Joint Commission Accreditation: Helping to Improve Health Care Organizations’ Quality and Safety

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The Joint Commission
Illinois Association for Healthcare Quality
April 23, 2010
The Joint Commission’s Vision

“All people always experience the safest, highest quality best-value health care across all settings”

The Joint Commission’s Mission

To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.
Don’t Just Talk the Talk

by Nicole Adrian, contributing editor

The Joint Commission tackles its own processes with lean and Six Sigma

In 50 Words Or Less

- The Joint Commission recently looked inward to improve processes and customer service.
- The improvement process started with five into one projects and a green and black belt training program.
- The organization understands the importance of applying tools and ideas in house that it promotes externally.

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Recent Efforts

- Received deeming authority from the CMS
  - Hospitals
  - Critical Access Hospitals
  - Ambulatory Surgery Centers

- Refined The Joint Commission mission statement
  - *Evaluating and inspiring*

- Continual evolution of Joint Commission’s culture
  - Adoption of Lean, Six Sigma, and change acceleration processes
  - Focus on customer service and “common sense”
  - Simplification of processes
  - A re-focus on the value of Joint Commission accreditation and the “Voice of the Customer”
Recent Efforts

- Implemented Robust Process Improvement (RPI) throughout the enterprise
  - Consistency of Standards Interpretation (COSI)
  - Posted survey reports within 10 days of survey
- Enhanced customer services and communication
  - Customer Value Assessment Survey
  - Customer Feedback Database
- Implemented a methodology to award accreditation decisions based on “criticality” of the issue to patient care and safety, manner and degree rather than on a “threshold”
- Launched “BoosterPaks” for the most complex standards
Recent Efforts

- Evaluated, and processing revisions, to challenging Joint Commission requirements
  - Staffing Effectiveness
  - Medication Reconciliation
  - Universal Protocol
  - Critical Results
- Implemented a Leading Practices Database
- Introduced 2nd Generation Tracer Methodology
- Launched the Center for Transforming Healthcare to provide solutions to challenging patient safety problems
## Recent Efforts Addressing Challenging Standards/NPSGs

<table>
<thead>
<tr>
<th>Standard/NPSG</th>
<th>Status</th>
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<tbody>
<tr>
<td>MS.01.01.01 (formerly MS.1.20)</td>
<td>- In 11/09, The Joint Commission Board of Commissioners authorized a formal field review based on the recommendations of the Task Force</td>
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<td></td>
<td>- Results of the field review presented to the Board of Commissioners in March, 2010 and approved for implementation in March 2011</td>
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| Medication Reconciliation        | - Still under evaluation  
|                                  | - Survey findings on NPSG.8 will continue not to factored into an organization’s accreditation decision                               |
| Universal Protocol               | - Beginning 1/10, new requirements affecting pre-procedure verification (UP.01.01.01, EPs 1 & 2), site-marking (UP.01.02.01, EPs 1, 2, 3, & 7)  |
|                                  | - and time-out (UP.01.03.01, EPs 1, 5 & 6)  
|                                  | - New requirements focus on the original intent of the UP, making sure the correct patient, correct procedure and correct site are involved |
| Staffing Effectiveness           | - Beginning 7/10 new interim requirements at PI.02.01.01, EPs 12, 13 & 14 and LD.04.04.05, EP 13 will be effect until more extensive research is completed |
| Hand Hygiene                     | - Focus is now on performance improvement: the organization has a hand hygiene program based on either CDC or WHO guidelines              |
What do you need to know about Joint Commission’s new hospital deeming authority?

- It’s effective for a four-year period beginning July 15, 2010
- All CMS CoPs have been cross-walked to Joint Commission standards and EPs
  - E-dition identifies the cross-walk
- CMS defines a “hospital” in terms of a CMS Certification Number (CCN)
- All hospitals are required to be accredited in accordance with their (CCN)
  - There needs to be a one-to-one match between a hospital CCN and a Joint Commission’s accreditation decision
What do you need to know about Joint Commission’s new hospital deeming authority?

