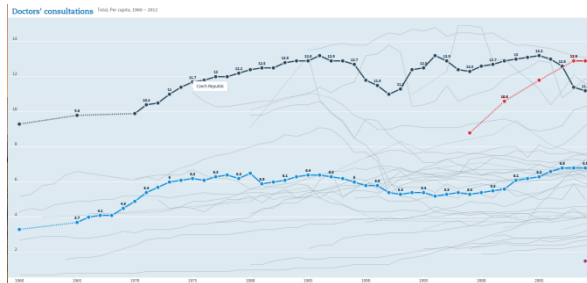

Chart 03 Health Spending Total % of GDP,1960 – 2012[5]
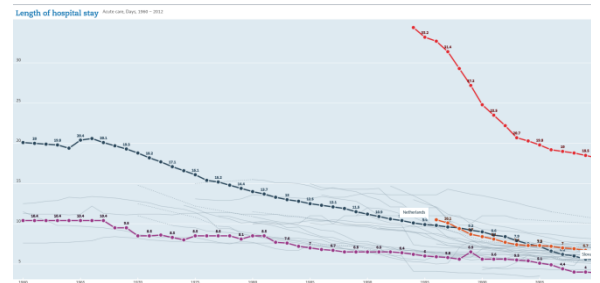**Source: Health expenditure and financing: Health expenditure indicators**

Chart 04 Health Spending Total % of GDP,1960 – 2012[6]
Source: Health expenditure and financing: Health expenditure indicators
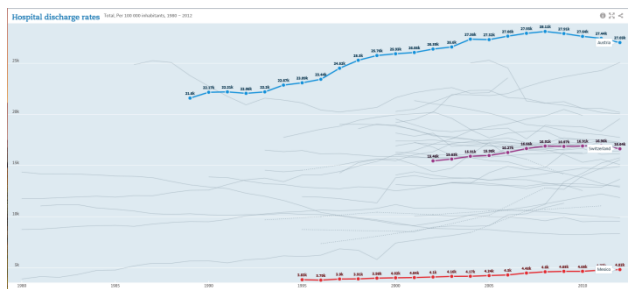

Chart 05 Health Spending Total % of GDP,1960 – 2012[7]
Source: Health expenditure and financing: Health expenditure indicators

Below are nine reasons why UTMB believes the creation of this technical area of work is timely, would be supported by the technical community, and provides significant social and economic benefits to its stakeholders.

Justification 1: Establishing healthcare administrative standards will slow if not reduce the cost of providing healthcare through the widespread adoption of interoperable metrics and practices. Standards in healthcare administration will facilitate the sectors movement from a volume-driven systems to value based, patient centered systems of care while encouraging coordinated healthcare services across entities. The proper application of voluntary standards to an area of management can dramatically reduce the cost of "back office" functions support the organizations principal operations.[8]

For healthcare entities, the most important assets are not the buildings or investment portfolios. Instead it is the workforce — the individuals who directly or indirectly care for patients. The recruitment, management and retention of the hospital workforce have a direct impact on the cost of patient care. The American Hospital Association (AHA) reports that labor costs are the single most important driver of spending growth for hospitals, accounting for about 35 percent of overall growth. Growth in labor costs also accounted for

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[5] Accessed from https://data.oecd.org/healthres/health-spending.htm on August 17, 2015
[6] Accessed from https://data.oecd.org/healthres/health-spending.htm on August 17, 2015
[7] Accessed from https://data.oecd.org/healthres/health-spending.htm on August 17, 2015
[8] http://www.standardsboostbusiness.org/case-cost.aspx

more than half of the growth in the cost of purchased goods and services. Other components included: prescription drugs, 5 percent; professional fees, 5 percent; professional liability insurance, 2 percent; and all others, 18 percent. **All told, the increased cost of these goods and services purchased to provide care represented 64 percent of overall growth in spending on hospital care from 2004 to 2008**. By comparison, rising demand for care (i.e., change in the number of services provided) drove 34 percent of spending growth, while increased intensity of hospital care and other factors accounted for only 2 percent of the increase.[9] The lion's share of cost in the healthcare field is found in management costs. Lowering healthcare operational costs will result in lower insurance premiums. For employers, the reduction in premiums can be translated into more money for growth and expansion of business.

