

**THE JOINT COMMISSION NEWS CONFERENCE
TO DISCUSS PROGRESS AND HEALTHCARE QUALITY
FACING AMERICAN HOSPITALS
ON NOVEMBER 12, 2007
AT 11:45 A.M. CENTRAL TIME**

CATHY BARRY-IPEMA: Welcome to The Joint Commission news conference to discuss progress and health care quality in American hospitals.

Today we'll be discussing the findings of the 2007 Annual Report from The Joint Commission. Dr. Dennis O'Leary, who is the president of The Joint Commission, will offer some brief remarks. Also joining us today from The Joint Commission are Jerod Loeb, who is executive vice president in the division of Quality Measurement and Research, and Steven Schmaltz, associate director and senior biostatistician, who will assist in answering any questions you may have following Dr. O'Leary's opening remarks.

In addition to the reporters who are here at the National Conference in Chicago, we also have a number of reporters who are listening in by telephone and will also have an opportunity to ask questions.

Finally, before we get started I want to let you know that complete press kits - that includes the news release, speaker biographies, copies of The Joint Commission Annual Report and other related information - is available on The Joint Commission website at www.jointcommission.org.

I would like to now introduce Dr. Dennis O'Leary.

DR. DENNIS O'LEARY: Thank you Cathy. Thank you for joining us today to talk about this second annual report from The Joint Commission on quality and safety in the nation's hospitals. It is our hope that this report will spur further improvements in health care quality

and patient safety in the nation's hospitals while also broadening the information base for activists of health care consumers.

American hospitals have significantly improved the quality of care provided to patients with heart attacks, heart failure, pneumonia and various surgical conditions. This is especially good news because these are the most common conditions amongst hospitalized patients. These achievements have saved many lives, have resulted in better health and better quality of life for thousands of patients who are hospitalized each year, and have contributed to more efficient use of scarce health care resources. However, the data also identified areas in which hospitals must strengthen their efforts to consistently deliver safe and effective care.

Second annual means more reports are coming. This is actually the second this year, but these will come out every fall in the future. And our measurement arsenal is continuing to expand.

You may wonder why this is only our second annual report. It does take time to advance enough good data in order to provide really useful information. We do this undertaking as the principal part of our accountability responsibility as an accrediting body. It is our responsibility to provide performance information on the organizations we accredit. And, similarly, it is an accountability responsibility on their part to participate in this process, and indeed, last year's report was particularly well received by the hospital field.

All of the accountability work that we have done has occurred well before we entered the age of transparency, which we are obviously now in.

This report complements our longer standing Quality Check™ website, which we also invite you to visit. There you can find information on individual organizations and their performance. This report provides you aggregate information on the performance of hospitals across the country.

Although this report has its primary focus on performance measurement using performance measures, performance measurement is a multi-faceted set of activities. Just to remind ourselves, the standard basic accreditation process, the use of National Patient Safety Goals and their requirements, and then the measurement data reporting process itself.

The combination of these activities permits the deployment of a comprehensive monitoring and evaluation process. Each are addressed within the report but the performance measurement of these get the lion share of the attention. The National Patient Safety Goals are also addressed and then we have a little bit of data on standard compliance problem areas.

Underneath the data there is a substantial consensus building in a quality control set of processes. When we're talking about standards or performance measures or our National Patient Safety Goals, these are all evidence-based, the measures are specified at the data element level, and everything undergoes testing out in the field whether that is a field review, or in the case the performance measures, we're talking about actual on the ground evaluation of the measures for their reliability and their validity.

It is this process of establishing an evidence-based specifying data element and field testing that separates the weak from the champ amongst performance measures. We're also reminded that measured development is a team sport. This is about consensus and collaboration.

We have actually a formal contract with the Centers for Medicare and Medicaid Services to make sure that we have identity at the data element levels and that's a very high level of agreement. We have agreed not to deploy measures unless they are also endorsed by the Hospital Quality Alliance and we do not deploy measures unless they are National Quality Forum endorsed.

Quality measures are also not enough and you must be sure that you have high quality data and, to that end, we contracted 51 performance measurement systems and hold them to a series of obligations on a contractual basis and then we monitor the data that they submit through a fairly elaborate process.

