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The Joint Commission issues revised 2009 accreditation requirements

Biggest changes concern restraint and seclusion

Less than three months after releasing an addendum to its 2009 accreditation standards, The Joint Commission is telling hospitals to throw it out and refer instead to a newly revised edition.

The revisions, released March 26, were prompted by The Joint Commission's work with the Centers for Medicare & Medicaid Services (CMS), which will determine by the end of the year whether TJC will continue to enjoy deeming authority.

In a conference call announcing the revisions, **Robert Wise**, MD, vice president of The Joint Commission's division of standards and survey methods, said the biggest group of changes concerns the issue of restraint and seclusion. "[W]e decided to take our existing restraint and seclusion standards and remove those and replace them in a wholesale fashion with those from CMS. The reason for that is if you look at your current restraint and seclusion standards, they are driven specifically by the purpose of the restraint and seclusion — was it a medical reason or was it a psychiatric reason? — and this was in fact the way CMS set it up a few years ago.

"CMS has rethought this," Wise added, "and they have moved to a behavioral-based decision on restraint and seclusion regardless of the etiology of behavior. When we looked at the two strategies, we realized they were incompatible, and even though we believe we have good EPs [elements of performance] in restraint and seclusion, rather than mix apples and oranges we have decided to replace them with the new CMS ones. As time goes on, we will see whether there were any important criteria that were left out."

Standards, EPs decrease from 165 to 87

The Joint Commission, with guidance from CMS, evaluated the 165 standards and EPs released in January and deleted 78 that CMS believed were already included in TJC's standards and survey processes, reducing the total number of new or revised standards and EPs to 87 in the latest version of its manual. "Of the 87, they fell into two categories: About 37 include new expectations, and the others have already been handled but not to this level of specificity," Wise said.

In its evaluation, Wise said The Joint Commission used these guiding principles:

- to reduce the overall burden of selection and measurement on the field and the surveyors;
- to integrate CMS' conditions of participation (CoPs) for ease of compliance;
- to, where possible, use existing EPs rather than creating new ones.

"The other [standards or elements of performance] that are new relate to an updating of the history and physical and some requirements around pre- and post-anesthesia. That represents about another 10," Wise said. "The remaining are the ones that we believe we've already been handling, but now there's greater specificity, and those are the ones related to blood infusion and the handling of infected blood."

No show-stoppers

"I don't think [the changes] will be big show-stoppers for organizations," says **Kurt Patton**, CEO of Patton Healthcare Consulting in Glendale, AZ, and former executive director of accreditation services at The Joint Commission. "They'll have to do some fine tuning; it's by no means like trying to implement med rec or the Universal Protocol."

He applauds the changes, in general for bringing CMS and TJC in closer alignment. Now that the approaches of both organizations "are one in the same... I think hospitals will actually embrace that. Because previously they were trying to deal with both, so it sort of makes things easier for the hospital."

Pointing to the teleconference The Joint Commission held to discuss the new document, Patton says, "I found it very curious that they added in some new elements of performance for all hospitals, including those that are not participating in Medicare." He adds "that's just curious why they need to rush that if it applies to everybody and there isn't pressure from CMS."

Highlighting changes

Of the changes, Patton highlights one requiring that controlled substance losses be reported to the CEO of a hospital. "That's sort of a change for hospitals," he says, adding that if the missing element was a truckload of substances, the CEO would definitely know about it. But "if one syringe is missing, it's probably unlikely that there's a reporting process to get that information in front of the CEO. So hospitals are going to have to design some sort of an aggregation process where they can tally that, and quarterly or every six months, get that information to the CEO of the organization."

Another change he notes is where the requirements for an H&P are placed. "The medical staff bylaws have to contain the requirements for what constitutes a history and physical. And I think many hospitals have the requirements, but they're

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spelled out in rules and regulations or policies or procedures of the medical staff as opposed to being in the bylaws." Why the change? Patton says "there's no real logic to it" other than the fact that when the CoPs were written in 1965, the term medical staff bylaws was used, not rules, regulations, policies, or procedures.