Justification 2: Reducing the cost of healthcare will make these services more affordable and thereby provide an opportunity for greater access to society. The WHO has identified steady increases in the expenditures on healthcare among developing countries. These increases are attributed to population movements to urban centers where a more sedentary lifestyle has increased the risk of heart disease, cancer and other maladies that require longer term care. The WHO estimates that the minimum spending per person per year needed to provide basic, life-saving services is $44 US.[10] Currently there are 34 countries that spend $50 or less per person on healthcare. Among the OCED countries 84% of the world's total financial resources devoted to their healthcare needs while they comprise only 18% of the world's population.[11] Healthcare standardization will relieve cost pressures for developing countries and will offer them the opportunity to spend more of their limited healthcare funds on clinical needs. In the US the Centers for Disease Control (CDC) has reported the result of three National Health Interview surveys that indicate that the cost of healthcare is restricting the access to these services.[12] The table below indicates that the problem is getting progressively worse. Administrative standards that reduce the variety of back office practices and metrics will generate economies of scale and reduce redundancy and waste in classified (non-clinical/ non-revenue generating) activities in healthcare organizations.   The normalization of these practices and metrics should translate into lower costs, improved service cycle time, and greater accessibility by consumers. These standards could dramatically achieve a social good once they bend the cost curve toward greater healthcare access.
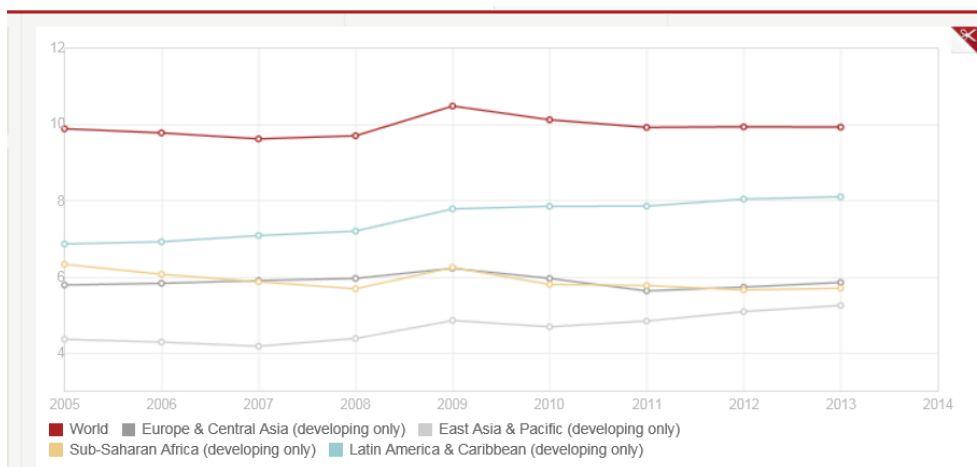

Chart 06: Health expenditure, total (% of GDP)[13]

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[9] http://www.fiercehealthcare.com/story/labor-costs-are-key-driver-hospital-cost-growth/2010-03-15
[10] Accessed from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-7E-4E-ZF-XJ?display=graph on 17 August 2015
[11] Accessed from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-7E-4E-ZF-XJ?display=graph on 17 August 2015
[12] http://www.cdc.gov/nchs/health_policy/reduced_access_due_to_cost.htm
[13] Accessed from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-7E-4E-ZF-XJ?display=graph on 17 August 2015
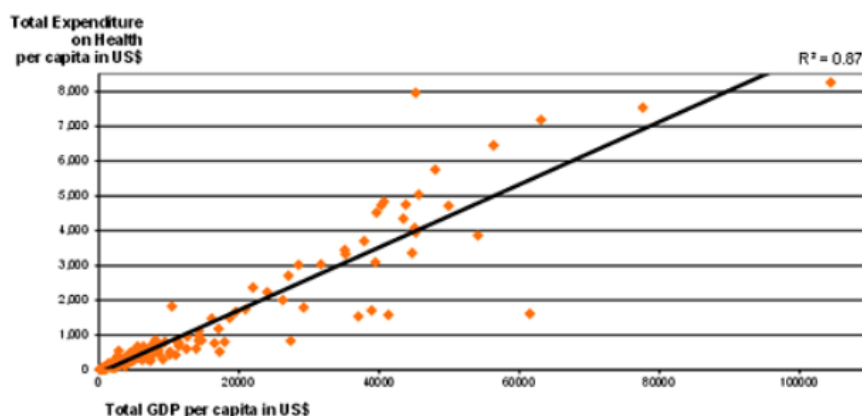
Chart 07: Wealth and health expenditure are correlated (2009) [14]

