



Physicians and The Joint Commission:

The Patient Safety Partnership



**Part I: The role of the physician
in The Joint Commission**

**Part II: Focus on patient safety —
accreditation process, standards and
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**Part IV: Enhancing physician involvement
in quality and safety improvement initiatives**



Part I: The role of the physician in The Joint Commission

Historical ties between physicians and The
Joint Commission

Evolution of The Joint Commission

The Joint Commission today

Historical ties between physicians and The Joint Commission



Ernest Codman, M.D.

1910 Ernest Codman, M.D., proposes the “end result system of hospital standardization.”

1913 American College of Surgeons is founded at the urging of Franklin Martin, M.D., a colleague of Dr. Codman. The “end result” system becomes an ACS stated objective.

1918 The ACS begins on-site inspections of hospitals. Only 89 of 692 hospitals surveyed meet the requirements of the *Minimum Standard*.



1951: The Joint Commission on Accreditation of Hospitals

The following organizations entered a “joint” agreement with the American College of Surgeons to create the Joint Commission on Accreditation of Hospitals, an independent, not-for-profit organization whose primary purpose was to provide voluntary accreditation.

- American College of Physicians
- American Hospital Association
- American Medical Association
- Canadian Medical Association



The evolution continues...

- ▶ **1959** The Canadian Medical Association withdraws to form its own accrediting organization.
- ▶ **1979** The American Dental Association becomes a JCAH corporate member.
- ▶ **1988** The name changes to the Joint Commission on Accreditation of Healthcare Organizations to reflect an expanded scope of activities.



Mission statement

- ▶ **1999** The Joint Commission's mission statement is revised to explicitly reference patient safety:

"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."



The Joint Commission in 2007

- ▶ The name is changed to **The Joint Commission**. The new brand reflects The Joint Commission's continuing efforts to improve the value of accreditation and its utility as a mechanism for improving the quality and safety of patient care.
- ▶ A new mantra is adopted to reflect The Joint Commission's commitment to the organizations it accredits and the public it serves:
"Helping Health Care Organizations Help Patients"



The Joint Commission today

- ▶ The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States.
- ▶ The Joint Commission's comprehensive accreditation process evaluates an organization's compliance with state-of-the-art standards, National Patient Safety Goals, and other accreditation requirements.
- ▶ Joint Commission accreditation is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
- ▶ To earn and maintain The Joint Commission's Gold Seal of Approval™, an organization must undergo an on-site survey or review by The Joint Commission at least every three years (every two years for laboratories).



Accreditation

The Joint Commission provides evaluation and accreditation services for the following types of organizations:

- ▶ General, psychiatric, children's and rehabilitation hospitals
- ▶ Critical access hospitals
- ▶ Home health agencies, home medical equipment services, hospice services and other home care organizations
- ▶ Nursing homes and other long term care facilities
- ▶ Behavioral health care organizations, addiction services
- ▶ Rehabilitation centers, group practices, office-based surgeries and other ambulatory care providers
- ▶ Independent or freestanding laboratories



Certification


- ▶ The Joint Commission awards Disease-Specific Care Certification to primary stroke centers, inpatient diabetes programs, chronic kidney disease programs, asthma management programs, and many other chronic disease programs.
- ▶ The Joint Commission's Health Care Staffing Services Certification Program recognizes excellence in supplemental staffing agency performance.
- ▶ Transplant Center Certification provides national standards and recognition of exemplary performance for kidney, heart, lungs, liver and other transplant programs.
- ▶ Health Care Services Certification focuses on improvement at the microsystem level for special services such as palliative care, physical rehabilitation, subacute care or wound care.



The Board of Commissioners

The Board consists of 29 individuals, including physicians, administrators, nurses, employers, a labor representative, quality experts, ethicists, consumer advocates and educators.

- Three ACS representatives
- Three ACP representatives
- One ADA representative
- Seven AMA representatives
- Seven AHA representatives
- Six public members
- One at-large nursing representative
- Joint Commission President
- Non-voting members represent Home Care, Long Term Care and Behavioral Health Care



Part II: Focus on patient safety — accreditation process, standards and performance measurement

*The patient care experience is at the center of
who we are and what we do*

- ▶ The Joint Commission's mission is focused on continuously improving the safety and quality of care provided to the public.
- ▶ The public is demanding more information about safety and quality of health care.
- ▶ Physicians are a vital link in improving patient safety and delivering high quality health care.



