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May 2012: Vol. 37, No. 5
Pages 49-60

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Financial Disclosure:
Editor Lisa Hubbell, Executive Editors Russ Underwood and Gary Evans, Associate Managing Editor Jill Von Wedel, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

AHC Media

A tool for every task, for every task a tool

Even if you know what you're doing, this kit can help

Let's say you have a pretty robust system of patient safety and quality improvement (QI) and are up on all the latest trends in determining what needs attention and how to make effective changes. You still might benefit from some aspect of the new tool kit for improving your performance on the 28 quality indicators and 17 patient safety indicators of the Agency for Healthcare Research and Quality (AHRQ).

Late in winter, the agency held a webinar to go over the tool kit, including discussion by one of the kit testers — Harborview Medical Center in Seattle — about how even a large tertiary facility with a long history of QI can still learn a new trick or two.

The tool kit includes information on a variety of topics, including:

- determining readiness to change;
- applying quality indicators to the hospital data;
- identifying priorities for quality improvement;
- implementing improvements, including a five-step implementation cycle of diagnosing the problem, planning and implementing best practices, measurement and analysis of results; evaluation of how effective actions were; and evaluation, standardization, and communication;
- monitoring progress for sustainable improvement;
- analyzing return on investment;
- using other resources.

Patient safety indicators

The kit also includes a roadmap that outlines what tools are most effective for each step in the process.

The tool was designed in collaboration with RAND and the University Health System Consortium (UHC), says **Joanna Jiang**, PhD, senior research scientist at AHRQ's Rockville, MD headquarters. The effort started in 2009. Eleven of the UHC hospitals participated in the development process, and six were involved in the alpha testing. Interestingly, although all the testers made use of different elements of the kit, they all chose to address various patient safety indicators, including:

- death among surgical inpatients with serious complications;

• central venous catheter-related bloodstream infection;
• postoperative pulmonary embolism or deep vein thrombosis;
• postoperative sepsis;
• accidental puncture/laceration;
• obstetric trauma-vaginal delivery without instrument.

Hospital Peer Review® (ISSN# 0149-2632) is published monthly and Patient Satisfaction Planner™ is published quarterly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Peer Review®, P.O. Box 105109, Atlanta, GA 30348.

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for Hospital Peer Review® is hospital-based quality professionals and accreditation specialists/coordinators.

Opinions expressed are not necessarily those of this publication.

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Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $78 each. (GST registration number R128870672.)

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During the webinar, the rationale for the emphasis on patient safety was credited to the increased emphasis on those indicators by the Centers for Medicare & Medicaid Services (CMS) through its value based purchasing initiative, and the large number of other measurements and data collection required by other organizations.

The first round of testing of the kit resulted in some concerns among the hospital users — that hospitals need to be sure of their data, that priority setting is hard, and that the tools to assist need to be short and simple. As a result, changes were made that addressed the concerns: a documentation and coding tool that was designed to improve patient safety indicator validity; a flexible prioritization tool that could be tailored to the needs of a particular facility; and simpler tools.

"Our mission for many years has been to improve quality of care," Jiang says. The tools and measures that the agency has developed is one part of that. While most organizations have heard of AHRQ's quality and patient safety indicators, more and more are adopting them now. "We started to see a need to help organizations implement quality improvement projects around those indicators," she says.

The hospital component

After the initial proposal for the kit was made, AHRQ decided that the advisory panel it used to create the kit had to include not just experts on quality improvement and researchers, but also quality officers from hospitals and health systems, Jiang says. "We really wanted the hospital component who would make use of these tools to tell us what they needed up front."

The panel conducted a literature review on the use of hospital indicators and quality improvement strategy, and the findings of that search provided the basis of the tool kit's development. "We wanted the team to determine the principles that would guide the tool kit's design," she says. "We wanted to focus on the most useful key factors — useful to a wide range of hospitals — and make sure that what we created was easy to use."