Reduced access to medical care during the past 12 months due to cost among adults 18-64 years of age: United States, 1997-2007
(Data are based on household interviews of a sample of the civilian noninstitutionalized population)

	Did not get medical care due to cost			Delayed medical care due to cost			Did not get prescription drugs due to cost		
	1997	2006	2007	1997	2006	2007	1997	2006	2007
	Percent								
Total, crude	6.0	7.8	7.8	9.5	10.2	10.3	6.3	9.3	9.6

Justification 3: Improving the administrative and managerial performance of healthcare entities results in better healthcare outcomes for patients. As in other process driven environments, if key lines of service are managed more effectively, the end user will more likely be satisfied with their experience. This appears to be true in healthcare as well. A 2011 study of the nursing staff of Magnet® hospitals shows that "superior work environments and better nurse and patient outcomes in Magnet® recognized hospitals…"[15] Hospitals that follow Magnet® standards also demonstrate "lower surgical mortality and failure to rescue…."[16] A 2013 study found that "improving nurses' work environment and reducing nurses' workload are organization-wide reforms that could result in fewer readmissions for Medicare beneficiaries with common medical conditions.[17] Preventable hospital readmissions are a source of unnecessary costs to Medicare – over $15 billion annually.[18] Another 2013 study found that Registered Nurse "workgroup job satisfaction is significantly and inversely associated with patient falls…."[19] This study again highlights the relationship between effective management practices for clinical staff and better patient outcomes. According to Greta Cummings in a 2011 article in *Perspectives in Nursing Leadership*, "After controlling for patient demographics, co-morbidities and institutional and hospital nursing characteristics, high-resonant

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[14] Accessed from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-7E-4E-ZF-XJ?display=graph on 17 August 2015

[15] Kelly, Lesly A., McHugh, Matthew, Aiken, Linda H. October 2011. "Nurse Outcomes in Magnet® and Non-Magnet Hospitals." *The Journal of Nursing Administration*. Volume 41, Number 10, pp 428-433,

[16] McHugh, Matthew D., Kelly, Lesly A, Smith, Herbert L., Wu, Evan S, Vanak, Jill M. and Aiken, Linda H. Aiken. (2013) "Lower Mortality in Magnet Hospitals." *Medical Care,* 2013;51(5):382-388. Reprinted in JONA • Vol. 43, No. 10, p.387

[17] McHugh, Matthew and Ma, Chenjuan. .January 2013. "Hospital Nursing and 30-Day Readmissions Among Medicare Patients With Heart Failure, Acute Myocardial Infarction, and Pneumonia." *Medical Care*. Volume 51, Number 1. Reprinted in JONA • Vol. 43, No. 10. p. 57

[18] Ibid p. 51

[19] Choi, JiSun Choi and Boyle, Diane K. 2013. "Workgroup Job Satisfaction and Patient Falls in Acute Care Hospital Units." *The Journal of Nursing Administration*. Volume 43, Number 11, pp 586-591, Copyright *B* 2013 Wolters Kluwer Health | Lippincott Williams & Wilkins, p. 590