One "nice" change he points to, on page 12 of the hospital deeming application, centers on what constitutes a good H&P. In previous versions, he says, using the term "admission" in these EPs was confusing. "In this document, it's clear that's it's either admission for an inpatient or registration for admission as an outpatient." Generally, he thinks the elements relating to H&Ps are much clearer than before.

"The other thing that's developed that will be important for hospitals is the post-anesthesia assessment within 48 hours. That really is a new expectation from The Joint Commission. Traditionally, they've had some sort of a post-anesthesia assessment as the patients move from the OR over to the post-anesthesia care unit. And this really is requiring evaluation after the patient is totally recovered from anesthesia."

Hospitals, he says, will have to work on this, but he adds that The Joint Commission probably will have to spell out this issue as part of its education programs. "They'll probably have to make it clear that they're not talking about the evaluation the anesthesiologist does coming out of the OR. It's after recovery from anesthesia."

Another element hospitals will have to work on, he says, relates to patient rights and the complaints resolution process. Hospitals should "make sure that their policy includes informing patients that they can complain to the quality improvement organization in the state, making sure they have a ledger that has a timely response and all complaints and grievances are submitted. That might not have been well established at hospitals," Patton says.

Echoing Patton's assertion that the changes are marked mostly by nuanced differences, **Sandy Burke**, RN, MPH, LHRM, consultant with The Mihalik Group, says, "I don't note significant changes. There is a new requirement for a policy on how the organization will deal with potentially contaminated blood. The restraint requirements are actually a little less restrictive."

Patton says he would not necessarily characterize the requirements as less restrictive, but rather "clearer and less confusing." He says the most significant change "was the elimination of special restraint standards for psychiatric reasons in a behavioral health setting. The simplification is now two choices: restraint for medical reasons and restraint for psychiatric reasons, regardless of location." In the old standards, there were requirements for medical restraint, psychiatric restraint in a medical unit, and psychiatric restraint in behavioral health settings. In addition, PC.03.02.01 to PC.03.03.31 have been removed, Patton says.

Burke says the main difference she sees is in "the requirement for a licensed independent practitioner conducting the face to face. TJC did require that within four hours of the original order and then at least at every other order cycle. I am still cautioning people to leave it the old way until we actually get the manual update that shows those standards are deleted. The March update did not show PC.03.03.15 EP 1 or PC.03.03.19 EP 3 deleted."

As far as the alignment of CMS and TJC measures, Burke notes that the surveys each organization conducts are still quite different. "In states that have an active health department that conducts visits on behalf of CMS, organizations know the CoPs. In states the state does not visit (and yes, there are many), the organizations do not know the regulations."

So the learning curve will vary by institution.

Darla Farrell, RN, BS, MBA, FACHE, CHCQM, FAIHQ, CPHQ, president and CEO of Quality Management Consultation Services in Diamond Bar, CA, also works in the compliance department of Kindred Healthcare. What concerns her "is the PPR. The PPR is the periodic performance report that [hospitals] have to prepare and send to The Joint Commission to let TJC know where the hospital stands with standards that require measurement or standards that they identified need improvement," she says.

The Joint Commission won't be using the 87 new standards to determine accreditation until July 1, but what about hospitals that have to submit a PPR, say June 30, Farrell asks. "They haven't been measuring [the new standards] yet. Many are planning to do a small side by side to show that they are addressing the new standards. Because in actuality, July 1, TJC will begin surveying against them. So one day TJC is not scoring the standards in the accreditation process and the next day they are."

After July 1, hospitals will have to show they have a plan in place for monitoring these 87 standards, and "it would behoove them to know and understand the standards, show they have indeed

monitored and addressed them, and implemented a plan if they weren't in compliance."

She adds that the automated PPR won't be ready until the end of the year, and she expects the standards to keep evolving until that point as well. "Why not wait until August when [The Joint Commission does] their new manual and put the standards into effect Jan. 1 like they usually do?" she asks. Now hospitals will have to put the standards into the PPR manually, as The Joint Commission has no provision for them yet. "That's going to be a burden," she adds.

"I don't recommend to my clients that they submit their PPR," says Burke. "My reasoning for this is that I don't believe organizations are hard enough on themselves... I believe the spirit of the PPR should be conducted to be a thorough and honest evaluation. The organization needs to conduct a mock survey. Evaluation should be done the same way that TJC will evaluate. You cannot conduct a PPR sitting in a room with policies."