Once they developed an initial kit, it was field tested at a half-dozen hospitals. During and after the testing, the development team inter-

viewed the users, conducted formal evaluations, and even did site visits. It was these interviews and evaluations that led to some of the addition of coding and documentation guidance and best practices for patient safety indicators.

Jiang says they understand that every hospital is different, and while some have years and years of quality improvement initiatives under their belts, others are just getting started. "It is a master shopping list," she says. "We do not require that they use it from front to back. They can pick and choose what they need from it, and adapt those options so that they fit the situation."

Implementing improvements

Harborview Medical Center in Seattle is one of those facilities with a lot of QI experience, but it still found a lot of help in the kit, says **Ellen Robinson**, PT, clinical quality specialist at the hospital. "It was designed to make it easier to use the AHRQ software, and we had been using that," she explains. "We thought it could help us do a better job."

For Harborview, Robinson says the best parts of the kit were from section D, about implementing improvements. The eight tools in that section are:

- Improvement Methods Overview;
- Project Charter;
- Examples of Effective PSI Improvement Strategies;
- Selected Best Practices and Suggestions for Improvements (for eight patient safety indicators);
- Gap Analysis;
- Implementation Plan;
- Implementation Measurement;
- Project Evaluation and Debriefing.

"As a nurse or a physical therapist, you might not have all the background you need in quality improvement to do things like a gap analysis," Robinson says. "This gives you easy-to-use tools to help your project management skills and help move a project along."

She also appreciated the roadmap, which helped her to see where she was in the process. "I think we already had a good system in place, and figured the tool kit would be positive for us. And we did not have to start right at the top and work our way through because we were already on the road." But Robinson says it still helped her to identify events and areas that could use a second look and potential improvement projects.

Among the issues that the test brought to her attention was venous thromboembolism (VTE). "It validated that we were giving good care, particularly with chemical prophylaxis," Robinson says. "But now that we know that, we can look at other areas, like mechanical prophylaxis." It also helps to identify events faster than when they were using data from UHC, which could be three months old before they got to it. Now, it is usually not more than a couple weeks old. That means that the same residents who were at the hospital during an event are likely still there, so they can get information on events directly from people who were involved. Some of the hospitals get new data even more often — weekly or even daily, she says. Harborview opts to run it on its biweekly billing cycle.

Patty Calver, RN, Harborview Medical Center's administrative director for quality improvement says she likes the kit because it is another way to meet CMS goals for harm reduction in areas such as hospital-acquired infections. "It is also reactive, rather than predictive," says Calver. That means that they can quickly find cases of possible preventable harm, and find ways to standardize referral of possible cases across all the teams in the hospital.

It allowed Harborview to move from rate-based tracking to something that can lead to real changes based on real cases and can also help the facility figure out exactly what the next step would be if they found an area of possible concern that needs attention.

The webinar for the tool kit can be viewed at Webinar on AHRQ Quality Indicators Tool kit for Hospital http://www.ahrq.gov/qual/qitoolkit/webinar0215/video/, where there are also links to the tools themselves.

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How to get house staff involved in QI and safety

Idea from NY-Presbyterian garners award

How do you get residents interested and involved in patient safety and quality improvement? It is, after all, one of many requirements made of medical students by the American Council of General Medical Education.

But at NewYork-Presbyterian/Columbia and NewYork-Presbyterian/Weill Cornell Hospital, house staff members themselves came up with a unique way of engaging and making a difference to the safety of their patients, says **Eliot Lazar**, MD, MBA, senior vice president and chief medical officer for quality and patient safety at the two facilities. The residents' efforts led the National Quality Forum and Joint Commission to name NewYork-Presbyterian a winner of the 11th annual John M. Eisenberg Award for Patient Safety and Quality.

The Housestaff Quality Council was created in 2008, and since then has promoted greater house staff participation in quality and patient safety initiatives by partnering with key constituencies to ensure that processes and systems are in place to avoid medical errors, says Lazar.