We are very mindful of how the data come to us. There is a data collection burden associated with all of this and that is increasing even as hospitals have become more facile in doing this work. We should all be worried that as the data collection burden increases because of the demands now coming from government, that there are potential data quality challenges because all of this work is done by hand. Eventually, electronic health records will solve this problem but they are probably three to five years away.

Finally, as an overview comment, this report deals more with process outcomes than it does with outcomes, process measures than it does with outcome measures. We're very much aware of the romance around outcomes measures, but this report, future reports and other endeavors like it are likely to continue to focus on process measures. We have a sufficiently strong evidence base to be assured that they are proxies for likely future outcomes.

Among the findings in this report, I would comment as follows. First of all, it's very obvious that what gets measured, gets done because we have seen continuous steady improvement almost across the board for all of these measures.

Performance measures principally are addressing errors of omission, things that you didn't do but you should have done and if you do them, the patient will get better care and then better outcomes. That's relatively easy to measure and also easy to correct.

We have seen variable degrees of improvements since 2002 ranging from about 4 percent up to about 50 percent. Some of the most dramatic improvements have been in

providing smoking cessation advice for patients with heart attacks, heart failure and pneumonia. But there's also lots of room for improvement.

We have only four measures for which hospitals are achieving overall 90 percent compliance and we have lots of inconsistencies across the states. For instance, for discharge instructions for patients of heart failure, compliance ranges from 49 percent to 91 percent

On the patient safety side, the challenges have obviously been greater. Of the 16 National Patient Safety Goal requirements, hospitals are generally over 90 percent of the compliance with 10 of these, but six of them have non-compliance rates of 16 percent to 37 percent. Here we're talking about some of the things that are harder to do particularly in terms of care process redesign – medication, reconciliation, patient handovers, reporting of critical test results and things like that.

This is a test of hospital competency and redesigning care processes. And our experience to date is that many hospitals simply superimpose the safety goal requirement on top of what they're doing and that does not work. And so there is a challenge, I think, across the country in developing internal engineering capabilities that will permit organizations to design care processes that prevent the key inevitable human error from reaching the patient.

In this very fluid environment, the states for measurement and for improvement are steadily rising. These measures are no longer just for quality improvement or even for accountability in informed decision making, this is now about pay for performance accounts.

Reports such as this one, based on credible evidence-based performance measures and high quality data, will be an increasingly critical element of the future landscape.

Ready for questions.

REPORTER: I was wondering if you could tell us a little bit about hospital compliance with National Patient Safety Goal Eight which relates to medication reconciliation. The numbers don't look all that high. I was wondering if you could comment on that for me.

DR. DENNIS O'LEARY: Well, that's one of those areas where we're talking about a care delivery process and medication reconciliation, as you probably are aware, involves transfers within the hospital both at the nursing level and at the doctor level or transfers between organizations including taking patient from hospital to home.

It's seemingly simple to get the list of medications from where the patient was to where the patient is going straight, but it in fact is a terrible challenge and we have had both national audio conferences and a national summit on this. And I don't think anyone disagrees with the need for this and we know this is the most common cause of medication error, but people are just having a terrible time doing it. And it is a care process design challenge.

REPORTER: Okay, are you finding common issues that are keeping hospitals from complying at the level that you might want them to?

DR. DENNIS O'LEARY: I would say the answer to that is yes and the one that I hear the most concern about is when the patient is discharged. The requirement that a correct updated list of medications be provided both to the patient and to all of the physicians that are still caring for the patients. That seems to be harder for hospitals to do than anything else. But it is very important. If the patient is going to continue being under the care of one physician or three physicians or whatever it is, they need to have that information.

REPORTER: Can you speak about ventilator associated pneumonia? Have accredited hospitals in the last year or two been successful at reducing their incidents of ventilator associated pneumonia? And if so, how are they doing it? And if not, why haven't they been successful?

JEROD LOEB: The metrics that we look at in the ventilator associated pneumonia measure set comprise a group of metrics that when taken together are designed to reduce the likelihood of ventilator associated pneumonia.

As you heard Dr. O'Leary mentioned earlier, the challenge associated with reporting, collecting and reporting on clinical outcome is not insignificant. It's not insignificant for a variety of reasons not the least of which you need patient level data, good risk adjustment methodologies, and so on to do that. So we've chosen at this point to focus on the process related steps which we know have an inextricable linkage to outcomes.