- Each hospital must be able to demonstrate compliance with the CoPs independent of any other hospital.
- All condition-level findings will require a follow-up survey.
- A conditional-level finding does not mean that the hospital is in conditional accreditation.
Joint Commission Standards and Federal Requirements: A Similar Structure

<table>
<thead>
<tr>
<th>The Joint Commission</th>
<th>Federal Requirement</th>
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<tbody>
<tr>
<td>Standard</td>
<td>Condition</td>
</tr>
<tr>
<td>Element of Performance</td>
<td>Standard</td>
</tr>
<tr>
<td>Element of Performance</td>
<td>Standard</td>
</tr>
</tbody>
</table>
Crosswalk Example:

Joint Commission Requirements

LD.04.03.01, EP 2
RC.01.01.01, EP 1
RC.01.01.01, EP 7
NR.02.03.01, EP 4

Medicare Requirements

§482.24
Condition of Participation: Medical Record Services
A-TAG: A-0431

§482.23
Condition of Participation: Nursing Services
A-TAG: A-0385
Current State

Core Services:
- Survey
- Dedicated Account Rep
- PPR Options
- S3
- E-dition
- Perspectives

Outcome = Successful Survey

Desired State

Objective and Rigorous Evaluation + Enhanced Core Services

Continuous Touch-Points
- Customer Value Assessment
- Mentoring/Education
- Merger/Acquisition Support
- Adverse Event Management

Leading Practices
- CFTHC knowledge

Segment-Specific Standards
- Composite Performance Measure
- Enhanced S3

Outcome = Patient Care Improvement

Transformational Shift:
Change Focus of Activities from Survey Success to Continuous Patient Care Improvement
Standards Renewal Project

Purpose:

– To assess the value of hospital standards so that the “high-value” standards (those related to patient safety and quality of care) are retained and “low-value” standards are eliminated

– Definition of “high-value”
  – Strong evidence-based or “iron-clad” rationale/expert consensus
  – Impacts quality or safety
  – Leads to improved outcomes
Principles For Standards Development

1. Relates to Quality of Care and/or Safety
   - YES: Has a Positive Impact on Outcomes
   - NO: Standard is NOT Developed

2. YES: Has Value & a ROI In Quality & Patient Safety
   - YES: Can be measured/surveyed
   - NO: Standard is NOT Developed

Standard IS Developed
Tracer Exploration Domains

- Natural Exploration
  - A process that any trained clinical will use to begin to understand the care situation that they are encountering

- Focused Exploration
  - Specific to the Joint Commission, the use of algorithmic information from Priority Focus Process to initially focus the tracers

- Refined Exploration
  - Most important feature, a trained surveyor will begin to process all of the above information and develop specific concepts to review during tracer activity

- Detailed Exploration
  - A process of looking intensely at a specific area and at associated areas to determine compliance, (i.e. drilling down)
2nd Generation Tracer

Risk Process:
- Patient Flow

Risk Process:
- CDS

Unit of Care

Emergency

Surgery

ICU

RN

MR

MD

Environment of Care

Future
Features of the Customer Value Assessment Survey

- On an annual basis, accredited organizations will be asked to identify up to five expectations for Joint Commission’s accreditation
  - The organization will be asked to weigh the importance of each expectation
- This information will be provided to the surveyors before a full survey
- After the survey, the organization will be asked to evaluate whether their expectations were met
Uniform Criteria

Throughout the accreditation process, Joint Commission provides consistent and clear responses to questions, including those related to standard interpretations.

Joint Commission’s accreditation process demonstrates a collaborative approach.
## Selection Criteria

1. Throughout the accreditation process, The Joint Commission (TJC) provides consistent and clear responses to questions, including those related to standards inquiries.