He calls the results achieved by the council "amazing," including greater than 90% compliance with medication reconciliation — the result of a quick-turnaround program that in a matter of weeks produced an information technology solution that inserted a hard stop into the electronic health record and computerized physician order entry (CPOE). The results were published last year in the *American Journal of Medical Quality*[1].

The group also achieved a 70% reduction in the use of paper in laboratory orders, and creation of a process to codify situations in which house staff need to seek advice from more senior staff.

Resident quality and patient safety officer

One of the most novel results of the council was the creation of a resident quality and patient safety (QPS) officer, Lazar says. "I think this may be the first time in the nation that there someone who is formally designated for this role."

It was such a boon to helping both a hospital achieve its patient safety goals and residents to meet the core competency requirements as defined by the ACGME, that Lazar and colleagues wrote the idea up for publication last summer in *Academic Medicine*[2]. He says the council is "an integral part of the rigorous goal setting process. We have seven main categories, 30-plus initiatives and 50 'elements of performance.' And the council members' input is a key part of the process."

House staff are in the thick of health care, and have a great perspective of what areas need attention, Lazar notes, so when some house officers and a faculty member approached Lazar and other administrators to get more involved in quality and patient safety, they thought it was a great idea.

There are now two councils, one associated with NewYork-Presbyterian/Columbia, and one with NewYork-Presbyterian/Weill Cornell. They meet monthly to discuss quality and safety issues, often come up with the solution to any problems, and then act as the conduit to get input from other house staff members — there are some 2,000 on the two campuses — and disseminate the solutions.

Recognition, validation

"I do not think we would have identified all of the issues without their input," says Lazar. There are a number of issues he does not think administration would have known about and no forum for house staff to voice their concerns or ideas about them.

"And I do not think we would have been able to make the kind of improvements as rapidly as we have been able to do because of their willingness and commitment to disseminate the message," he says. "We have a situation, we bring it to them, we say, 'Here is the problem, what is the solution?' Even if we thought of the solution, we have a venue with a dialogue that can determine if it will work. It is the ultimate beta test."

Since the council was formed, the council members have spoken about it in numerous venues, and Lazar says other training programs have contacted the hospitals to see if it is something they could incorporate into their programs.

But the recognition of the Eisenberg Award

is beyond that kind of validation. "The most important element is that it is recognition for the founders and the council leaders, and it reinforces that groups like this are really important," says Lazar. "I wish we had something like this when I was a house officer. This will spur on others to follow suit and let them know they can make a significant difference."

NewYork-Presbyterian's chief executive officer, **Steven Corwin**, MD, says that the council is a "prime example of how engaged clinicians help the hospital to fully understand and address quality and safety challenges" and that the great progress made recently in patient safety and quality improvement at the two hospitals "would not have been possible without our outstanding residents and the culture of teamwork that has become embedded in our institution and fostered by the Housestaff Quality Council. [It] is emblematic of how we can successfully collaborate with multiple disciplines to deliver the safest and most compassionate care, and the best outcomes for our patients and their families."

Other winners

The Eisenberg Awards were delivered in Washington, DC, on April 5, 2012. They recognize major achievements of individuals and organizations in improving patient safety and health care quality, consistent with the aims of the National Quality Strategy — better care, healthy people and communities, and affordable care.

Other winners included:

• **Kenneth I. Shine**, MD, University of Texas, "for his multiple leadership roles that have helped to improve quality and safety in health care nationwide," according to the TJC announcement.

"Over the course of his tenure as president of the Institute of Medicine, Shine established the Quality of Care in America Project, which led to the landmark reports, *To Err is Human* and *Crossing the Quality Chasm*, helping to put safety and quality on the national agenda. As the founding Director of the RAND Center for Domestic and International Health Security, he led the efforts to make health a central component of US foreign policy and guide the center's evolving research agenda," according to TJC.

A cardiologist and physiologist, Shine is now executive vice chancellor for health affairs for the University of Texas Medical System.