Physician involvement in the accreditation process

- ▶ May be asked to be a part of the organization's team conducting the periodic performance review (mid-cycle assessment).
- ▶ During the on-site survey, physicians may be interviewed as part of the patient tracer or system tracer activities to discuss their involvement in:
 - National Patient Safety Goal compliance
 - Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ use
 - Performance measurement activities



Accreditation process

- ▶ Is continuous, data-driven and focuses on operational systems critical to the safety and quality of patient care.
- ▶ At its most fundamental level, accreditation is a risk-reduction exercise.
- ▶ Has undergone two major re-inventions that emanated from patient safety issues: the 1986 Agenda for Change project and the 2004 Shared Visions-New Pathways project.



A recent study determined that:

“Joint Commission accreditation is a key predictor in the implementation of systems that promote patient safety by hospitals.”

“Accreditation status was the only organizational characteristic that consistently emerged in identifying which hospitals have more extensively implemented patient safety systems.”

“...The Joint Commission should continually strive to maintain evidence-based and state-of-the-art standards that advance the aim of providing the best possible care for hospitalized patients.”

(Longo et al, *Journal of Healthcare Management*,
May/June 2007)



Patient safety-focused standards

- ▶ More than 50 percent of standards are directly related to safety, addressing: medication use, infection control, surgery and anesthesia, transfusions, restraint and seclusion, staffing and staff competence, fire safety, medical equipment, emergency management, and security.
- ▶ Include requirements for the response to adverse events; the prevention of accidental harm through the analysis and redesign of vulnerable patient systems (e.g., the ordering, preparation and dispensing of medications); and the organization's responsibility to tell a patient about the outcomes of the care provided to the patient—whether good or bad.



Developing new standards

- ▶ New standards are added only when they will have a direct effect on the quality of care, or in response to environmental changes.
- ▶ The Joint Commission seeks best evidence available
 - Supported by well-designed studies
 - Expert opinion
- ▶ Recent examples of standards changes:
 - Influenza immunization
 - Emergency management
 - Pharmacist review of medications in the ED

Example 1: Medication Management

Opportunities for error

- Look alike-sound alike drugs (15% of USP database)
- Illegible handwriting
- Similar labeling/packaging
- Incorrect drug selection from computerized list
- Wrong drug or dose especially high alert meds
- Drug interactions
- Lack of medication reconciliation
- Abbreviations, acronyms, symbols misunderstood
- Administered to wrong patient



Medication Management standards

MM.1.0-MM.8.10

A well-planned and implemented medication management system supports patient safety and improves the quality of care by:

- Using evidence-based good practices to develop medication processes (MM.6.10)
- Monitoring medication management processes across the hospital to improve the medication management system (MM.8.10)
- Handling all medications in the same manner, including sample medications (MM.2.10)
- Reducing practice variation, errors and misuse (MM.5.10)



Example 2: Surveillance, Prevention and Control of Infection

- ▶ Prevention of health care-associated infections represents one of the major safety initiatives a hospital can undertake.
- ▶ CDC estimates that each year approximately two million patients acquire infections not related to their condition.
- ▶ These infections result in about 90,000 deaths and add between \$4.5 to \$5.7 billion per year to patient care costs.



Surveillance, Prevention and Control of Infection standards IC.1.10-IC.9.10

The goal of an effective IC program is to reduce the risk of acquisition and transmission of health care acquired infections. The hospital's program should:

- Establish a hospital-wide infection control program that identifies the risk for the acquisition and transmission of infectious agents (IC.1.10 and IC.2.10).
- Incorporates relevant guidelines into the infection control and preventions activities (IC.4.10).
- Offer influenza immunizations to staff and licensed independent practitioners (IC.4.15).
- Evaluate the effectiveness of the program (IC.5.10).
- Be prepared to respond to an influx, or the risk of influx, of infectious patients (IC.6.10).



Example 3: Credentialing and Privileging

- ▶ Determining the competency of practitioners to provide high quality, safe patient care is one of the most difficult decisions an organization can make.
- ▶ The credentialing and privileging process collects, verifies and evaluates data relevant to a practitioner's performance.
- ▶ These activities serve as the foundation for objective, evidence-based decisions regarding appointment to the medical staff and the granting of privileges.



Credentialing and Privileging standards

MS.4.00-MS.5.10

- ▶ The hospital collects information regarding each practitioner's current license status, training, experience, competence and ability to perform the requested privilege (MS.4.10).
- ▶ The decision to grant or deny privileges or to renew them is an objective, evidence-based process (MS.4.15).
- ▶ The medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional practice (MS.4.30).
- ▶ The medical staff provides the oversight for the quality of care, treatment and services by recommending members for appointment to the medical staff (MS. 4.60).