And if you look at the data, you will see consecutive year-by-year increases in terms of compliance with the various performance measures that we know if followed result in fewer cases of ventilator associated pneumonia.

Now, whether there's specific data to suggest that the actual incidents of ventilator associated pneumonia is decreasing, we don't have those numbers for you and hopefully at some point downstream we might. There's certainly been a lot of recent publications, most notably a project that's called the Keystone Project out of the Michigan Hospital Association which was in the *New England Journal of Medicine* probably about six or eight months ago, has shown absolutely that if these evidence-based practices are complied with and complied with 100 percent the incidence of ventilator associated pneumonia drops precipitously and can, in fact this is the data from the *New England Journal of Medicine* article, actually reach zero.

So you know our quest here is to create what at least in literature has been called high reliability organizations where the right things are done 100 percent of the time for every patient for whom a particular process measure is the specific candidate.

DR. DENNIS O'LEARY: I do think that as we go downstream and you know that each of the measure sets are going to need to have risk adjusted outcomes and measures. At least one associated so that there can be a correlation between the process measures and the outcome measures. But we're just not there yet. I don't think that there is any national data on ventilator associated pneumonia yet.

REPORTER: Are you finding hand washing becoming more customary, especially with the introduction of new hand gels that are out right now?

DR. DENNIS O'LEARY: We would like to believe that's true but we don't believe that's true. I think there are isolated organizations that have solved the problem by literally weaving that into their culture. But your typical American hospital, probably the best that any of them do, is around 35 percent compliance. That's the best data we have. And it really speaks to both the culture across professionals who work within the hospital setting and the fast pace of care. I mean nurses will simply tell you they would, they know it's important, they would like to do it, but they are on the run literally taking care of patients.

So one of the things that we have pushed hard for is to engage the patients in the process to have patients ask caregivers whether they've washed their hands. It is effective, but you have to have a little spine in order to do that.

JEROD LOEB: I would also add that, and it's actually connected to my previous comment relative to the Keystone Project, one of the things that is crucial is breaking down the cultural barriers—a nurse or pharmacist or administrator. Stopping the line, if you will, and saying wait a minute I didn't see you wash your hands. I mean something as simple as that, as part of a cultural acceptance as being norm is really going to change things. And right now there are very few hospitals that have achieved that level of cultural norm as part of their every day practice.

REPORTER: This is something that would seem to be fairly simple and that's 2b, the standardized abbreviations and acronyms and symbols. We've got a 37 percent non-compliance rate, could you speak to that just a bit?

DR. DENNIS O'LEARY: Yes, that's a source of very great frustration. The problem is this is less a system's problem and more a behavior problem. And basically you've got physicians who say excuse me I was taught to use these abbreviations in medical school and I'm using them.

Unfortunately, no one taught them to write legibly in medical school and so this is a real problem and when physicians blow this off and they have illegible handwriting or not very legible handwriting and somebody can't make out the dosage or the medication correctly and, you know, we get medication accidents and there are classic illustrations of this.

Going downstream, the great challenge is going to be when we get into fully electronic records is to make sure that all of those abbreviations have been eliminated so that you avoid create a forcing function and make it impossible to use abbreviations.

But we have already seen where it was some electronic records that these abbreviations creep into the text of the records, the orders and everything else and so, even, we have a certain amount of rework to do even with the electronic records that we have in place. This is one of those very deep cultural issues but we know that this practice of using abbreviations is unsafe.

REPORTER And is there anything behaviorally or culturally that you've looked at that might be able to address this a little more successfully or does it fall into the hand washing category as just a tough nut to crack?

DR. DENNIS O'LEARY: It certainly falls more into the hand washing category, but I think it does speak to the fact that you are going to have difficulty making some of these major changes. Even including care process redesign in the absence of the creation of cultures of safety within organizations where safety is the top priority, it's the over the fold issue and we do have organization like this in country but you can almost name them.

JEROD LOEB: I would just add one piece to what Dr. O'Leary has said and that is part of this relates to the issue of tolerating deviant behavior. And, unfortunately, in a fair number of America's health care institutions, such deviant behavior is simply tolerated and that's a cultural norm which needs to change.