• **The Society of Hospital Medicine** (SHM) of Philadelphia, PA, for "its Mentored Implementation model, designed to further front-line quality initiatives," according to TJC.

"By employing a mentor, typically a hospitalist-expert in quality improvement and other relevant content, hospital teams are provided with the guidance they need to implement best practices and improve quality more rapidly," according to TJC.

"To date, SHM's mentors are in place in more than 300 hospitals around the US and Canada in three signature quality improvement initiatives focusing on care transitions, glycemic control, and venous thromboembolism prevention," according to TJC.

• **Henry Ford Health System**, Detroit, MI, in recognition of its No Harm Campaign, launched in 2008 "to integrate harm reduction interventions into a systemwide initiative and eliminate harm from the health care experience," according to TJC. "The campaign aims to decrease events through enhancing the system's culture of safety by reporting and studying them, researching their cause, identifying priorities, redesigning care to eliminate harm, and employing a comprehensive set of measures across their facilities. From April 2008 to June 2011, using a defined set of measures that has expanded over time, the system experienced a 26% reduction in harm events and 12% reduction in mortality."

• **Jerod M. Loeb**, PhD, The Joint Commission, awarded an honorary lifetime achievement award to recognize his "extraordinary and sustained contributions to health care quality and patient safety."

During his 18 years at The Joint Commission, Loeb has led efforts to identify, evaluate, and implement performance for Joint Commission accreditation and certification programs.

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REFERENCES

1. Evans AS, Lazar EJ, Tiase VL, et al. The role of house staff in implementing medication reconciliation on admission at an academic medical center. *Am J Med Qual*. 2011 Jan-Feb;26(1):39-42. Epub 2010 May 25.
2. Fleischut PM, Evans AS, Nugent WC, et al. Ten years after the IOM report: Engaging residents in quality and patient safety by creating a House Staff Quality Council. *Am J Med Qual*. 2011 Mar-Apr;26(2):89-94. ■

Hospital achieves consistent success

How it made the Top 100 list five times

Out of the 5,800 hospitals in the country, which is the best? Your answer probably depends on the criteria you use to measure the hospital and the peer group against which you measure it. But for nearly two decades, Thomson Reuters has put out a list of the 100 Top Hospitals, and while none is named "best," the list is certainly the cream of the crop.

Scripps Clinic and Green Hospital in San Diego has made the list five times, including in each of the last three years, says **Maida V. Soghikian**, MD, FACP, FCCP, medical director, performance improvement and associate program director, internal medicine residency program at the 173-bed teaching hospital in La Jolla, CA. It was one of just a handful of California hospitals named to the list.

Soghikian thinks the culture of the hospital is part of what sets it apart. While all hospitals aim to provide patients with the best possible care, "we have learned how to effectively and efficiently design teams that are able to use scientific data to develop excellent processes," she says. "We work hard to identify champions amongst our staff and medical staff who not only help motivate, but are also critical to defining sustainable work flow." With that kind of "high-level engagement" and performance oversight, they are able to identify breakdowns and opportunities to improve.

The hospital uses standard performance improvement methodology — emphasizing the Plan, Do, Check, Act process, and reviews metrics every year to determine if the facility leadership needs to modify its focus, she says. "These reviews are critical not only to ensure that we remain in line with our own facilities' needs, but also that we are aligned with Scripps Health and current healthcare requirements." Once they determine the metrics for the year, they focus on achieving 100%, rather than just exceeding state or national norms. They set high goals and assign responsibility and ownership for specific indicators and processes to ensure that someone is accountable for meeting the goals.

Being named one of the 100 top hospitals validates that the facility's commitment to the provision of high-quality patient care, and its methodology is on track with national benchmarks and the performance of other leading facilities, says Soghikian. "In other words, we can see that our efforts are working, particularly after receiving this award in consecutive years. In these challenging economic times, it also reflects our ability to do more with less. This is truly a motivator for our staff and medical staff, particularly when we reflect on the impact our performance has on mortality, morbidity and patient safety."