2. The accreditation process and standards interpretation demonstrate a collaborative approach.

3. The Joint Commission standards address patient safety and quality of care.

4. The Joint Commission helps you to improve the care you provide to your patients.

5. The Joint Commission’s survey process is comprehensive.

6. The Joint Commission’s survey process is patient-focused.

7. The Joint Commission accreditation process addresses systems and processes of care.

8. The Joint Commission accreditation process helps to identify risk points in the delivery of care.

9. The Joint Commission provides helpful education and assistance.

10. The surveyors were knowledgeable.

11. The surveyors acted professionally.

12. My account representative is knowledgeable and able to answer my questions.

13. The pre-survey process was efficient.

14. The scheduling process was appropriate (if applicable).

15. The survey report reflected what was communicated to us during the survey prior to the exit conference.

16. The post-survey process was appropriate, clear and timely.

17. The Joint Commission’s accreditation services provide value to our leadership.

18. Joint Commission helps organizations advocate for important areas in the delivery of health care.
Leading Practices Database

First Phase: January 2010

Provide surveyors with examples of patient care and safety practices to provide to health care organizations

- Surveyors will help to populate the database

Second Phase: Summer/Fall 2010

Accredited health care organizations will have access to the database at no charge
Leading Practices Database

<table>
<thead>
<tr>
<th>Leading Practices Database</th>
<th>Folders</th>
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<tbody>
<tr>
<td>- Approved by SIG-West</td>
<td>- In SIG Review</td>
</tr>
<tr>
<td>- Pending SIG Review</td>
<td>- Reference Materials</td>
</tr>
<tr>
<td>- Ambulatory Care</td>
<td>- Behavioral Health Care</td>
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<tr>
<td>- Disease-Specific Care</td>
<td>- Disease-Specific Care</td>
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<tr>
<td>- Health Care Staffing</td>
<td>- Home Care</td>
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<tr>
<td>- Home Care</td>
<td>- Hospital</td>
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<tr>
<td>- Laboratory</td>
<td>- Laboratory</td>
</tr>
<tr>
<td>- Long Term Care</td>
<td>- Long Term Care</td>
</tr>
</tbody>
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The Joint Commission
“BoosterPaks” for Complex Standards

Contents
A. Description of Standard and Implementation Expectations
   - Section A1 Standard Rationale, EPs, scoring categories, examples of implementation expectations and tips for implementation
   - Section A2 Information about how The Joint Commission assesses compliance with the standard

B. Frequently-asked Questions, Definitions and Additional Information about Specific Topics
   - Section B1 Frequently-asked questions (FAQs)
   - Section B2 Definitions of key terms
   - Section B3 Additional information on specific topics

C. Supporting Documentation, Evidence, Value, Historical Information and Additional References and Links
   - Section C1 CMS tags, evidence-base, development process and section
   - Section C2 Field testing, value, relationship to measures and other initiatives
   - Section C3 Historical information including date first implemented, changes over time, crosswalk 2009 to 2008 EPs
   - Section C4 Additional references and links to related sites
Standards *BoosterPaks*

- MM.03.01.01—Safely storing medications (*Developed*)
- MS.08.01.03—Ongoing Professional Practice Evaluation (*In development*)
- MS.08.01.01—Focused Professional Practice Evaluation (*In development*)
- NP.15.01.01—Identifying patients at risk for suicide (*In development*)
And, what’s on the horizon?

- Further enhancement of the 2nd generation tracer process
- Further population of the Leading Practice Database
- A more “relationship-based” accreditation model
- A re-focused intracycle monitoring process
- Completion of the standards renewal process
- Integrating accountability measures into standards
- A revised approach to “near misses” and sentinel events
- Development of an evaluation capability for emerging health care delivery models
- Additional solutions from The Center for Transforming Healthcare
A Framework for Patient Safety

High-Reliability Organizations

Resilience Engineering

People

Process & Workflow

Technology

Facilities

Culture of Safety

Performance Measurement/Management

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Top Ten Factors Identified for Sentinel Events Reported in 2009