Farrell concurs with both Patton and Burke that the changes don't really represent anything new, and in areas such as restraints and seclusion, the changes make it "a little more open and less stringent than what The Joint Commission had before."

The Joint Commission also released the scoring impact of the new standards, which "will assist the field to begin their improvement and compliance plans, in addition to being able to demonstrate positive outcomes when TJC begins scoring the standards after July 1," says Farrell. ■

Memorial Hermann wins national quality award

Dashboard one winning element of system

Houston-based Memorial Hermann Healthcare System will be honored this month at a gala event in Washington, DC, as the winner of the National Quality Forum's (NQF) 2009 National Quality Healthcare Award. **Michael Shabot**, MD, system chief medical officer, explains why the health system was chosen and how it met the five criteria NQF established for the award:

• Effective prioritization of performance improvement goals.

Shabot says Memorial Hermann has a "very small goal-setting mentality." Detailed annual goals are created for quality and safety, operational efficiency, and financial goals. Criteria include employee satisfaction and physician involvement. Metrics are approved yearly by the health system's board.

• Well designed and deployed "dashboard" to measure and manage whole system performance.

"The operation of the Memorial Hermann health system is very strongly metrics-based. By that I mean we have our dashboards actually embedded into our computerized operating environment," Shabot says. A daily "flash report" resides on each desktop as an icon at the bottom right part of the screen and blinks to notify when new data are added. All data included are current. When an employee clicks on the icon, he or she can see the hospital's censuses and financial standing, which Shabot says is up to date through midnight of the previous day.

All publicly reported core measures and multiple quality measures are available in the flash report in real time. Each operating unit has its own drop-down menu. The dashboard includes a year's worth of data, which are color coded. "If a hospital is high performing, then that cell is colored blue for blue ribbon. If they're just in the good stage, they might get a green. Yellow is warning, and red is below our standards," Shabot says.

For core measures, only 100% performance gets coded as blue. And since the system "is very strict on core measures," Shabot says he sees a lot of blue.

All inpatient and outpatient quality measures play a role in the dashboard. Shabot says the system's focus on health care-associated infections is robust and doesn't focus only on infections but the bundles proved to help prevent them from occurring.

"Our dashboards include 11 items for central line insertion. Everything from the caregiver washing their hands before the procedure to the use of chlorhexidine to directing the patient. All of those are individually scored criteria for replacing the central line. And we score compliance on those," he says.

Every central line is audited each day and recorded, and actual nosocomial infection rates are shown. Catheter-related blood stream infection, ventilator-associated pneumonia, surgical site infections —"those are all shown, along with their bundle prevention scores... We're really performing very well and have eliminated those from some of our hospitals for a long time."

The health system just added a new page to the report for ambulatory core measures and is adding patient safety indicators from the Agency for Healthcare Research and Quality. Reports are prepared from the dashboard results, which also are reviewed by the C suite. "We're very heavily dashboard oriented," says Shabot.

• Commitment to transparency. Data-driven improvement of chronic care, with an emphasis on care coordination and disparities reduction.

"We've got both internal and external commitments," Shabot says. Internal is the flash reports, which "literally thousands" have access to. Shabot says the system focuses on data-driven improvement in chronic care and care coordination. "Our physician groups that have set down their quality measures document their performance through their [electronic medical records]. The quality scores actually come directly out of their EMR, which is the way EMRs are supposed to be used." Monthly performance data are shown in real time.

Regarding transparency outside the system, Shabot says, "I think we were one of the first hospitals in the country to put our current core measures scores on our public web site. If you go to memorialhermann.org, you can click on the front page. There's a quality and safety icon on the home page, and it'll take you right into more current scores. The data on the Hospital Compare site are usually almost a year old. We update our site every quarter."

• Demonstrated results on publicly reported performance measures.

"Our publicly reported core measures are high," Shabot says, adding that the system has won numerous awards from VHA for going 12 consecutive months without any cases of catheter-related blood stream infections or ventilator-associated pneumonia.

