The Future of The Joint Commission
Standards and Survey Process

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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.
**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
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 intake 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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Implemented Recent Improvements

- Accreditation decision focused on compliance with Direct Impact Standards (Criticality)
- Developed evidence-based criteria for new standard development
- S3 for clinical risk identification enhanced
- “Uncoupled” linear impact of other programs and hospital adverse decisions
- “Observed but corrected during survey” procedure implemented
- Electronic standards manual (allows text search)

- Enhanced customer service and communication
  - Training for surveyors, SIG and account representatives
  - Customer Value Assessment Survey
  - Team leader training
- Account representatives assigned by program
- Posted reports within 10 days of a survey
- Suspended scoring on difficult standards/NPSGs
- Began standards “renewal” project
Post Survey

Current State Map of TAT for

VOC = E10

= WAIT

Field Rep

= REWORK

= PROCESS STEP

Process begins at end of
Post Survey

Revised Current State Map of TA

Field Rep

VOC = FQN

= WAIT

Process begins at end of survey (EOS) – field rep provides findings to
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

- Relates to Quality of Care and/or Safety
- Has a Positive Impact on Outcomes
- Has Value & a ROI In Quality & Patient Safety
- Can be measured/surveyed

Standard IS Developed

Standard is NOT Developed

Standard is NOT Developed

Standard is NOT Developed
“Standards Booster” for Challenging 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
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 2010
Accredited health care organizations will have access to the database at no charge
Leading Practices Database
Planned Current and Future Enhancements: Examples

- Relationship accreditation model
- E-application simplification
- Intra-cycle monitoring (PPR)
- Second generation tracers
- Revisions to the *Sentinel Event Policy* and processes
Supporting Health Systems’ Focus on Quality and Patient Safety
Participating Hospitals

- Cedars-Sinai
- Exempla
- Fairview
- Froedtert
- Hopkins
- Intermountain
- Kaiser-Permanente
- Mayo
- Memorial Hermann
- NY-Presbyterian
- North Carolina Baptist
- North Shore-LIJ
- Partners
- Stanford
- Trinity
- Virtua
Main Causes of Failure to Clean Hands (across all participating hospitals)

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

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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.
Effective Hygiene is in Our HANDS

**Habit**
- Always wash in and wash out upon entering/exiting a patient care area and before and after patient care
- 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

**Active Feedback**
- Coach and intervene to remind staff to wash hands
- Clearly state expectations about when to sanitize hands to all staff members
- Communicate frequently – provide visible reminders and ongoing coaching to reinforce effective hand hygiene expectations
- Engage staff – real time performance feedback
- Tailor education in proper hand hygiene for specific disciplines
- Provide just-in-time training
- Use technology-based reminders and real time feedback
- Celebrate improved hand hygiene

**No One Excused**
- Protect the patient and the environment – everyone must wash in and wash out
- Make it comfortable to wash hands with soap or use waterless hand sanitizer
- Identify proper hand hygiene as an organizational priority and performance expectation
- Hold everyone accountable and responsible – doctors, nurses, food service staff, housekeepers, chaplains, technicians, therapists
- Apply progressive discipline from the top – managers must hold everyone accountable for proper hand washing
- Commitment of leadership to achieve hand hygiene compliance of 90+ percent
- Serve as a role model by practicing proper hand hygiene

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

**Systems**
- Focus on the system, not just on people
- Make it easy; examine work flow of health care workers to ensure ease of washing hands:
  - Provide easy access of 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
- Limit entries and exits from a patient’s room – make supplies available in room and eliminate false alarms that require staff to leave room to turn alarm off
- Identify new technologies to make it easy for staff to remember to wash hands, i.e. radio frequency identification, automatic reminders, warning systems, real time scoring
Performance Measures: Rapid Improvement

In 2000, few measures, no national data collection or reporting

- No real-world experience
- Resistance among hospitals

Today---all that has changed

In a very short time, hospitals have made major progress toward establishing consistent excellence
Joint Commission Accreditation Does Make A Difference

AMI: Aspirin at discharge

HF: LVF assessment

PN: Antibiotic selection - Non ICU

TJC Accred

- Yes
- No
Hospital Performance on Accountability Core Measures

Percent of Hospitals Over 90% Performance

- Percent >90%
- Median # Measures

Median # Measures per Hospital

2002 2003 2004 2005 2006 2007 2008

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Key Findings from The Joint Commission’s 2009 Annual Report on Quality and Safety

- Hospitals accredited by The Joint Commission have significantly improved the quality of care provided to heart attack, heart failure and pneumonia patients over a seven-year period
  - The 2008 heart attack composite care result is 96.7%, which compares favorably to 86.9% in 2002
  - These hospitals provided evidence-based treatment 967 times for every 1,000 opportunities
  - The 2008 heart failure composite care result is 91.6%, an improvement of 31.9 percentage points over the 59.7% in 2002
  - The 2008 pneumonia composite care results is 92.9%, an improvement of 20.6 percentage points over the 72.3% in 2002

- Hospital performance on two individual measures of quality relating to inpatient care for childhood asthma is excellent after only one year of measurement.
Key Findings from The Joint Commission’s 2009 Annual Report on Quality and Safety (cont’d.)