- Leadership: 67.9%
- Human Factors: 64.8%
- Communication: 64.4%
- Assessment: 58.8%
- Information Management: 23.7%
- Physical Environment: 23.7%
- Care Planning: 14.3%
- Operative Care: 13.2%
- Continuum of Care: 10.5%
- Medication Use: 8.1%

% of 577 Incidents
The Principles of Error Management

- Errors are consequences rather than causes
- Many errors fall into recurrent patterns
- Safety-significant errors can occur at all levels
- Error management is about managing the manageable
- Error management is about making good people excellent
- There is no one best way
- Effective management is achieved through continuous improvement
The Principles of Error Management

- Human error is both universal and inevitable
- Errors are not intrinsically bad
- One cannot change the human condition, but you can change the conditions in which humans work
- The best people can make the worst mistakes
- People cannot easily avoid those actions that are unintentional
“…there are many good reasons to think of safety as the presence, rather than the absence of something. We should therefore look or indicators that somehow represent this presence and that reach a higher value as safety improves.”

In Resilience Engineering Perspectives, Vol.1: Remaining Sensitive in the Possibility of Failure, 2008
Required Qualities of a Resilient System

ANTICIPATION
Knowing what to expect

ATTENTION
Knowing what to look for

RESPONSE
Knowing what to do

Competence

Resources

Knowledge

Time

Updating

Learning

“A different type of accountability [is needed], one that requires an employee to raise her hand in the interest of safety. Not reporting your error, preventing the system and others from learning – this is the greatest evil of all.”

David Marx, JD
2001
Patient Safety and the “Just Culture”
The Three Imperatives of a Patient Safety Culture

- Improve
- Report
- Trust
The Three Groups that will Drive a Hospital Patient Safety Culture

- Medical Staff
- Governance
- Hospital Leadership
Do Hospitals Board Value Clinical Quality?

- Half of the board chairs for the nation’s nonprofit hospitals did not rank clinical quality as one of their two highest priorities.

- Interestingly, chairs of the boards that did prioritize quality as a top concern govern hospitals that performed better on national Hospital Quality Alliance (HQA) measurements than those who did not.

- Nearly three-fourths of board chairs of all hospitals reported that their boards have moderate or substantial expertise in quality of care.

*Health Leaders Survey, 11/9/09*
Do Hospitals Board Value Clinical Quality?

- Only 20% of board chairs reported that the board chair, the board itself or one of the board committees, was one of the two most influential quality forces at the hospital.

- More than two-thirds of board chairs reported being somewhat or very familiar with Joint Commission core measures or with HQA measures.

- Quality performance was on the agenda at every board meeting in 63% of U.S. hospitals, whereas financial performance was on the agenda in 93% of the board meetings.

*Health Leaders Survey, 11/9/09*
Supporting A Culture of Accountability

- Responsible performance expectations
  - Applied fairly, expectations similar for all
  - Appropriate carrots and sticks used to drive system toward excellence

- “No-blame” is the dominant front-line culture
  - For innocent slips and mistakes

- Clear demarcation of blameworthy acts
  - Individual, managerial, and organizational
    - Examples are gross incompetence, failure to heed reasonable safety/quality rules, disruptive behavior
Example: Commitment to Patient Safety
Principles

- First and foremost, we strive to deliver ever safer and more effective care
- We support the efforts of every member of the healthcare team to deliver the best care possible
- We promote open discussion within our organizations to learn about adverse events and potential causes of patient harm
- We will promote interdisciplinary discussion and the analysis of adverse events and potential patient harm
- We will inform patients and family members, healthcare providers, leadership and trustees about actions that have been taken to improve patient safety
- We will measure our success in promoting and environment of patient safety

Source: Partners Healthcare and the Dana Farber Cancer Institute Commitment to Patient Safety (adapted from Frankel, Gandhi, and Bates 2003), cited in Frankel et al., Health Research Education Trust, 2006
How to Curb Behaviors Which Can Disrupt a Culture of Safety: Pragmatic Suggestions