nursing leadership contributed to lower patient mortality rates at statistically significant levels."[20] Finally and international study of the relationship between patient outcomes and effective staff management found that "deficits in hospital care quality were common in all countries. ***Improvement of hospital work environments might be a relatively low cost strategy*** [Emphasis Added] to improve safety and quality in hospital care and to increase patient satisfaction."[21] Improving patient and staff outcomes could also be enjoyed by not only hospitals, but also other healthcare entities once interoperable healthcare administrative standards are established and adopted. The chart below shows that the "living" year of 59% of the lower income populations is shorter than the living year of upper income populations (8%). We also see that life expectancy is correlated with healthcare expenditures.
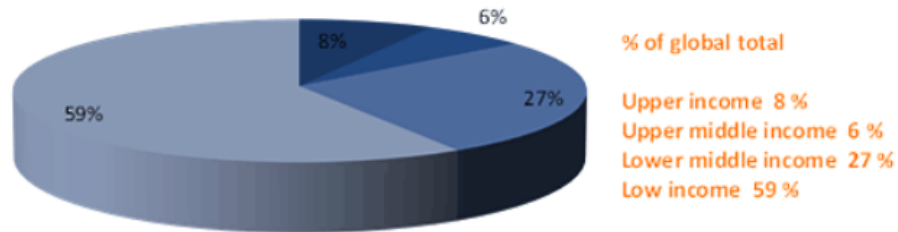
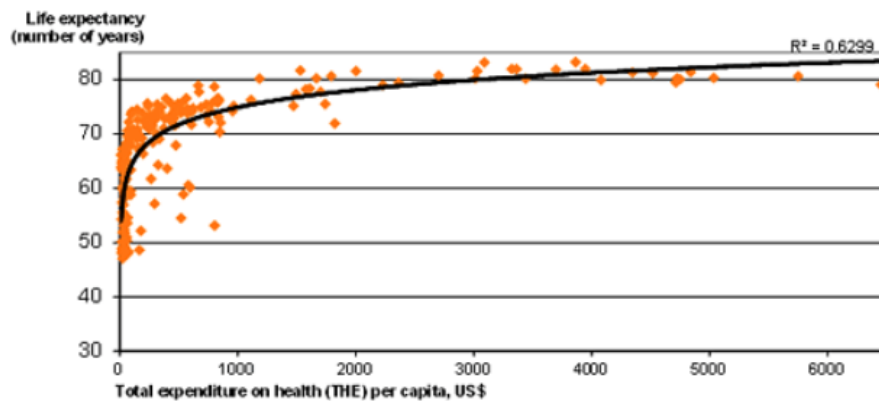**Chart 07: DALYs lost by World Bank income region projected 2005**[22]

Chart 08: Correlation between expenditure on health and outcomes (2009)[23]

Justification 4: Although numerous standards exist for the laboratory protocols, clinical services and patient care functions of healthcare organizations, there are scant standards that address administrative functions or these standards are specific to a particular healthcare entity. The best known organizational standards setting and certifying bodies in healthcare focus their efforts on clinical effectiveness and patient outcomes. Their impact on healthcare resembles the effects that quality and safety standards have on manufacturing and engineering environments. These narrowly focused categories of standards and certifications also tend to serve specific healthcare entities and not others: Magnet® for nursing and hospitals, Joint Commission for hospitals, and CHAP for home health organizations. The UN, though the WHO has standards for leadership, accounting and performance management in healthcare, but most of the non-clinical guidance they give are in guidelines, research, and nonbinding checklists. As healthcare organizations consolidate and acquire different healthcare entities to diversity their service lines, maintaining and integrating the requirements and certifications of these "boutique" standards bodies will be

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[20] Cummings, Greta. June 2011. "The Call for Leadership to Influence Patient Outcomes " *Perspectives in Nursing Leadership*. 24(2) June 2011: 22-25.doi:10.12927/cjnl.2011.22459 http://www.longwoods.com/content/22459

[21] Aiken, Linda H et al.2013. "Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United States." *BMJ* 2012;344:e1717

[22] Accessed from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-7E-4E-ZF-XJ?display=graph on 17 August 2015

[23] Accessed from http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries/1W-7E-4E-ZF-XJ?display=graph on 17 August 2015

problematic. Establishing a new standards setting body that can serve as a "rallying point" for administrative standards seems timely and appropriate.

Justification 5: Standardizing Healthcare administrative metrics will create apple-to-apple comparisons of organizations performance that will better educate consumers and drive process improvement activities. Healthcare entities regularly share metrics with regulators, certifying organizations, patients, and insurers. The most common form these metrics take are:

- Financial- Track overall facility/system financial performance from a business perspective.
- Utilization - Characterize the number/type of basic services rendered and resources used (without regard to cost).
- Cost/Productivity - Principally used by healthcare providers to reduce supply/labor costs and increase productivity.
- Clinical Performance - Characterize the quality of patient care (e.g., mortality); also called "patient outcome" data.
- Patient Safety - Nearly 100,000 Americans die each year from preventable medical mistakes during in-patient hospitalizations (Institute of Medicine, 1999); many more mistakes lead to permanent disabilities and longer recoveries. These metrics characterize preventable medical mistakes that are made.
- Patient Satisfaction - Measure satisfaction from a patient's perspective and are typically based on patient surveys after treatment/release.[24]

Since clinical performance, patient safety, and patient satisfaction are measurements that have for many years determined reimbursements by payers, these metrics are relatively uniform and consistent. However, financial, facility, utilization, cost, labor, and productivity measures are often determined locally, since they are considered the proprietary information each individual healthcare entity. This proprietary view of core administrative metrics curtails their development into generally accepted measurements for data each in the marketplace. Payers, investors, patients, and healthcare entities themselves lose the opportunity to compare performance and pursue evidence-based organizational improvement strategies where the largest cost of the healthcare enterprise resides. Establishing patient focused, industry wide administrative measures and practices in healthcare would provide far ranging benefits for the patient, the healthcare provider, insurance companies, employers, health ministries and other societal stakeholders.