But we can do better:
- While hospitals averaged 90% or better performance on most individual quality measures, more improvement is needed
  - 52.4% performance on providing fibrinolytic therapy within 30 minutes of arrival to heart attack patients
  - 60.3% performance on providing antibiotics to intensive care unit pneumonia patients within 24 hours of arrival

Where a patient receives care makes a difference
- Not all hospitals deliver the same level of quality
- Some hospitals perform better than others in treating particular conditions and in achieving patient satisfaction
Because of Correlation Between Clinical Quality Risk Management and Consumer Satisfaction

In December 2008, The Joint Commission performed a study to compare performance on CMS’ Hospital Consumer Assessment of Healthcare Providers (HCAHPs) data versus performance in S3 for Joint Commission accredited organizations.

There was a statistically significant difference between performance on the HCAHPs measures between the top decile of performers on Priority Focus Process point totals (an output of S3) and the bottom decile of performers on PFP point totals.

- Organizations whose S3 data suggested the most risk had poorer results on their HCAHPs measures.
- Organizations whose S3 data suggested the least risk had better results on their HCAHPs measures.
Hospital Patient Safety: Characteristics of Best-Performing Hospitals

Daniel R. Longo, Sc.D., professor, Department of Family Medicine, Virginia Commonwealth University School of Medicine, Richmond; John E. Hewett, Ph.D., professor

We found that, for both univariate and multivariate analyses, Joint Commission accreditation was uniformly, strongly, and consistently associated with more extensive implementation of patient safety systems, both at specific points in time and with respect to change over time. Accreditation status was the only organizational characteristic that consistently emerged in identifying which hospitals have more extensively implemented patient safety systems. Using the summary measure, we found that accredited hospitals had statistically significant improvement (p = .01), while nonaccredited hospitals did not (p = .21).
Comparing The Joint Commission Accreditation and State Certification

**The Joint Commission Accreditation**
- Collaborates with health care organizations to provide safe, quality care
- Focuses on patient safety and quality improvement
- Uses leading health care practices standards and National Patient Safety Goals
- Employs experienced health care professionals who must pass a certification exam and continuing education
- Offers a patient-centered and process-focus evaluation which uses a “tracer methodology” to follow and evaluate the quality of a patient’s health care experiences as a cornerstone of its on-site survey

**State Certification**
- Focuses on compliance with regulations only
- Uses a variable, episodic inspection approach which focuses on documentation requirements, rather than continuous quality improvement
- Does not evaluate the performance of health care organizations against current health care practice
Comparing The Joint Commission and State Certification (cont’d.)

The Joint Commission
- Provides an objective, “open-book” decision methodology
- Provides on-going support to health care organizations; e.g.,
  - Account Executive
  - SIG support
  - Patient safety information (Booster Paks leading practice database)
  - S3 and life safety services
- Advocates on behalf of the American public and influences national health care policy
- Is recognized by various payors and for
- Helps manage risk associated with prevention of adverse events and quality lapses

State Certification
Recent Customer Comments

“We are endeavoring to establish The Joint Commission brand as a proxy for patient safety. This survey experience demonstrated vividly how this can be done. The focus [of the survey] was always on making the hospital safer for patients. We are charged up to get even better after this survey.”

CEO, large southern hospital
The Next Generation of The Joint Commission

1. Provide help on the “How” – clear actionable information about proven, successful interventions that address weak “defenses” commonly involved in adverse events

2. Invest in producing new knowledge and tools to guide more effective investigation and analysis of adverse events, including near misses

3. Increase our confidence that performance measures, standards and National Patient Safety Goals (NPSGs) contribute to improved health outcomes
The Next Generation (cont’d.)

4. Review and make explicit the evidence base for standards and NPSGs and cull out minimally impactful requirements

5. Improve the efficiency of our internal operations to provide highly valued accreditation services

6. Lead effort to “harmonize” hospital performance measures and focus improvement efforts on highest priorities

7. Implement new programs -- in partnership with leading hospitals -- to use Robust Process Improvement methods to enhance the quality and safety of patient care
Building Quality and Patient Safety To Reach the “Gold Seal”

- The Joint Commission’s Advocacy on Behalf of Patients and Patient Care
- Accreditation-Related Research That Drives Improvements in Clinical Care
- The Joint Commission’s State-of-the-Art Standards & National Patient Safety Goals
- Quality Framework: Systems Approach (e.g., Baldrige, Lean, Six Sigma)
- Foundation: CMS CoPs

Elements Toward Safe, High Quality Patient Care