REPORTER: A little about The Joint Commission itself, I heard Dr. O'Leary speak about a year ago at the Quality Colloquium at Harvard in August '06. You mentioned that there was a bit of a high turnover rate in your surveyor core and you attributed it to the increasing complexity of the standards and, I guess, the increasing complexity of doing the job of

surveying. Can you speak a little about how you develop surveyors? Where do they come from? What are their backgrounds? And are you shorthanded or at full strength right now in your surveyor core?

DR. DENNIS O'LEARY: We're at full strength right now and the turnover has abated significantly. We probably had a major turnover as a consequence of a policy change. And then there were stresses associated with the democratization process, some cognitive and some physical, because they're moving around a lot because of the patient tracer methodology.

I would say the surveyors coming out, they all have the standard requirements for medical staff – leadership roles, experience in quality improvement, many of them have previously been medical directors or vice presidents for medical affairs in the institutions that they have served. The nurse surveyors are almost uniformly former chief nurse executives and the nurses now make up the majority of surveyors in our core. And we still have some administrative surveyors, although smaller in numbers, and then a pretty significant number of life safety code specialists. These are people who are looking at fiscal plans and environment in life safety code requirements.

That's quite a stable group of people. So overall we're pretty pleased with them.

One of the ways I think you can tell that they are getting their feet on the ground and starting to feel comfortable is that some of the National Safety Patient Goals where the non-compliance rates are going up over time, that is almost certainly a matter of surveyors becoming more skillful and sophisticated in evaluating compliance. And because it's really doubtful that that would be explained by anything else.

REPORTER: Good afternoon. Dr. O'Leary, I was interested in the remarks you were making about government requirements and I wondered if you would speak a little bit about how well or to what extent you're working with the government on these measures and where the cooperation is not so strong as you would like it to be or you think it ought to be?

DR. DENNIS O'LEARY: Well, the way things are working now is that the requirements have been formulated in legislation and legislators and Hill staff are not necessarily highly knowledgeable about this process. So these requirements then get handed off to CMS usually to do the implementation where there is interpretation afforded with regards to legislation.

But at that level, we're talking about measurement at the organization and particularly at the hospital level, we work very closely with CMS. That's really not a significant problem. And I think much of the current fervor and stirrings around measurement of position performance, which is an area of which we have a lot of interest but not a lot of responsibility, as yet.

My comment was really meant to say that the government has taken over calling the shots on the performance measurement requirements and it's not always sensitive to what's possible. It would be one thing to create these requirements in the space of an environment of which everybody is using electronic records. That would be relatively easy if those were all in place, but we know the level of adoption across the country is pretty modest and furthermore, most of those electronic record systems have not been designed to capture performance measurement data as a bi-product of care. So even the ones that are deployed are going to have to be reworked in order to have this capability.

I think we also know that the road has got to run both ways that measure sets are going to have to be modified to fit into electronic records. I think most of us didn't realize

that that was going to be true. So the performance measurement world keeps changing fairly rapidly.

JEROD LOEB: We certainly have worked very closely with CMS as far as creating, not just aligned but identical measures, but there's an exquisite dependency now that is in fact kind of a worrisome dependency in that the vast majority of the data, in fact 93 percent of the data to be exact, that is being delivered by the nation's hospitals to the QYO warehouse for use to meet the legislative mandates that Dr. O'Leary spoke of, come through Joint Commission listed vendors.

We at the moment are the only ones that have contractual relationships with the vendors. Neither CMS or the QYO programs do. Thus when you think about the quality of the data and the various uses to which these data are being put, including accountability, public reporting, payments, et cetera, one needs to assure themselves that the data quality are of the highest level possible. And we're the only ones that have the ability to hold anyone's feet to the fire.

But I think collectively what has been built is a very tenuous house of cards because not all the players are connected as they should be in this process. So these dependencies are rather interesting when you look at them from the outside and the house of cards could fall at any moment in time.

REPORTER: When you say that not all the players are connected, you're saying that you are the only one with the direct connection to the vendors, right?

JEROD LOEB: That's correct. Even though 93 percent of the data that gets transmitted for use in meeting both the Medicare Act and the subsequent pieces of legislation, deficit

reduction, tax care and health relief et cetera, all of those individual data transmissions, at least 93 percent of them are coming through the vendor community with whom we have contractual relationships but CMS does not. But we all play nice in the sandbox to make this work.