The system also implemented an initiative it calls "Breakthroughs in Patient Safety." In mid-2006 it decided to "implement a cultural change across the entire health system changing the way everybody does their work." Consultants from the nuclear power safety industry were brought in to help carve out this foundation and "build in safety precautions that weren't there before. Building in the kind of culture change that has made air travel, federal aviation, nuclear power so safe. These are all high-risk industries that have been made low risk by cultural change."

Employees were pulled out of work for cultural training and one-on-one classroom training for three to four years. "This is being applied to our 20,000 employees and as many physicians as we can rope into training. We have currently completed our hospital training, that is all 14,000 employees. When I say 'all,' I don't just mean the nurses and pharmacists; we include everyone — housekeepers, our maintenance people, our construction people, because they all work in hospitals and they all have an opportunity to prevent an accident or to prevent a mistake."

Shabot says the system goes beyond Joint Commission or Medicare requirements to monitoring "what we call a serious safety event rate. And every event is classified with a classification system that came in with our Breakthroughs in Patient Safety campaigning."

Successful HAI initiative

Shabot points to one successful initiative to show how the system approaches challenges — eliminating hospital-acquired infections (HAIs). When he joined Memorial Hermann in January 2007, he began to evaluate the rates that were a part of the monthly dashboards. Individual units may have had successes, but those had come and gone. "Preventing HAIs, you never really solve that problem," he says. "Because the organisms are always present in the environment, you actually have to run the initiative continually and permanently." So he employed the Six Sigma process to approach HAI rates. All the process owners were involved in workout sessions to put a plan into place by May 1, 2007, which "began the bundle auditing in a uniform way across all of our hospitals." The system saw dramatic results.

"The No. 1 factor [to success of preventing HAIs] is continuous auditing of infection prevention bundles — every line insertion, every ventilator, every ventilator day, every line day, close attention to antibiotics and SCIP [Surgical Care Improvement Project], getting those rates to 100%," he says. ■

National push for surgical safety checklist under way

Use of checklist removes reliance on memory

If flight crews have to do it before takeoff, why shouldn't surgical teams do it before cutting into a patient?

Safety checklists aren't about second-guessing anyone's clinical judgment, experts say; they're about making sure, in a systematic way, that the team is ready to proceed, rather than relying on sometimes fallible human memory.

Surgical safety checklists, in particular, have received increasing attention in the last few months, thanks to an important study, a pair of major initiatives, and a memorable scene in a popular television show.

On Jan. 29, *The New England Journal of Medicine* published "A surgical safety checklist to reduce morbidity and mortality in a global population," spotlighting the favorable outcomes of using a checklist developed by The World Health Organization (WHO). **(See "Study: Surgical safety checklist reduces complications, mortality," *Hospital Peer Review*, March 2009, pg. 28.)**

More recently, the TV show *ER* presented a fictional scenario in which a surgical safety checklist headed off potentially serious problems in a transplant operation.

Now the Institute for Healthcare Improvement (IHI) and Washington state-based SCOAP (Surgical Care and Outcome Assessment Program) have implemented programs to get hospitals on board with using a surgical safety checklist, beginning by implementing it in just one OR.

IHI's surgical safety checklist sprint

First announced at its national forum, the IHI's Surgical Checklist Sprint, a voluntary initiative, asks hospitals to implement the use of the checklist in one OR by April 1 "because we advocate doing small tests of change," says **Fran Griffin**, MPH, IHI director. "When you test something small then you can learn very quickly whether or not it's going to work as it is or you have to make modifications."

Participating hospitals were asked to report to the IHI if they were going to try to implement it and then follow up as to whether they did. As illustrated in the *ER* episode, Griffin points to the three areas she sees the most push back to using the tool.

First is the perception that "we're doing this already." While Griffin says it very well may be true that hospitals are doing most of the things on the checklist, the intent is do to *all* of these things *all* of the time for *all* patients. She says the purpose of the checklist is not to fill out another form, but is threefold: One is to take three pauses

at critical points of a surgery in which the whole team stops and pays attention. The second is that, at a minimum, the team is verbally confirming every element of the checklist. "In fact to meet The Joint Commission's Universal Protocol, they have to go beyond the WHO version, but they're verbally confirming every item."