Create awareness of potential behavior issues so people aren’t afraid to talk about them or report problems

Put a system in place for filing complaints and allow for due process

Obtain medical staff and leadership support for policies

Institute educational, training and counseling programs

Intervene early, but use punitive measures as a last resort
Joint Commission September 2009 Alert on Leadership and Safety

- Urges health care leaders to step up efforts to prevent errors by taking the zero-defect approach used in other high-risk industries, such as aviation and nuclear energy.
- Recommends that the governing body, chief executive officer, senior managers and medical staff leaders at health care organizations take a series of 14 specific steps, including
Joint Commission September 2009 Alert on Leadership and Safety

- Define and establish an organization-wide culture that includes a code of conduct for all employees
- Institute an organization-wide policy of transparency that sheds lights on all adverse events and patient safety issues
- Make the organization’s overall safety performance a key, measurable part of the evaluation of the CEO and all leadership
- Ensure that all caregivers involved in adverse events that result in unintentional patient harm receive attention that is just, respectful, compassionate, supportive, and timely
Joint Commission September 2009 Alert on Leadership and Safety

- Create and communicate a policy that defines behaviors that are to be referred for disciplinary action and a timeframe for that action to take place
- Add a human element to safety improvement by having patients communicate their experiences and perceptions to leadership
- Reward and recognize staff whose efforts contribute to safety
Joint Commission Center for Transforming Healthcare

Bringing the Leading Health Care Organizations Together to Solve Challenging Health Care Problems

Cedars-Sinai Health System
Exempla Healthcare
Froedtert Hospital
Memorial Hermann Healthcare System
The Johns Hopkins Hospital and Health System
Trinity Health
Virtua
Wake Forest University Baptist Medical Center

Fairview Health Services
Intermountain Healthcare
Kaiser Permanente
Mayo Clinic
New York-Presbyterian Hospital
North Shore-Long Island Jewish Health System
Partners HealthCare System
Stanford Hospital & Clinics
Rhode Island Hospital
Newport Hospital

How Will We Get There?
Change Management • Lean Six Sigma • High Reliability

The Roadmap to Developing Solutions

• Measureable Success
• Targeted Solutions
• Industry Engagement
• Sustainability
The Center’s First Patient Safety Challenge

Eight leading hospitals and health systems volunteered to address hand washing failures as the Center’s first project:

- Cedars-Sinai Health System – Los Angeles, CA
- Exempla Lutheran Medical Center – Denver, CO
- Froedtert Hospital – Milwaukee, WI
- The Johns Hopkins Hospital and Health System – Baltimore, MD
- Memorial Hermann Health Care System – Houston, TX
- Trinity Health – Novi, MI
- Virtua – Marlton, NJ
- Wake Forest University Baptist Medical Center – Winston-Salem, NC
Why Hand Hygiene?

In the United States, one in 136 hospital patients become seriously ill as a result of acquiring an infection in the hospital. This is equivalent to two million cases a year.

And the costs.....“the overall annual direct medical costs of HAI to U.S. hospitals ranges from $28.4 to $45 billion.. the benefits of prevention range from a low of $5.7 to $6.8 billion to a high of $25.0 to $31.5 billion.”

R. Douglas Scott II, Economist, Division of Healthcare Quality Promotion, CDC, March 2009

“Every day, 247 people die in the USA as a result of a health care-associated infection.”
This is equivalent to a 767 aircraft crashing every day or more than 90,000 deaths annually.”

WHO Guidelines on Hand Hygiene in Health Care

World Health Organization

SAVE LIVES: Clean Your Hands

World Health Organization is the primary measure to reduce health care-associated infection

Launched 5 May 2009, the SAVE LIVES: Clean Your Hands initiative aims to support health-care workers to improve hand hygiene and stop the spread of infection.