It is different winning it the fifth time than the first, she says. Initially, the entire staff celebrated because they had been working to evolve quality metrics and performance improvement. It was something that encouraged them to keep moving forward. But being repeatedly awarded — especially the last three consecutive placements on the list — is "more powerful," says Soghikian. "Our care was consistently and reliably outstanding; therefore our message of commitment and clinical excellence had really sunk in to all of our providers."

Scripps Green Hospital meets or exceeds national norms and even the rates of peer hospitals for many of the data points used to create the top 100 list. Some of the areas are still things that give Soghikian and her colleagues pause — like reducing heart failure readmission rates. "That work continues," she says. "We certainly want to improve on all of the readmission measures and focus on identifying any potentially preventable reasons for patient readmissions. As we drill down on the readmission data, we hope to develop additional processes to keep our patients and their primary caregivers well informed of their medications, their next appointments and what to do if they are not improving."

Strategic objectives

Making the list is not on her mind every year, but the data the list makers use is something that should be at the forefront of any quality improvement and patient safety goal list. "We do not try to reinvent the wheel each year. We know that many national awards and report cards focus on evidence-based guidelines." So every year, they review the patient population, any new procedures, any new high-risk, high-volume, or problem-prone conditions, and

determine if there should be additional review. The leadership team looks at Scripps Health's strategic objectives so that their goals align with the hospital's, and they evaluate any new or changed regulatory or reporting requirements. They also look at the issues that quality, safety, and regulatory agencies and organizations are looking at to see if they missed something. Only after all that is done do they develop the plans and priorities for the hospital.

This fiscal year, they have focused on a long list of issues:

- Joint Commission core measures;
- readmission rates;
- hospital-acquired infections;
- venous thromboembolism (VTE) prophylaxis;
- turn-around time for imaging studies;
- glycemic control;
- operating room safety;
- patient satisfaction.

"We also routinely look at our registry and national databases including NSQIP, ACC, STS, UNOS, and FACT, which provide outstanding benchmarked data to demonstrate our performance," she says.

She is particularly happy with the progress made on VTE prevention. "We have been working with the nurse managers on the units to get them involved in the process of evaluating patients for VTE prevention," Soghikian says. "Our goal is that all patients with a length of stay over 24 hours will be evaluated by a physician and a nurse for preventive measures. If not indicated or contraindicated, we request that the physician document this."

When Scripps Green started the process, the performance on this was just 68%. Now, there is 100% compliance on the telemetry floor, as well as the surgical and medical units. "The next steps are to implement the process in other units and to evaluate if there is an associated outcome benefit."

With results like that, being named a top hospital is just icing on the cake.

For more information on this topic, contact Maida V. Soghikian, MD, FACP, FCCP, Division of Pulmonary and Critical Care Medicine, Medical Director, Performance Improvement and Associate Program Director, Internal Medicine Residency Program. Scripps Clinic & Green Hospital, La Jolla, CA. Telephone: (858) 554-9100. ■

How do they pick the 100 Top Hospitals?

There are some 3,000 hospitals whose data are checked and measured to come up with the 100 Top Hospitals list each year. If every hospital performed as well as those on the list, there could be 186,000 lives saved, 56,000 more complication-free patients, half a day less in the average length of stay and some $4.3 billion saved, according to Thomson Reuters.

This year, it helped to be from Texas, California, or Florida, which had a disproportionate number of winners. Many states had none at all.

The winners all do better in mortality rates — by about 8% in small hospitals and 3% in large teaching facilities — complication rates (5% less than expected, while non-winners had 1% more than expected), and better 30-day mortality and readmission rates. Winners follow evidence-based protocols better and more often than non-winners. They have some 18% fewer adverse events than those who do not make the list, and in small hospitals, the difference is even greater, with winners having nearly a third fewer adverse events than the small hospitals who did not make the cut.