Third is that "the verbal review is done using some reference that doesn't rely on memory." Moving away from reliance on memory is one of the integral components use of the checklist represents. Staff reluctance to use the checklist, she says, is a misperception of the "process that goes along with the document."

"Another push back we get, and it's not so much push back as much as people being concerned, legitimately so, about the fact that this will not meet the Universal Protocol," she adds. The Universal Protocol, she says, was intended primarily to avoid wrong site or wrong surgery. The checklist, however, was not designed with this in mind but rather to provide safer surgical care. She insists that the two can be used as complements to one another, especially as the IHI promotes modifying or adapting the checklist to include what elements you want.

The third most common push back, Griffin says, which they expected to encounter more often then they have, is from physicians. She says often older surgeons tend to be the ones who are most resistant and who might have been trained to think differently about the OR. "They view this as people second guessing their ability, their judgment, their intellect, and of course we all know that's not the goal here at all."

Griffin and other experts *Hospital Peer Review* spoke with don't favor legislation or regulation regarding the list. Rather than being mandated, Griffin hopes it just becomes a standard of care. And unlike the Universal Protocol, which focuses on wrong site and wrong surgery, which she says is a very rare occurrence, use of the checklist "is not so punitive and blameful to a lot of surgeons."

While she already has seen documents from one state considering mandating the checklist, she says "legislation can sometimes have unintended consequences." The beauty of the Sprint, she says, is that there aren't set-in-stone actions. The intent is to take the three pauses and fulfill what the checklist is designed for. She says the fact that it is a checklist with boxes often gives the wrong perception — that users are supposed to check off the boxes. It's not about checking boxes but asking the questions and taking the time to note that everything that should be done or made ready is. "Sometimes people shoot themselves in the foot in making these things more complex than they need to be. And my worry would be that if you legislated this, it would come out as too prescriptive," she says.

The checklist represents a lot of the characteristics integral to a high-reliability organization (HRO) — a concept Griffin often speaks about — for instance, preoccupation with failure. "When we go into the OR, the assumption is that everything is going to go well," she says, but "it's about being ready, recognizing that no matter how good anybody is that nobody is 100% all of the time, humans are fallible, and the policies and processes we're using were designed by humans. So failure is a given."

The checklist, she says, addresses possible failures "that if they occur are going to put us in the greatest risk of harm to the patient. Failure to give the antibiotic is one. Failure to have the blood in the OR and ready if we need it is another."

Another HRO component — deference to expertise — also is highlighted by the checklist. Griffin asks, "Who is the best person in the room to answer questions about the airway? The anesthesiologist. But prior to the WHO checklist, were people pausing to ask the anesthesiologist: Do you think the airway is easy or difficult today? That information was known to the anesthesiologist but not the rest of the team. Deference to expertise means you're going to the one on the team that best knows that answer. Going to the scrub nurse to ask if we have everything we need. Did we check the equipment? Did we give the antibiotic?"

Griffin points again to eliminating the variability that comes from reliance on memory as one of the key benefits of using the checklist.

SCOAP scopes out checklist

SCOAP is a nonprofit, voluntary, physician-led collaborative to improve the quality of surgical care. And among its programs is one promoting use of a surgical checklist. Its goal is to have every hospital using it in every OR in the state by the end of the year. At press time, there were about 35 hospitals signed on with the checklist initiative.

Rosa Johnson, ARNP, MN, CPHQ, SCOAP

Skagit Valley gets checklist on board with physician champion

Joyce Cardinal, RN, MBA, director of quality at Skagit Valley Hospital in Mount Vernon, WA, says she was lucky. One of Skagit's surgeons is on the SCOAP data committee, and after she attended a meeting about the surgical checklist, she already had a physician champion on board to get it started.

That surgeon started it first in his own OR and then worked on implementing it with other specialties. "At the same time, we got anesthesia on board so they could really help us promote it," she says. Copies were placed in all of the anesthesia charts and posted in rooms. Copies also were placed on the hospital's PACs, a computer system used to display X-rays and other medical images. The checklist became the screensaver on all the PACs monitors. "So it's right there in front of everyone. That helped promote it, too," Cardinal says.

