



## NEWS RELEASE

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### **Electronic Patient Referrals a Promising Alternative to Face-to-Face Consultation**

*Article Featured in August 2016 Issue of The Joint Commission Journal on Quality and Patient Safety*

(OAK BROOK, Illinois, July 28, 2016) – [Joint Commission Resources, Inc.](#) today released the August 2016 issue of [The Joint Commission Journal on Quality and Patient Safety](#). The issue features the article, “Minding the Gaps: Assessing Communication Outcomes of Electronic Preconsultation Exchange,” by Erika Leemann Price, MD, MPH, and co-authors, on the development and use of an electronic referral and consultation system at Zuckerberg San Francisco General.

The system, eReferral, was developed in response to the shortcomings of specialty referral systems in primary care, which can lead to missed and delayed diagnoses. It was piloted for the gastroenterology clinic and then rolled out for medical and surgical specialties across the health care system (San Francisco Health Network).

Price et al. evaluated communication and referral outcomes for patients referred to the gastroenterology clinic through eReferral who were not scheduled for in-person visits. Results showed that for 68 percent of referrals reviewed in the study, patients were not ultimately considered to require in-person gastroenterology clinic appointments or were appropriately redirected for scheduling via other routes. About half of these patients (32 percent of all referrals reviewed) were not scheduled because they were resolved via preconsultation exchange. Very few (3 percent) patients received emergency or hospital care while awaiting resolution of gastroenterology referrals.

In an accompanying editorial, “Electronic Referrals: Not Just More Efficient, but Safer, Too,” Christopher Stille, MD, MPH, states that the eReferral system “enables

identification of referrals at risk of being lost to follow-up, something that might be useful even in a nonelectronic referral system. This capability alone could significantly enhance patient safety by triggering enhanced follow-up for those patients.”

The remaining articles from the August 2016 issue are:

### **Global Health**

#### **SafeCare: An Innovative Approach for Improving Quality Through Standards, Benchmarking, and Improvement in Low- and Middle-Income Countries**

*Michael C. Johnson, MSc, MA; Onno Schellekens, MSc; Jacqui Stewart; Paul van Ostenberg, DDS, MS; Tobias Rinke de Wit, PhD; Nicole Spieker, PhD*

SafeCare was created to provide innovative health care standards; surveyor training; a grading system for quality of care; a quality improvement process that is divided into achievable, measurable steps to facilitate incremental improvement; and a private sector–supported health financing model. More than 800 primary and secondary facilities in six sub-Saharan African countries have participated in SafeCare.

### **Accreditation and Certification**

#### **Hospital Disease-Specific Care Certification Programs and Quality of Care: A Narrative Review**

*Eyad Musallam PhD, MSN, RN; Meg Johantgen, PhD, RN; Ingrid Connerney, DrPH, MPH, RN*

Disease-specific care certification (DSCC) was developed to improve the quality and performance of programs or services that may be based within or associated with a hospital or other health care organization. In the first known narrative review on the topic, only six articles were identified that reported empirical data. More research studies are needed to evaluate the effectiveness of DSCC in improving outcomes of care, particularly patient-centered outcome measures.

#### **How Does Disease-Specific Care Certification Affect Quality and How Can We Measure It?**

*David W. Baker, MD, MPH, FACP; Scott Williams, PsyD*

In an accompanying editorial, the authors present a theoretical model to guide research on the association of certification with quality.

### **Performance Improvement**

#### **Implementing Delivery Room Checklists and Communication Standards in a Multi-Neonatal ICU Quality Improvement Collaborative**

*Stacie C. Bennett, MD; Neil Finer, MD; Louis P. Halamek, MD; Nick Mickas, MD; Mihoko V. Bennett, PhD; Courtney C. Nisbet, RN, MS; Paul J. Sharek, MD, MPH*

To promote optimal communication during active neonatal resuscitation, the Readiness Bundle (RB) was integrated within the larger change package deployed in the California Perinatal Quality Care Collaborative's 12-month Delivery Room Management Quality Improvement Collaborative, in which 24 neonatal ICUs participated. The RB consisted of (1) a checklist for high-risk neonatal resuscitations and (2) briefings and debriefings to improve teamwork and communication in the delivery room. The RB was rapidly adopted, with compliance sustained for 6 months after completion of the collaborative. Inclusion of the RB in the next generation of the Neonatal Resuscitation Program guidelines is encouraged.

### **Safety Culture**

#### **Patient Safety Culture and the Second Victim Phenomenon: Connecting Culture to Staff Distress in Nurses**

*Rebecca R. Quillivan, MS; Jonathan D. Burlison, PhD; Emily K. Browne, DNP; Susan D. Scott, PhD, RN; James M. Hoffman, PharmD*

In a cross-sectional survey study, 169 (47.2 percent) of 358 nurses at a specialized pediatric hospital completed two surveys—one on patient safety culture and the other on second victim experience and support. The dimension *nonpunitive response to error* was significantly associated with reductions in the dimensions *psychological*, *physical* and *professional distress* ( $p < 0.001$ ). Reducing punitive response to error and encouraging supportive coworker, supervisor and institutional interactions may be useful strategies to manage the severity of second victim experiences.

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