Justification 6: Rural communities and developing countries will have access to effective practices that offer a roadmap to improve their own quality of healthcare services they receive.
Due to the high cost of healthcare services, providers in rural communities and developing countries tend to offer fewer options of often lesser quality in healthcare. The also lack the discretionary resources to hire consultants or purchase off-the-shelf solutions for their administrative and operational challenges. The charts below show that a richer population quintiles of the get a greater share of healthcare spending within the same country than poor quintiles. The second chart shows that poor quintiles tend to use critical services less. The table below shows the access to healthcare based on income levels in the U.S. Percent of poverty level is based on family income and family size and composition using U.S. Census Bureau poverty thresholds. This table reveals the more impoverished a person is, the less likely they are to receive care.

Share of Public Health Spending Received by Poorest and Richest Quintiles, Selected Countries

Country, Year	Poorest quintile	Richest quintile
Jamaica, 1989	30	9
Malaysia, 1989	29	11
Brazil, 1985	17	42
Egypt, 1995	16	24
Vietnam, 1992	12	29
Indonesia, 1989	12	29

Source: W. Hsiao and Y. Liu, "Health Care Financing: Assessing Its Relationship to Health Equity," in *Challenging Inequities in Health: From Ethics to Action*, ed. T. Evans et al. (2001): 271.

Inequalities in the Use of Health Services, 1990–2002

Average ratio of rate in richest quintile to rate in poorest quintile

All recommended childhood immunizations (55 countries)	Professional delivery assistance (55 countries)	Modern contraceptive use, women (49 countries)
2.3	5.2	4.6

Note: Ratios are not adjusted for differences in population size across countries. Countries with indicator values <1 percent were excluded from the calculation so as not to skew the results.
Source: D. Gwatkin et al., *Initial Country-Level Information About Socio-Economic Differences in Health, Nutrition, and Population,* Volumes I and II (November 2003).

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[24] http://www.rwilliford.com/healthcare_metrics.html

Reduced access to medical care during the past 12 months due to cost among adults 18-64 years of age, by percent of poverty level: United States, 1997-2007[25]
(Data are based on household interviews of a sample of the civilian noninstitutionalized population)

Percent of poverty level	Did not get medical care due to cost			Delayed medical care due to cost			Did not get prescription drugs due to cost		
	1997	2006	2007	1997	2006	2007	1997	2006	2007
	Percent								
Below 100%	14.1	16.1	16.1	16.5	17.9	17.9	14.8	19.7	18.8
100%-less than 200%	11.1	14.0	14.3	15.8	16.3	17.0	11.6	16.4	17.2
200%-less than 400%	5.2	7.4	8.3	9.5	10.6	11.4	5.5	8.7	10.6
400% or more	1.6	2.8	2.7	4.2	4.8	4.7	1.7	3.0	3.0

The next table shows that people in communities outside of "metropolitan statistical areas" (MSA) are generally less likely to access care due to cost.

Reduced access to medical care during the past 12 months due to cost among adults 18-64 years of age, by location of residence: United States, 1997-2007[26]
(Data are based on household interviews of a sample of the civilian noninstitutionalized population)

Location of residence	Did not get medical care due to cost			Delayed medical care due to cost			Did not get prescription drugs due to cost		
	1997	2006	2007	1997	2006	2007	1997	2006	2007
	Percent								
Within MSA	5.7	7.3	7.5	9.0	9.8	9.9	5.9	8.9	9.2
Outside MSA	6.9	10.1	9.9	11.3	12.2	12.9	7.9	11.0	11.7

In 2009, patients living in rural areas of the United States were transferred to other facilities for care at a rate three times higher than that of patients in large central metropolitan areas.[27] Healthcare services for Native American communities is uniformly of less quality that their urban counterparts.[28] It is self-evident that actions to improve the performance and keep open healthcare entities in rural communities will improve the patient outcomes in those communities.