After starting in a few rooms, the nurses started reminding the physicians to do it, and the anesthesiologists on board reminded them, too. Because it's voluntary and not regulated, Cardinal says having a physician champion is essential to get willing participation. The nurses are embracing the checklist, and because most staff know each other in the 137-bed rural hospital, the OR team started adding little-known facts about themselves when they introduce themselves. "So it's really a team-building thing," Cardinal adds.

Staff particularly like that the checklist always reminds them about film so if an X-ray is needed, it's already there. They also like having the anesthesia plan at hand.

The question she always hears from other quality improvement directors is: How did you get your doctors on board? "First and foremost," she says, "physicians want to know how it benefits the patients." Using anecdotes helps them to see the value. "So if you've got some things that have happened in the past, you can use that when you're discussing it with the physicians. Like, 'Do you remember the time we almost operated on the wrong limb?'" If doctors can see the benefit to the patient, they're more likely to buy in and not beleaguer the fact that it takes time to do it.

Cardinal has seen dramatic results from using bundles for central-line infections and ventilator-associated infections and sees the checklist, in essence, as another bundle-type approach. "When you think about just the simple thing of marking the surgical site and what a difference that has made in wrong-site surgery. And that's a checklist, even if it's one box. It makes a difference, and that's where we have to get. We have to get to more and more of doing that. There's too many variables in health care."

Using the checklist also has helped Skagit in its compliance with regulatory requirements. "The pieces of the surgical checklist, like making sure everyone's on the same page, making sure everyone knows the plan, making sure all the right equipment and the things you need for surgery are there does make a difference, even though it's not regulatory. For hospitals that might be struggling with regulatory [components] if they adopt the checklist, I think it probably will help them." ■

program director, says use of the surgical checklist is "very logical, very practical." The checklist differs a bit from the WHO checklist and includes "a number of process of care measures. Like being sure that the patient whose blood glucose is high gets treated and beta blockers are continued." In the checklist, step two, intended to be checked prior to skin incision, includes elements such as: active warming in place, DVT/PE prevention plan in place, antibiotic redosing plan in place, specialty-specific checklist needed, and agreed-upon plan to prevent sharps injury. For these elements, hospitals are asked to track whether each has been confirmed as part of the checklist. (To view the checklist, visit www.scoap.org.)

Costco printed poster-sized checklists at no cost to SCOAP that facilities can order. The posters are 2x3 feet and are laminated so hospitals can hang them in ORs and can use them over and over. Another suggestion Johnson makes for implementing the checklist is putting it in the basic sterile pack. Other suggestions are listed on the web site, but Johnson says SCOAP has not been prescriptive on how hospitals use the checklist.

"We basically tell them, like you do anything where you're going to have something really happen, you need to develop a team and you need to have your leaders or champions." SCOAP offers a pre- and post-implementation survey hospitals can use to gauge perceptions on how the checklist has or has not changed safety in the ORs. And she, like Griffin, points to one of the greatest benefits of the checklist approach.

"I think it's a very practical way to improve care in the OR and represents the recognition that we are people and we are human and we can't

remember everything. Things are complex. Just like pilots who can't remember everything. So they have a checklist to remember. I think it's an acknowledgement that surgeons and staff can't remember everything and we need a checklist to help us remember." ■

AHA, TJC get with the guidelines for heart failure

AHA updates guidelines for hospitalized patients

In conjunction with the American Heart Association's updated Get With The Guidelines program on heart failure, The Joint Commission is now offering hospitals a certificate of distinction in heart failure, as part of its disease-specific care advanced certification program.

The advanced certification program is "differentiated from accreditation in a number of ways," says **Jean E. Range**, MS, RN, CPHQ, executive director, disease-specific care certification. "Accreditation, of course, is an overall evaluation of health care from top to bottom including bricks and mortar, as we like to say. Certification is a focused evaluation of a clinical treatment program" that evolved beginning in the late 90s with "the burgeoning population of Americans with chronic diseases, all the baby boomers, and the realization by health care providers that our delivery system really doesn't have the structure to optimize care of patients with chronic diseases."

To gain certification, compliance with certain standards is required, as well as acknowledgment that "a formalized program is in place and that the structure of the program is adequate in that the leadership has ensured that adequate resources are going" to be available to the clinical team providing care.