Influencing patient safety standards — Physician input


There are several ways that physicians influence the standards development process:

- ▶ Traditional methods
 - Expert panels
 - Expert opinion
 - Field reviews
 - Electronic — allows structured analysis
 - Written — typically used by professional orgs
- ▶ Newest method
 - WikiHealthCare™

WikiHealthCare™

- ▶ A collaborative approach to the development of accreditation and certification standards.
- ▶ Designed to enable and encourage discussion and collaboration among *all* users for the purpose of improving health care quality.
- ▶ The Joint Commission provides the forum; users control the content.
- ▶ Access it on the Joint Commission home page or go to <http://wikihealthcare.jointcommission.org>





“By incorporating real ‘teeth’ into its patient safety standards as well as into its accreditation process, The Joint Commission provides the motivation for hospitals nationwide to follow its lead. This is a public trust that The Joint Commission must keep sacred.”

—Robert G. Kiely, FACHE
President and CEO
Middlesex Health System



The Joint Commission survey is patient-centered

Throughout the survey, physician participation is critically important to evaluating the quality of the care, treatment and services that the patient received.

- ▶ Surveyors use the “**tracer methodology**” to assess the patient’s care experience and the organization’s system for providing care and services.
- ▶ Surveyors retrace the specific care processes that the patient experienced by observing and talking to staff, including physicians, in areas that the patient received care.
- ▶ The tracer activity provides opportunities to provide education to organization staff and leaders, as well as, to share best practices from other health care organizations.



The Joint Commission survey is systems-focused

- ▶ Surveyors conduct “**systems tracers**” to analyze key operational systems that directly affect the quality and safety of patient care.
- ▶ System tracers involve discussion and education about the use of data in performance improvement (as in core measure performance and the analysis of staffing), medication management, infection control, emergency management and other current topics of interest to the organization.



Benefits of the survey process

- ▶ Surveyors concentrate on the issues most important to each organization surveyed.
- ▶ The survey process is customized to the organization's settings, services, patient population and demographics.
- ▶ The process focuses on the delivery of care (guided by the Priority Focus Process and tracer methodology).
- ▶ Less paperwork and burden of preparing documentation for survey because surveys are unannounced.



Performance measurement

Performance measurement was first introduced into the accreditation process in 1997. The ORYX Initiative allows The Joint Commission to review data trends and to work with organizations as they use data to improve patient care.

- ▶ During the on-site survey, surveyors assess organizations' use of measures in their performance improvement activities.
- ▶ For hospitals, The Joint Commission also collects data on standardized or “core” performance measures.
- ▶ The Joint Commission is working with CMS to align current and future core measures.
- ▶ Currently, measures for heart attack, heart failure, pneumonia and surgical care are aligned.



Providing performance data to the public

Improving America's Hospitals is an annual report first published in 2006, which focuses on the quality of care provided to patients with heart attacks, heart failure, pneumonia and surgical conditions.

- ▶ Portrays aggregate performance of accredited American hospitals against the standardized national performance measures and the National Patient Safety Goals.
- ▶ Is part of ongoing efforts to emphasize the importance of accountability in health care and continuous improvement for hospitals.
- ▶ Empowers consumers with information to make them more active participants in their health care.

Performance measurement activities have improved the quality of care

Article in *The New England Journal of Medicine*, “Quality of Care in US Hospitals as reflected by Standardized Measures, 2002-2004:”

- ▶ Examined hospital performance on 18 standardized indicators of the quality of care for acute myocardial infarction, heart failure and pneumonia
- ▶ Data was collected during a two-year period in 3,000 accredited hospitals.
- ▶ Descriptive analysis revealed a significant improvement ($P < 0.01$) in the performance of the hospitals on 15 of 18 measures. The magnitude of improvement ranged from three to 33 percent during the eight quarters studied.

(Williams, Loeb et al, *The New England Journal of Medicine*, July 21, 2005)



“Public reporting of standardized measures of quality has become an important component of quality improvement activities at national and local levels.

...other characteristics of hospitals, including ownership, teaching status, JCAHO accreditation, and investments in technology and nursing, were also strongly related to performance, and these characteristics are often remediable and can be used to influence patient choice.”

