

The Role of the Joint Commission in Health Care Quality

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of Healthcare Organizations**



Joint Commission Origins

...of Ernest Amory Codman, concerns about the quality of care in America's hospitals, and the great debate over outcomes measures versus standards



Mission Statement

The mission of the Joint Commission on Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.



Scope of Work

- Evaluation: the core competency
- Performance improvement support
- In the mainstream
- International spread



Deemed Status

- Definition
- Significance
- Basic requirements
- Associated baggage
- The balance of interests



Facilitative Joint Commission Roles

- As convenor
- As collaborator
- As listener



The Modern Joint Commission: Efforts in Service of Its Mission

- Accreditation and certification
- Patient safety
- Performance measurement
- Information dissemination
- Public policy initiatives



The Accreditation Art Form

- Standards development
- Evaluation against the standards
- Accreditation decision-making



Goals of the New Accreditation Process

- Continuous standards compliance
- Adoption as a management tool
- Organization ownership



Elements of the New Accreditation Process

- Periodic performance review
- Priority focus process
- Tracer methodology
- Surveyor development



Current Accreditation Focus Areas

- Medication management
- Infection control
- Emergency preparedness
- Data usage for improvement purposes



Current Accreditation Initiatives

- Intensified Life Safety Code compliance review
- Unannounced surveys
- Random validation surveys
- Data-based intra-cycle monitoring



Standards Development Priorities

- Credentialing and privileging
- Leadership responsibilities
- Enhanced emergency preparedness expectations
- HIT-related expectations



Patient Safety Linkages

- The nature of accreditation
- Standards issues
- Dealing with sentinel events



Creating a “Reporting for Learning” Model

- State database legacy
- Sentinel event database
- Sentinel Event Alerts
- National Patient Safety Goals



National Patient Safety Goals

- Goals vis-à-vis Requirements
- Philosophy
- Expert support
- Old Goals never die...
- Issues on the horizon



National Patient Safety Goal Wins and Losses

Wins

- Removal of concentrated KCL from in-patient units
- Re-design of infusion pumps

Losses

- Do-not-use abbreviations
- Universal Protocol for preventing wrong site surgery
- Hand-washing



Wins and Losses (cont.)

“Not-there-yet”

- Patient identification
- Reporting of critical test results
- Medication reconciliation



Other Patient Safety Beachheads

- Patient Safety Events Taxonomy
- Speak Up campaign
- Patient safety legislation
- International Center for Patient Safety



Performance Measurement Linkages

- Ties to quality improvement
- Ties to accreditation
- Measure sets: creating “portraits of performance”
- Evidence-bases for measures...and standards



Setting a High Bar for Performance Measures

- Expert panel analysis
- Measure set identification
- Measure data element specification
- Field testing for reliability and validity
- External validation



The Measurement Players

- Federal agencies (CMS, AHRQ)
- The accreditors (NCQA, Joint Commission)
- National Quality Forum
- The states
- Pay-for-performance programs (purchasers, payors)



Perennial Measurement Issues

- Low bar to entry
- Standardization needs
- Data collection burden
- Multiple data demands
- Priorities among structure, process and outcome measures
- Clarification of measure uses



Emerging Measurement Issues

- Volume of measures
- Absence of National Quality Goals
- Measurement of patient safety performance
- Data quality
- Data flow
- Embedding measures in electronic records



Information Dissemination Linkages

- Quality improvement stimulus
- Meeting public accountability expectations
 - For accredited organizations
 - For the Joint Commission



Evolution of Joint Commission Policy

- From a Confidentiality Policy to a Public Information Policy
- The troubled launch of Performance Reports
- The transition to Quality Check
- Evolution to current Data Use Policy



The Quality Check Evolution

- Basic content
 - Accreditation status information
 - National Patient Safety Goal compliance
 - Comparative performance measurement information
 - “Merit badges”
- Addition of quarterly measure data points
- Inclusion of non-accredited organizations



Public Policy Linkages

- Underlying rationale for Public Policy Initiatives
- Basis in mission: “...and related activities”
- Joint Commission assets as a public policy player
 - Convenor role
 - Purity of purpose



Public Policy Development Process

- Roundtable analysis
- National summit
- Issuance of white paper
- Determination of follow-up strategies



White Papers Issued

“Health Care at the Crossroads” Series

- “Strategies for Addressing the Evolving Nursing Crisis”
- “Strategies for Creating and Sustaining Community-Wide Emergency Preparedness Systems”
- “Strategies for Narrowing the Organ Donation Gap and Protecting Patients”
- “Strategies for Improving the Medical Liability System and Preventing Patient Injury”



In the Public Policy Pipeline

- Emergency Department Overcrowding
- Health Professions Education Reform
- Linkages Between Health Literacy and Patient Safety
- The Hospital of the Future
- Developing a National Data Management Strategy
- The Efficiency Dilemma: Identifying Opportunities for Waste Reduction in Health Care



What Will It Take to Succeed?



Culture Defined

A culture is defined by the customary beliefs, values, and behaviors – including traditions – shared by members of a group.



Barriers to Making It Happen

- Board and professional cultures
- Payment system design
- Medical liability system
- Health professions education design
- Professional shortages



Pushing the Culture Change Envelope

- Patient safety as “the” priority, not “a” priority
- Leadership engagement
- Transparency at all levels
- Systems re-design competency
- “Back to the basics” education



Culture Change Envelope (cont.)

- Focus on microsystems
- Patient engagement in reporting and problem-solving
- Investments in staff retention and recruitment
- Getting ahead of the power curve