From a consumer perspective, being at a better hospital does not appear to mean you'll pay more. Indeed, the better performing hospitals charge $464 less than non-winners, and large community hospitals have the lowest expenses among the winners. Patients had the best experiences at the winning hospitals, too, with small community hospitals doing the best on their Hospital Consumer Assessment of Healthcare Providers and Systesms (HCAHPS) scores.

The metrics used by Thomson Reuters to compile the list for 2012 were:

- risk-adjusted mortality index (in-hospital);
- risk-adjusted complications index;
- risk-adjusted patient safety index;
- core measures mean percent.
- 30-day risk-adjusted mortality rates for acute myocardial infarction (AMI), heart failure, and pneumonia;
- 30-day risk-adjusted readmission rates for AMI, heart failure, and pneumonia;
- severity-adjusted average length of stay;
- case mix- and wage-adjusted inpatient expense per discharge;
- adjusted operating profit margin;
- HCAHPS score (patient rating of overall hospital performance).

The report overview can be viewed at 100tophospitals.com/assets/100TopHospitals_National2012.pdf. ■

TJC begins advanced certification for hospice

Improving quality of life improves quality of care

The first hospice in the country, The Connecticut Hospice, opened its doors in 1974 and started a movement. Now in a serendipitous turn of events, that hospice was the first one to receive advanced certification under a new program from The Joint Commission.

After the Connecticut Hospice was certified, four other facilities quickly received their certifications, too: Regions Hospital in St. Paul, MN, Strong Memorial Hospital in Rochester, NY, Mt. Sinai Medical Center, New York City; and St. Joseph Mercy Oakland, Pontiac, MI.

Since it's been around so long, some might wonder just why The Connecticut Hospice would feel a need for advanced certification, but **Joseph Andrews**, MD, chairman of the Connecticut Palliative Group and medical director of The Connecticut Hospice, says that the program is a good external check on the organization's internal quality improvement and self-assessment programs. "The Joint Commission has a long history of rigorous checks, so it can act as a highlighter for us," he says.

The hospice sailed through without a single adverse recommendation, something Andrews is very proud of. "Surveys always find something. This gives us a good sense of our standing, that our methods are correct, and that we can continue to be a good resource for other organizations."

Sandy Klimas, MSN, MPH, senior vice president of clinical services and clinical development at the Bradford facility, said it "seemed right to try" for the certification, simply because they were the first hospice in the nation. "We are a leader, so being the first makes us proud."

Andrews says the surveyor was anxious to see the team in action and so came to watch the daily meeting of the interdisciplinary team that discusses patients. "We just did our usual thing. We did not rehearse or anything," he says. "I've been here five years and it still amazes me how well we know our patients, the interchange of information between us, and the knowledge we all have of where they are clinically, their pain management, what support they have, and any medication interactions they have. If I was watching us for the first time, I would have certified us."

To prepare for the certification survey, they studied the standards and made sure they were following them. It was time-consuming, but not difficult, says Klimas, mostly because the program is so established. She could see a newer program having more difficulty.

Spreading the word

One key to achieving readiness was spreading the word that they were going to attempt this advanced certification. Klimas says they used the leadership team to do that. Then they just made sure they were following all the standards and choosing elements to show off to the surveyor, such as a quality improvement project they did last year on hand-washing that led to 100% compliance. Another project they highlighted involved pain management assessment, she adds.

The ability to get certification is reflective of the entire movement to high-quality end-of-life care, says **John Coombs**, MD, president and chief operating officer at the Center for Healthcare Governance, part of the American Hospital Association in Chicago. "This way of caring should be used for all patients: teamwork, patient involvement, communication, patient-centeredness. I think over time you'll see many more palliative care programs attempting this certification."

After Connecticut Hospice was certified, Andrews says they had several calls asking about how they prepared. "We have been a bellwether for a long time," he says. "We are in a good position to help others and look forward to doing that."