(Landon et al, *Archives of Internal Medicine*, 2006; 166)



Part III: Patient Safety Initiatives

In addition to the standards, The Joint Commission demonstrates its commitment to patient safety through:

- Sentinel Event Policy
- *Sentinel Event Alerts*
- Sentinel Event Advisory Group
- National Patient Safety Goals
- National Patient Safety Summits: Wrong Site Surgery, Medical Abbreviations, Medication Reconciliation
- The Universal Protocol™



Sentinel Event Policy

- ▶ A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. "Sentinel" because they signal the need for immediate investigation and response.
- ▶ The Sentinel Event Policy, implemented in 1996, is designed to help health care organizations identify sentinel events and take action to prevent their recurrence.
- ▶ Any time a sentinel event occurs, the health care organization completes a root cause analysis, implements improvements to reduce risk, and monitors the effectiveness of those improvements.
- ▶ The Joint Commission shares de-identified, aggregate information about sentinel events at:
www.jointcommission.org/SentinelEvents/Statistics

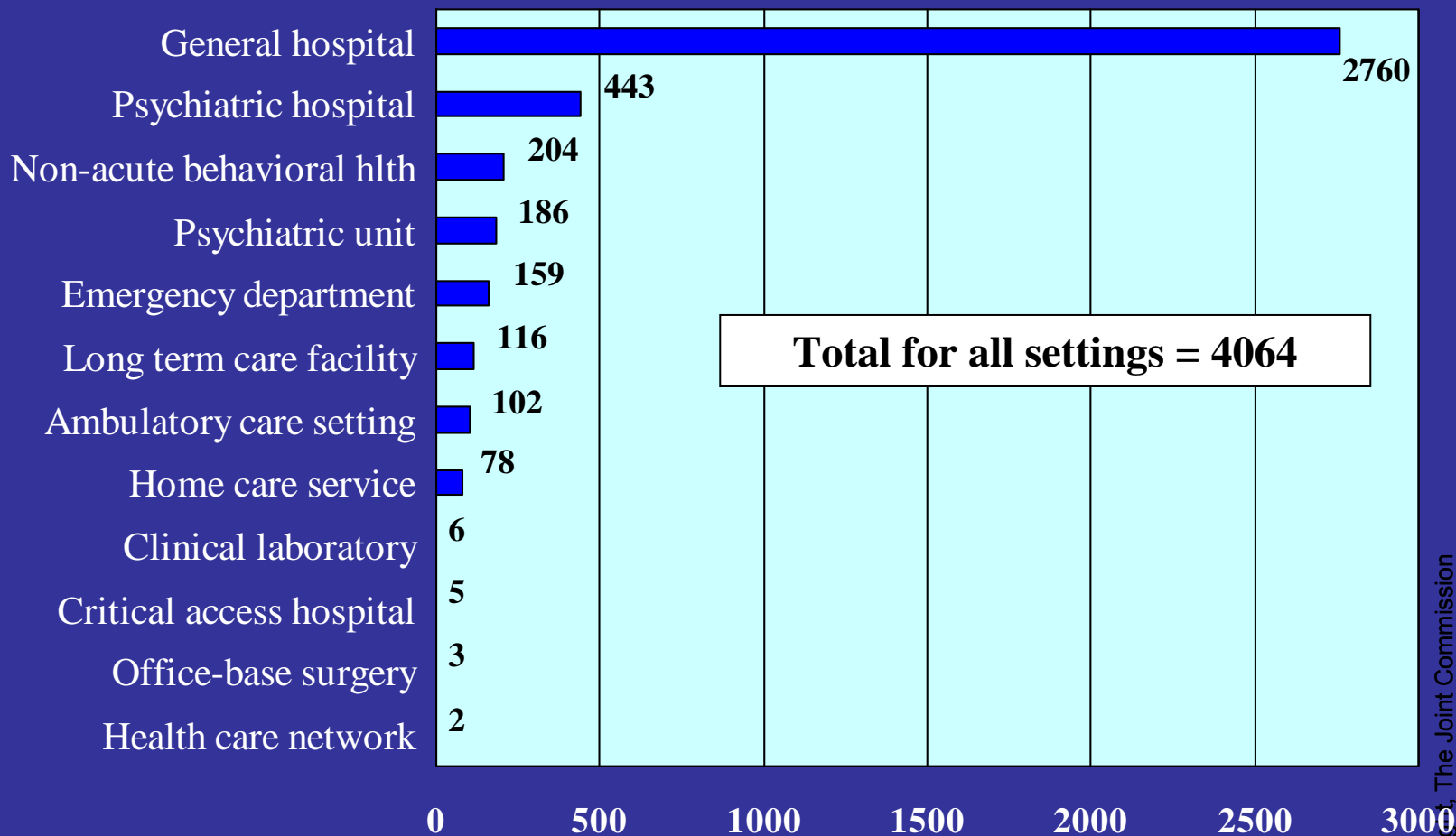
Sentinel Event experience

Of 4,064 sentinel events reviewed by the Joint Commission, January 1995 through December 2006:

- 531 events of wrong site surgery
- 520 inpatient suicides
- 488 operative/post op complications
- 385 events relating to medication errors
- 302 deaths related to delay in treatment
- 224 patient falls
- 153 deaths of patients in restraints
- 138 assault/rape/homicide
- 125 perinatal death/injury
- 94 transfusion-related events
- 85 infection-related events
- 72 deaths following elopement
- 66 fires
- 67 anesthesia-related events
- 51 retained foreign objects
- 763 "other"

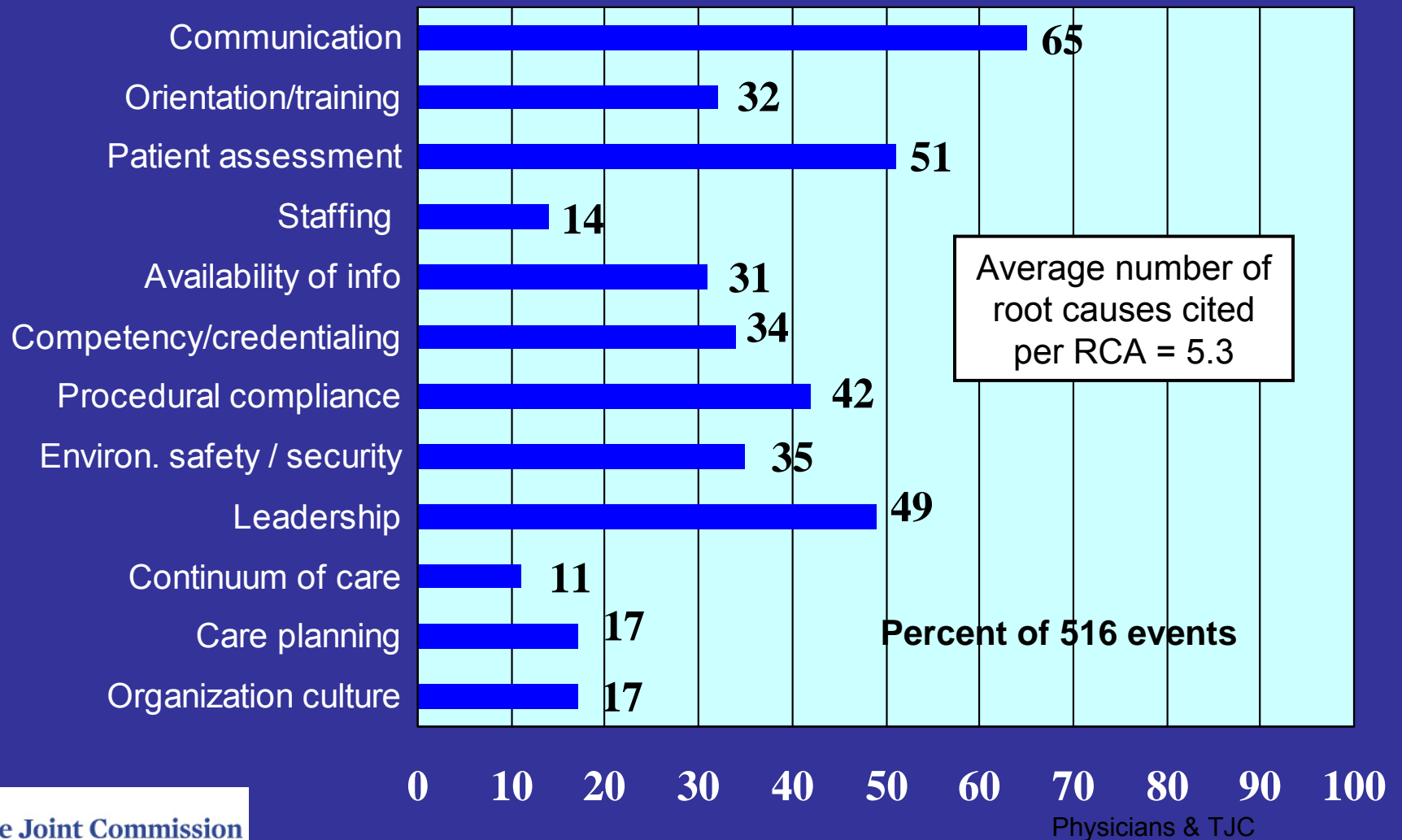
Settings of Sentinel Events

January 1995 through December 2006



Root causes of Sentinel Events

(all categories 2006)





Sentinel Event Alert

- ▶ A newsletter that identifies specific types of sentinel events, describes their common underlying causes, and recommends steps to prevent occurrences in the future.
- ▶ Information comes mainly from The Joint Commission's sentinel event database, experts and other organizations.
- ▶ Shares important "lessons learned" and provides important information relating to the occurrence and management of sentinel events.
- ▶ Raises awareness in the health care community and the federal government about the occurrence of adverse events and ways they can be prevented.
- ▶ Topics have included medication errors, wrong-site surgery, restraint-related deaths, blood transfusion errors, inpatient suicides, infant abductions, fatal falls and operative/post-operative complications.
- ▶ 38 *Alerts* have been issued since 1998.