Health Care Associated Infections (HAI) affect hundreds of millions of people worldwide and are a major global issue for patient safety.

“Yet hand hygiene improvement is not a new concept… long lasting improvements remain difficult to sustain……”

WHO, Guide to Implementation of the WHO Multimodal Hand Hygiene Improvement Strategy
Findings

- The Center’s initial work demonstrated that random observation is an unreliable measure of compliance.
- It is believed that the high compliance rate that many hospitals are reporting is probably not accurate.
- In aggregate, these eight hospitals identified that staff wash their hands less than 50 percent of the time.
- A recent survey of America’s hospitals found that nearly 87 percent were not following recommended guidelines to prevent many of the most common HAIs.
Main Causes of Failure to Clean Hands (across all participating hospitals)

- Ineffective placement of dispensers or sinks
- Hand hygiene compliance data are not collected or reported accurately or frequently
- Lack of accountability and just-in-time coaching
- Safety culture does not stress hand hygiene at all levels
- Ineffective or insufficient education
- Hands full
- Wearing gloves interferes with process
- Perception that hand hygiene is not needed if wearing gloves
- Health care workers forget
- Distractions

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.
Identifying Causes, Targeting Solutions

**Causes**

- Hand Hygiene compliance data are not collected or reported accurately or frequently
- Safety culture does not stress hand hygiene at all levels
- Ineffective placement of dispensers or sinks
- Hands full

**Solutions**

- Data provide a framework for a systematic approach for improvement
- Utilize a sound measurement system to determine the real score in real time
- Scrutinize and question the data
- Measure the specific, high-impact causes of hand hygiene failures in your facility and target solutions to those causes

- Make washing hands a habit – as automatic as looking both ways when you cross the street or fastening your seat belt when you get in your car
- Commitment of leadership to achieve hand hygiene compliance of 90+ percent
- Serve as a role model by practicing proper hand hygiene
- Hold everyone accountable and responsible – doctors, nurses, food service staff, housekeepers, chaplains, technicians, therapists

- Provide easy access to hand hygiene equipment and dispensers
- Create a place for everything: for example, a health care worker with full hands needs a dedicated space where he or she can place items while washing hands
Hand Hygiene Measures: Expectations vs. Reality; Solutions Impact

Hand Hygiene Compliance (Aggregated)

Achieving 50% Breakthrough and Continuing Trend

Hand hygiene compliance improvement in pilot sites

Similar findings from WHO Pilots

Joint Commission Center for Transforming Healthcare
How to Sustain Improvement

Managing change is integral and must be explicitly included in improvement

\[ E = Q \times A_1 \times A_2 \]

Effectiveness (E) =
Technical quality (Q) x
Acceptance (A_1) x
Accountability (A_2)
Second Center Project

The Center’s second project will target breakdowns in hand-off communications – the transfer and acceptance of patient care responsibilities achieved through effective communication.

The hand-off communications project involves safety experts and several leading hospitals:

- Exempla Lutheran Medical Center
- Fairview Health Services
- Intermountain Healthcare
- The Johns Hopkins Hospital and Health System
- Kaiser Permanente
- Mayo Clinic
- New York-Presbyterian Hospital
- North Shore-Long Island Jewish Health System
- Partners HealthCare System
- Stanford Hospital & Clinics
Other Center Projects

The Rhode Island Universal Protocol Project includes Newport Hospital and Rhode Island Hospital – both from the Lifespan system:

- Project aims to improve safeguards to prevent patients from wrong site, wrong side and wrong patient surgical procedures
- Project includes all procedures performed in an operating room commencing with scheduling a surgical procedure and ending with confirmation that the intended operation was performed
- Solutions for this project are targeted for publication in June 2010

Future projects will focus on improving other aspects of infection control, mix-ups in patient identification and medication errors
The Joint Commission’s Vision

“All people always experience the safest, highest quality best-value health care across all settings”