David Eickemeyer, associate director at The Joint Commission, says that how hard the hospital will have to work to achieve this advanced certification depends on the maturity of the program. The service needs to be available 24 hours a day, seven days a week, but a lot of newer services are only operational from 9 a.m. to 5 p.m. That does not mean you have to be fully staffed all the time, he says, but it does mean you have to have made provisions for those other hours of the week. "You have to be there whenever the need arises."

The Joint Commission wants to see a multidisciplinary team, says **Michele Sacco**, MS, MPH, The Joint Commission's executive director for health staffing services certification and advanced certification for palliative care. "It can't just be one person," she says.

So far, there are some 20 applications from 11 states waiting for review at The Joint Commission, Sacco says, and Eickemeyer notes that this has taken off faster than any other program the commission has started.

"It is a win-win for the patient and the hospital. It can extend life and quality of life, and it can reduce length of stay in intensive care," Sacco says. "It's all good."

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TJC releases sentinel events report

The Joint Commission in April released a report on sentinel events between 2004 and 2011, during which time there were nearly 4,000 sentinel events in hospitals and some 2,200 in other facilities and venues.

The data in the report note that in 2011, there were more than 1,200 events, about three-fourths of which were self-reported, about 160 came to the attention of The Joint Commission in some other fashion, and about 25 were reported in the media.

Over the last five years, the number of reported reviewable events has steadily increased, from 790 in 2007 to 1,243 last year.

The complete report is available at http://www.jointcommission.org/sentinel_event.aspx. ■

Joint Commission gives HAIs own web portal

'We have both carrots and sticks.'

In yet another sign that infection control is becoming a national priority across a wide range of accreditors, regulators and state and federal agencies, The Joint Commission has created a new web portal to combine its full array of initiatives to prevent health care associated infections (HAIs).

"[We] have many moving parts that affect many aspects of health care," says **Jerod M. Loeb**, PhD executive vice president for healthcare quality evaluation at the Oakbrook Terrace, IL-based accrediting agency. "We have standards, performance measures, our center for transforming health care. The problem has been that they have all been located in silos."

The "HAI Portal" enterprise includes the Joint Commission Center for Transforming Healthcare, Joint Commission Resources, and Joint Commission International. The goal of the HAI Portal is to provide an integrated "kiosk" of HAI resources — including those that are free and for purchase — in one web view that is accessible through any of the Joint Commission related websites. Yes, there are Joint Commission related products for sale on the site, but Loeb says that was not the primary driver of the project.

"It was not built to be a marketing site," he says. "But just knowing a standard and knowing the elements by which a hospital might be surveyed doesn't give them all the other answers. So we have created a variety of tools and things that are available — many of which are free. If you are an accredited organization, for example, you can turn to our leading-practice library. If you have issues related to getting house staff to wash hands prior to central line insertion, for example, you can find dozens of things that other organizations that we accredit have identified as good solutions."

Other topics addressed on the site include, multidrug-resistant organisms, surgical site infections, catheter-associated urinary tract infections, and ventilator-associated pneumonia. *(See box, p. 58.)* The portal also includes resources on influenza, staff education and vaccinations.

"HAIs are harmful for patients, costly for health care organizations and largely preventable," Loeb says.

Indeed, The Joint Commission has clearly separated itself from the old dogma of inevitable HAIs that reigned over health care epidemiology for decades.

"The mindset has changed radically," Loeb says. "This [new view of HAIs] is sort of a huge amalgam at the national level, and we have a very important responsibility as an accreditor. We have a pathway that can help organizations comply with best practices, and that is called the accreditation process."

The tightened focus on HAIs comes against the backdrop of unprecedented national activity on infection prevention.

"I think we were actually ahead of that curve with respect to the Joint Commission standards that have been on the books for years as well as our patient safety goals," he says. "Clearly it is a national issue, but we have been involved in this for a long, long time. I do think that the stakes have changed with respect to issues around incentive payment, value-based purchasing and hospital-acquired conditions." The national attention associated with anything about HAIs is high."