A huge component of this and managing chronic conditions, Range says, is patients' self-management. The provider of care must be prepared to share clinical information with other providers "touching all points of the continuum of care" as these patients may be hospitalized or require home or long-term care. Hospitals must also show a systematic approach to dealing with the condition and that the care is evidence-based.

For heart failure certification, The Joint Commission also requires participating hospitals to "achieve and sustain for 90 days or more at least 85% of the achievement measures" of the AHA's Get With The Guidelines program on heart failure and to collect data on The Joint Commission's heart failure-related four core measures. The data collected must be used in facilities' ongoing improvement measures.

Evaluation of the latter is done on an annual basis for the two-year certification program, with Joint Commission personnel, one of whom is a clinical expert in the area of heart failure, visiting the facility every two years. In the middle of the "off" year, The Joint Commission has a conference call with the facility in which they "go over performance on the data collection and where they're at in terms of the measures themselves," Range says. Hospitals submit the results of their performance on a quarterly basis and report data on the core measures using an extranet portal. The cost for the two-year certification program is $9,200.

Get With The Guidelines changes

Updates to the AHA's guidelines on heart failure include a section specifically aimed at hospitalized patients "and there are a number of key recommendations with regard to care to provide during the hospital stay as well as key recommendations on that transition of care," says **Gregg Fonarow**, MD, chair of the Get With The Guidelines steering committee.

As part of the program, he says, AHA partners with individual hospitals. A key component is the web-based patient management tool, which AHA offers for a cost of $1,800. The tool allows "the clinician at the point of care to check that patient's care [against] the current version of the guidelines to ensure for each patient, each time the care being provided is evidence-based." It also provides benchmark quality reports, patient education materials, a link to coding instructions, information on drug therapies, and FAQs.

As far as benchmarking, Fonarow says, the case management tool allows you to capture historical and current ACE inhibitor or beta-blocker discharge rates and compare that to national benchmarks. Participating hospitals also can use the AHA's library of performance improvement tools, such as standardized order sets, charts, and checklists.

Participating hospitals can call the AHA help line for support, and field staff based in all of the organization's affiliates work closely with the

local hospital teams.

Fonarow also says beginning in June, the Centers for Medicare & Medicaid Services is going to start publicly reporting rehospitalization rates for heart failure, myocardial infarction, and pneumonia. He adds "there's been hints from the administration that they're interested in aligning the incentives, so you can imagine how there would be an impact on reimbursement to hospitals" with regard to higher rehospitalizations.

Do the guidelines provide actionable recommendations? Fonarow says yes. "These are firm recommendations with regard to therapy that should be provided and those processes that are strongly linked to clinical outcomes. And there's also practical information provided as to who are the appropriate candidates for therapy, what are the doses, and what is the monitoring that is necessary." The Get With The Guidelines program addresses diagnosis, treatment of the patient in the outpatient settings, medications, and diagnostic tests. With the hospitalized patient, Fonarow says, "it takes you all the way through admission, special populations, end-of-life arrangements, quality improvement, and implementation of guidelines." ■

Arming patients to partner in their care

Encourage patients to ask questions

Traditionally, patients have been cast in a passive role in their own health care. Now, "patient involvement" has become an oft-heard term in hospital regulations and discussion, with acknowledgement that patients themselves can play an integral role in their care. How does The Joint Commission promote encouraging patients to speak up?

There are two particular ways, says **Paul Schyve**, MD, senior vice president of The Joint Commission: National Patient Safety Goal #13 addresses patient involvement and the organization's "Speak Up" campaign. As far as complying with NPSG 13, which requires that "the hospital encourages patients and families to report concerns about safety," Schyve says hospital personnel must tell patients and their families how to do that. "Just to inform people about the method is not the same as encouraging it," he says. "I think it's important that it be told to the patient and the patient's family

CNE *questions*

17. In its March 26 release, how many new or revised standards or elements of performance does The Joint Commission add?
A. 75
B. 87
C. 92
D. 165

18. According to Michael Shabot, MD, one of the goals of the electronic medical record system is quantifying physicians' quality scores.
A. True
B. False

19. To gain a certificate of distinction in heart failure from The Joint Commission you must be 100% compliant with the American Heart Association's Get With The Guidelines program.
A. True
B. False

20. The Joint Commission's Speak Up campaign addresses which of the following issues:
A. avoiding mistakes during surgery
B. preventing errors with medication
C. planning follow-up care
D. all of the above

Answer Key: 17. B; 18. A; 19. B; 20. D.

CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

in a way that actually says, 'This is important. You can actually help us make use safer.'"

We're talking about more than patient rights, he says. It's something important and that must be actively encouraged and any concerns addressed must be taken seriously whether they are real or just imagined.

"While the idea is to fairly broadly identify ways to involve patients in their care and safety issues around the care, the specific requirements are first that patients be educated about how they can report their concerns," Schyve says. "Second is that, in particular, the patient be informed about what kind of inspection control measures are in place... A third thing is patients should also be told about what's being done to provide for their safety in surgery."

As part of its "Speak Up" campaign, The Joint Commission offers various brochures that can be downloaded from its site to encourage and educate patients on what they can, and should, ask about. Topics include avoiding mistakes during surgery, preventing errors with medication, and planning follow-up care

"I think making it part of the process to invite questions and invite the input makes a huge difference. So sort of building that into the scripts of patient interaction. 'What questions do you have? Is there anything you may be concerned about? Have I explained everything so that you understand?'" says **David J. Shulkin**, MD, president of Beth Israel Medical Center in New York City, who has written a book, *Patients need to ask: Essential information every patient needs to know,* to arm patients with information they should know to change their role from passive to active.

He says his goal in writing was to put himself inside the head of the patient. "This is not necessarily a new concept... But what I felt was really missing was having the specific information that patients needed to have when they came into the hospital. What types of questions, what types of issues should they really be alerted for, and what are the biggest vulnerabilities in hospitals?"

Quality improvement directors should be aware of the questions patients should ask to ensure safer care and encourage them to voice those questions. Shulkin says those include "the most obvious one," which is to teach patients that they have the right to ask every clinician who enters their room to wash their hands before an examination. Also, he says, "if you are going to be receiving blood, you should ask your nurses to

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- ■ NQF addresses cultural competency: How can you make a difference?
- ■ Which characteristics of an HRO can you use?
- ■ Gain commitment from your medical staff on safety
- ■ More on restraint and seclusion requirements

do two separate identification checks to make sure the unit that is going to be given to you is the proper one." He tries to empower patients to ask nurses when they come to administer medicine what the medications are and what the dose is. For patients coming to the hospital for a surgical procedure, physicians should let the patient know about the processes and procedures they employ for the safety of the patient.

If a health care professional puts anything invasive in a patient's body — for instance, a central line — and he or she isn't wearing a mask, gown, and gloves, the patient should speak up, Shulkin says. Patients should know when prophylactic antibiotics should be given prior to surgery and prompt the clinicians if they are not given. Also, they should be aware of how long catheters should be left in and prompt caregivers if they are left in longer than that.

Schyve cites a study, "Rehospitalizations among Patients in the Medicare Fee-for-Service Program" in the April 2 issue of *The New England Journal of Medicine* that looked at the number of patients readmitted to the hospital within 30 days of discharge. "In the case of 50.2% of the patients who were rehospitalized within 30 days after a medical discharge to the community, there was no bill for a visit to a physician's office between the time of discharge and rehospitalization," the authors write.

"In order to help provide for safety for the patient, one of the things that we encourage patients to do while in the hospital is to really be active themselves in getting their discharge planning going and getting their questions answered about what's going to happen after they leave the hospital," Schyve says.

Patients not looking at performance measures

Schyve says studies that have looked at how much patients use the public data available on sites such as Hospital Compare indicate that only a small minority use that information to make choices about their care. Most patients still rely on friends' or physicians' recommendations or word of mouth. "So the data that are available, even when you can look at it and say, 'Gee, it looks like it's pretty easy to understand and could be useful,' it's clearly not used to the extent people hoped." But that could change, he adds, as more data are released and more sources tell consumers it's there for their use. "Secondly, I think with a generational change, those who are used to going easily to the internet to get information are more likely to look for that information. And that probably increases the likelihood they're going to use it." ■