Sentinel Event Advisory Group

- ▶ Appointed in 2002, this group of experienced physicians, nurses, pharmacists and other patient safety experts advises The Joint Commission in the development of its National Patient Safety Goals.
- ▶ Conducts thorough reviews of all *Sentinel Event Alert* recommendations and identifies those that are candidates for inclusion in the annual NPSGs.
- ▶ Advises The Joint Commission as to NPSG face validity, practicality and implementation cost.
- ▶ Aligns potential NPSGs with the requirements of other organizations, such as the National Quality Forum and the Leapfrog Group, to the extent possible.



National Patient Safety Goals

- ▶ In July 2002, The Joint Commission approved the first set of six NPSGs with 11 related requirements for hospitals.
- ▶ In 2004, program-specific NPSGs were developed for all programs.
- ▶ NPSGs promote specific improvements in patient safety.
- ▶ All Joint Commission accredited health care organizations are surveyed for implementation of the Goals and Requirements—or acceptable alternatives—as appropriate to the services the organization provides.
- ▶ Each year, new recommendations are considered from *Sentinel Event Alert* and other sources.

2008 National Patient Safety Goals

- ▶ Patient identification
- ▶ Communication among caregivers
- ▶ Medication safety
- ▶ Health care-associated infections
- ▶ Medication reconciliation
- ▶ Patient falls
- ▶ Flu & pneumonia immunization
- ▶ Surgical fires
- ▶ Patient involvement
- ▶ Pressure ulcers
- ▶ Focused risk assessment (suicide, home fires)
- ▶ Rapid response to changes in patient condition
- ▶ Universal Protocol for Preventing Wrong Site Surgery™

National Patient Safety Goals

Non-Compliance Rates — Hospitals

	Year	2003	2004	2005	2006	2007*
NPSG	Full Surveys	1,249	1,528	1,573	1,429	330
1A	Two patient identifiers	3.8%	4.1%	4.7%	8.1%	3.9%
1B	“Time-out” before surgery (U.P.)	8.9%	8.0%	17.3%	25.8%	21.2%
2A	Read back verbal orders	7.4%	8.2%	12.3%	15.7%	5.5%
2B	“Do not use” abbreviations	23.5%	24.8%	38.6%	36.9%	36.1%
2C	Report critical test results			9.5%	26.9%	35.8%
2E	Hand-off communication				6.1%	5.8%
3C	Look-alike/sound-alike drugs			2.4%	7.4%	6.4%
3D	Label meds and solutions				8.9%	15.2%


*First quarter 2007

National Patient Safety Goals

Non-Compliance Rates — Hospitals

	Year	2003	2004	2005	2006	2007
NPSG	Full Surveys	1,249	1,528	1,573	1,429	330
4A	Pre-op verification process (U.P.)	1.5%	5.4%	4.5%	2.9%	0.3%
4B	Surgical site marketing (U.P.)	6.2%	4.6%	3.3%	6.6%	4.8%
7A	CDC hand hygiene guidelines		1.2%	3.6%	8.8%	6.4%
8A	Medication list & recognition			0.1%	33.9%	18.2%
8B	Transfer/discharge reconciliation			0.3%	27.5%	18.5%

*First quarter 2007



“Prior to JCAHO’s safety goal requiring read-backs of patient names and oral orders, virtually no American hospital had a strict policy mandating this commonsensical redundancy, despite the fact that many restaurants have long performed read-backs to avoid errors in processing take out orders.”

(Wachter, *Health Affairs*, November 2004)



National Patient Safety Summits

The Joint Commission convenes national meetings of experts and representatives of professional organizations, including physicians, to review pressing issues affecting patient safety, and to make recommendations.

- ▶ Medical Abbreviations Summit
- ▶ Wrong Site Surgery Summits
- ▶ Medication Reconciliation Summit



Medical Abbreviations Summit

- ▶ November 2004
- ▶ To gain consensus on:
 - Is there a problem? What is the evidence?
 - Where is the problem? Which documents?
 - Should there be a universal “do not use” list?
 - What should be on the list?
 - Should there be any exemptions?
 - How can a “do not use” requirement be effectively implemented?
 - What is a reasonable expectation for compliance?
 - How does this become a “natural” behavior?