The long shadow of the CMS

Indeed, in the shadow of an increasingly active Center for Medicare and Medicaid Services (CMS) — the federal agency that gives it deeming authority to grant accreditation — the Joint Commission is not likely to become less aggressive in the survey process. (As we previously reported, the CMS will begin unannounced inspections of infection prevention and hospital employee health programs later this year.)

"We certainly have worked closely with them and we will continue to work closely with CMS as part of our deemed status relationship," Loeb says. "People and professional societies can preach it, but if nobody is validating whether [infection control] is done or not, things often don't change. We have an interesting perspective here because we have both carrots and sticks. This portal is, we believe, a large carrot."

Of course, what infection preventionists and other clinicians are hoping is that the multiple oversight groups and recommending bodies trend toward standardization and collaboration, unifying the rules and making the expectations crystal clear.

"At the national level there is an awful lot of collaboration going on," he says. "We hope that the easily accessible information on the HAI Portal will assist health care organizations, practitioners and caregivers to prevent HAIs in their organizations, practices and homes."

In that regard, while hospitals are expected

Key HAI topics on new JC portal

The Joint Commission Healthcare Associated Infection (HAI) portal lists resources under three headings:

HAI Topics

- General
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Central Line-Associated Bloodstream Infection (CLABSI)
- Influenza
- Multi-Drug Resistant Organism (MDRO)
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia (VAP)

Infection Prevention and Control

- Environment of Care
- Hand Hygiene
- Patient Education
- Sentinel Event
- Staff Education
- Standards, National & International Patient Safety Goals
- Vaccination

HAIs by Setting

- Ambulatory Health Care (Includes Office-Based Surgery)
- Behavioral Health Care (Other than acute inpatient care)
- Critical Access Hospitals
- Home Care
- Hospitals
- Laboratory Services
- Long Term Care

The new Joint Commission Healthcare Associated Infection (HAI) portal can be accessed at http://www.jointcommission.org/hai.aspx. ■

to be the primary users, The Joint Commission designed the site to be accessible to a wide spectrum of health care settings and users.

"These are things infection preventionists, nursing home staff, health aides in a home health agency that we might accredit, all may want to know," he says. The HAI site may set the standard for similar web portals at The Joint Commission, Loeb adds.

"We decided to create a single door, a portal to get the [HAI] information that you might be seeking," he says.

However, in doing so, The Joint Commission was wary of creating a "menu" for standard compliance that could blunt critical thinking.

"If you open this portal and you are having a problem with a standard 'X,' you can utilize the tools," he says. "But we tried to be careful not to make this an artificial lock and key, forcing people to begin thinking they are doing 'X' because The Joint Commission says you have to comply with 'X.' We tried to get away from that mentality and mindset."

The Joint Commission HAI portal can be accessed at http://www.jointcommission.org/hai.aspx. ■

Hospital Report blog

For further analysis and discussion of topics important to hospital professionals, check out **Hospital Report**, AHC Media's new free blog at http://hospitalreport.blogs.ahcmedia.com/.

Hospital Peer Review's executive editor Russ Underwood and associate managing editor Jill Von Wedel both contribute. ■

COMING IN FUTURE MONTHS

- ■ Finding physician champions
- ■ Dissecting sentinel event data from TJC
- ■ Improving transitions for Medicare patients
- ■ Using Lean
- ■ More from the JC survey trenches

CNE QUESTIONS

1. AHRQ has how many quality indicators?
   a. 23
   b. 17
   c. 32
   d. 28

2. Eisenberg Award winner NewYork-Presbyterian achieved what percentages for medication reconciliation through the efforts of its Housestaff Quality Council?
   a. 90
   b. 80
   c. 92
   d. 83

3. The 100 Top Hospitals have some significant differences from their non-winning counterparts, including better complication rates. By how much are they lower?
   a. 8%
   b. 3%
   c. 5%
   d. 18%

4. The first hospice in the country was opened how many years ago?
   a. 38
   b. 74
   c. 19
   d. 27

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

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

CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■