Justification 7: Positive support have been received from other standards developers and members of the healthcare technical community. UTMB has reached out to other technical experts to determine if they 1) see a need for these standards and 2) would be willing to participate. We categorize the feedback as follows:

Strong need for the	University of Texas Health System (Six Campuses)

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[25] http://www.cdc.gov/nchs/health_policy/reduced_access_due_to_cost.htm

[26] http://www.cdc.gov/nchs/health_policy/reduced_access_due_to_cost.htm

[27] Kindermann, D; Mutter, R; Pines, JM (February 2006). "Emergency Department Transfers to Acute Care Facilities, 2009: Statistical Brief #155". PMID 24006549

[28] Yvette Roubideaux (2004) "A REVIEW OF THE QUALITY OF HEALTH CARE FOR AMERICAN INDIANS AND ALASKA NATIVES." The Commonwealth Fund.

standards and willingness to participate	Northwestern University, Searle Center on Law, Regulation and Economic Growth Murray State University, Baurenfeind College of Business OrcaEyes Workforce Planning and Analytics (healthcare analytics company) Member countries of ISO TC 260
Intrigued by the idea, would like to study the application before making a decision to participate	American Hospital Association American Dental Association (ANSI ASD) British National Health Service ANSI B11 Standards US Department of Health and Human Services ISO Chartered Institute of Personnel and Development (CIPD) Joint Commission The Walt Disney Foundation The Moody Foundation
Aware but not involved at this time	White House, Washington DC UK National Health Service

Once this application and its procedures have been submitted for review and placement into *Standards Action*, UTMB will reach out to its network of healthcare organization, payers, consultants, and other stakeholders and gather additional information about their support for these standards. UTMB will submit this feedback to ANSI and its members to consider with this application.

Justification 8: Standards will complement standards developing efforts of existing ISO standards developing committees.

- UTMB is eager to work with the American Dental Association to develop joint standards where dentistry practices and metrics overlap with the administrative standards we would develop.
- UTMB will encourage the relevant consensus bodies to adopt existing healthcare standards that are administrative in nature. For example, UTMB would encourage the adoption of the Association of periOperative Registered Nurses' ANSI standard: *AORN Guidance Statement: Perioperative Staffing*, AORN MAN-833-2013
- UTMB would recommend that the consensus body use the existing management system ISO9001 as the way to organize and develop its body of standards, rather than attempt to create a distinct system of standards around healthcare administration.

Justification 9: The healthcare community and its stakeholders are highly receptive to standardization and certification and will adopt approaches from these sources readily.

Unlike other sectors, healthcare entities welcome legitimate standards and certifications. Besides assuring patients that the organization provides the highest levels of care, healthcare entities also use these credentials as marketing tools to entice new healthcare customers and employees. 89.7% of hospitals agreed that the hospital's reputation was influenced by patient experience measures; agreement was 77.4% for mortality, 69.9% for readmission, 76.3% for process measures, 66.1% for cost measures, and 54.0% for volume measures.[29] This high interest in organizational credentialing in the medical field is understandable since there are particular regulatory and policy expectations that staff achieve personal certification in the area of professional specialty.

Prominent Standards Accrediting Organizations in U.S. Healthcare[30]

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Hospitals (see 2004 accreditation criteria), ambulatory care facilities, assisted living facilities, laboratories, long-term care facilities, and others
- Accreditation Association for Ambulatory Health Care: Ambulatory care facilities
- Continuing Care Accreditation Commission

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[29] Lindenauer PK, Lagu T, Ross JS, et al. October 2014. "Attitudes of Hospital Leaders Toward Publicly Reported Measures of Health Care Quality." *JAMA Intern Med.* Published online.. doi:10.1001/jamainternmed.2014.5161.
[30] http://www.rwilliford.com/healthcare_metrics.html

: Nursing homes, assisted living facilities, and retirement communities

- National Committee for Quality Assurance (NCQA): Health plans (e.g., HMOs, PPOs)

A Short list of <u>Commercial</u> Healthcare Metrics Providers[31]

- Solucient: Healthcare provider comparison data/tools
- Ingenix: An Internet subscription service offering healthcare provider comparison data/tools
- Premier: Healthcare provider comparison data/tools
- National Committee for Quality Assurance (NCQA): Health plan provider (e.g., HMO, PPO) comparison data/tools based upon the Health Plan Employer Data and Information Set (HEDIS) measures.
- Truven Health Analytics

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[31] Ibid.