Recommendations from the Summit

- ▶ Continue nationally standardized “do not use” list
 - Also consider prohibiting:
 - “>” and “<”
 - Abbreviations and acronyms for any drug names
 - R and L
 - Apothecary units
 - @
 - cc
 - μg

Official “Do Not Use” List¹

Do not use	Potential problem	Use instead
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write “unit”
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write “International Unit”
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “l”	Write “daily” Write “every other day”
Trailing zero (X.0 mg)* Lack of leading zero .X mg)	Decimal point is missed	Write X mg Write O.X mg
MS MSO ₄ and MgSO ₄	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write “morphine sulfate” Write “magnesium sulfate”

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Wrong Site Surgery Summits

- ▶ In 2003, The Joint Commission hosted the first Wrong Site Surgery Summit with the goal of obtaining consensus on the adoption of a “universal protocol” for preventing wrong site, wrong procedure and wrong person surgery.
- ▶ Participants agreed that:
 - A universal protocol would help prevent the occurrence of wrong site, wrong procedure and wrong person surgery.
 - The protocol should be specific, so as to eliminate confusion about site marking and facilitate communication among surgical team members.
 - It should provide the flexibility needed for unique surgical situations.

Universal Protocol Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery™

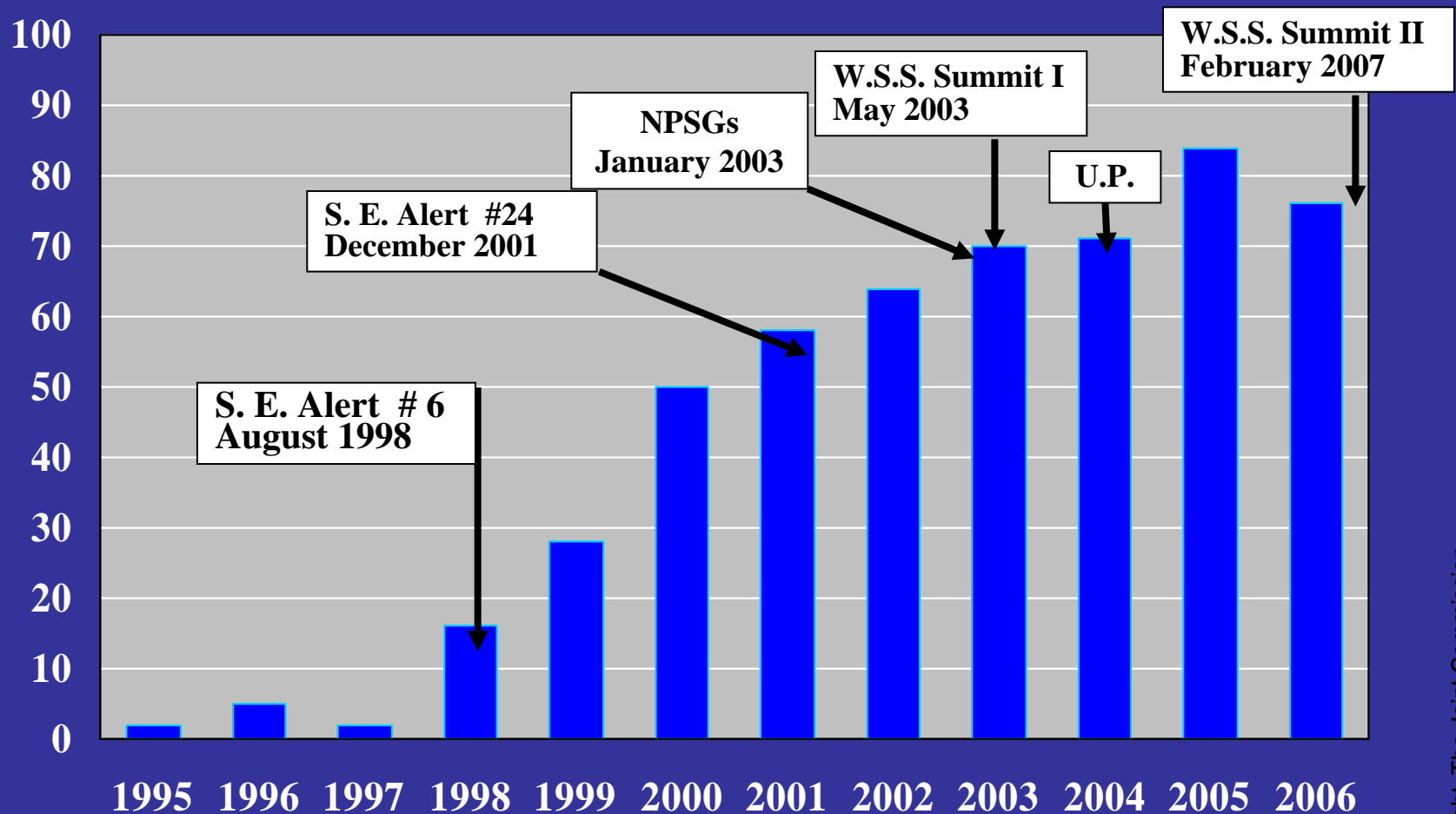
- ▶ Effective in January 2004.
- ▶ Created to address the continuing occurrence of medical errors.
- ▶ Applies to all operative and other invasive procedures. The components include:
 - Pre-operative verification process.
 - Marking of the operative site.
 - Taking a 'time out' immediately before starting the procedure.
 - Adaptation of the requirements to non-operating room settings, including bedside procedures.
- ▶ Endorsed by more than 50 professional health care associations and organizations.



Wrong Site Surgery Summits, *cont.*

- ▶ The follow-up Summit in 2007:
 - Reviewed experience with the Universal Protocol.
 - Examined the barriers to achieving consistent compliance with the performance expectations set forth in the Universal Protocol.
 - Explored other potential strategies for eliminating wrong site surgery.

Sentinel Event trends: Wrong-site surgeries reported by year





Medication Reconciliation Summit

- ▶ Held in September 2007.
- ▶ Participants discussed the challenges associated with reconciling medications in various health care settings.
- ▶ The consensus of the Summit was that the process of medication reconciliation—obtaining an accurate medication list from the patient and assuring its accuracy throughout the care continuum—improves patient safety.
- ▶ A document outlining the suggestions of the attendees and next steps is being developed.



Looking forward to 2009


Topics under consideration for the 2009 National Patient Safety Goals:

- ▶ Elimination of transfusion errors
- ▶ Prevention of multiple drug resistant organism infections
- ▶ Prevention of catheter-associated blood stream infections
- ▶ Prevention of surgical site infections



“...A recent survey of hospital leaders felt that the JCAHO was the most important driver of progress in patient safety.”

(Devers, Pham, Liu, “What is driving hospital patient safety efforts?” *Health Affairs* 23, 2004)



Part IV: Enhancing physician involvement in quality and safety improvement initiatives

The Joint Commission's Board of Commissioners has identified enhancing physician engagement in accreditation and other quality improvement initiatives as one of its top strategic priorities.

With an ability to serve as a bridge between patients and staff and staff and management, physicians play a unique leadership role in fostering improvements in care.

Physician leadership and involvement are critically important to the success of The Joint Commission's patient safety improvement efforts, including:

- Standards review
- National Patient Safety Goals
- Health care summits
- *Sentinel Event Alert* topics



Physician Engagement Advisory Group

- ▶ Established in 2005.
- ▶ Advises The Joint Commission on expanding physician participation in the accreditation process and broadening physician engagement in quality of care and patient safety initiatives.
- ▶ Members include physician quality directors and educators, chief medical officers, private practice physicians and other physician leaders from urban and rural areas.



Public Policy Action Plan

The Joint Commission's Public Policy Action Plan focuses on key areas related to patient safety and health care quality. In approaching these issues, The Joint Commission relies heavily on physician input when:

- ▶ Convening roundtables with experts and stakeholders who are knowledgeable about and affected by the issue. The role of the roundtables is to synthesize the problem and frame potential solutions and accountabilities.
- ▶ Developing white papers that include the prominent elements of the roundtable discussion.
- ▶ Holding national symposia that permit in-depth exploration of important aspects of the problem and the solutions.
- ▶ Conducting follow-up regional summits or other activities to maintain the visibility of the issue and facilitate pursuit of its resolution.



Current public policy initiatives

- Development of a National Performance Data Management Strategy
- Emergency Department Overcrowding
- Emergency Preparedness
- Health Care Professional Education
- Health Literacy and Patient Safety
- Hospital of the Future
- Nurse Staffing Crisis
- Organ Donation
- Tort Resolution and Injury Prevention

For more information about any of these topics, visit www.jointcommission.org

- Sign up to receive physician-specific information.
- Sign up for other Joint Commission info.
- Joint Commission International Center for Patient Safety
- Receive notification of field reviews and other news and events.