REPORTER: Well, you said you thought the house of cards could come tumbling down at any minute. What kind of scenario would make that happen?

JEROD LOEB: Well, there could be several. The issue with respect to how individual vendors wish to continue playing, I mean as you well know there is now a requirement for, as far as the Tax Care and Health Relief Act, for outpatient measures to be transmitted.

Now one of the issues that has really dogged the hospitals is they have no mechanisms to get those data to the QYO data warehouse absent using the vendor communities. And, again, since we're the only entity that has a relationship contractual, contract-wise with the vendor community, we decided that and our Board decided just in fact a week ago, to offer these measures as a mechanism to meet Joint Commission accreditation requirements which created some leverage for the vendors to implement these individual measures. Now, were The Joint Commission not to have done that, I think the house of cards could come tumbling down.

REPORTER: Yes.

JEROD LOEB: I think the wisdom of our Board was such that they saw a way to leverage implementation here, reduce the duplicative demand on the part of the hospitals, and essentially create a win-win.

REPORTER: I was wondering if internally you have cut these results in different ways, separating out let's say academic medical centers, or hospitals above and below certain bed sizes, or by metro versus non-metro, or any other way. It might be telling to see what kind of differences in clients there are. I'm thinking of some of the Dartmouth conclusions that show quality of care is not necessarily better in an AMC, or hospital associated with an AMC, than it is with a primary care facility. It would be interesting.

STEVEN SCHMALTZ: We have looked at it in different ways. A lot by the hospital care small and large bed size, teaching versus non-teaching, urban versus rural. But a lot of what we've looked at there seems to be a big effect to volume in that hospitals with small volume, whether they're an urban or rural hospital or that they're a large or small hospital, the small volume hospitals seem to have trouble with compliance than larger hospitals.

JEROD LOEB: I would just add to what Steve said. We literally just this morning had a paper accepted that deals with this volume issue and interestingly enough while folks have talked for years, as I'm sure you're aware, about volume, surgical volume, it's not the et cetera with the underlying notion that presumably that practice makes perfect. The question that we asked in this piece of work, which is now accepted but has not yet been published, is from a process measure standpoint would there be a correlation between organizations that see a particular number of patients and their ability to comply virtually 100 percent with any one of these process measures pertinent to heart failure, pneumonia, et cetera. And absolutely we see quite significant correlations between numbers of patients and it varies depending upon the clinical condition one is studying.

So, your point is well taken that what Jack Lindberg has been saying for years, for decades as it relates to geography being destiny in health care, it also is finding its way into

the kinds of data that we've been looking at and the various additional cuts of the data. And, obviously, there's sort of two spins here.

One spin is this report that's being issued today, which is a very high level sort of global view of American health care as it pertains to our accredited facilities. There's also the academic pursuit that we're undertaking relative to the various kinds of cuts that we can make and hopefully contribute to the literature base and ultimately improve quality and safety.

DR. DENNIS O'LEARY: If you want to match our stuff against Lindberg's you might say where they are doing a lot of these things they do them well whether they are necessary or not.

REPORTER: Right.

DR. DENNIS O'LEARY: I mean that's one way of looking at it.

REPORTER: Is the curve continuous as volume rise above however you define some threshold number?

JEROD LOEB: I'll let Steve speak in more details, but I'll skim the cream off the top here. The answer is that yes there's a threshold point after which once you have seen x number of patients, compliance doesn't increase with a greater number of patients. That it varies by measure and it varies somewhere between roughly, Steve, what, 90 patients and about 200 patients is the number. And again, it varies measure by measure but there's a threshold

effect that is absolutely clear when you look at the graphical analyses where you reach a point and it literally won't change after that.

REPORTER: Interesting. And in terms of volume, you've looked at large primary care versus large tertiary care centers?

STEVEN SCHMALTZ: We haven't looked to that level of detail yet but there's definitely a lot more that we could look at as far as subgroups.

DR. DENNIS O'LEARY: Yes, primary care is really outpatient care so we're not picking that up in this particular...

REPORTER: Well if you're thinking of heart attack and pneumonia and that sort of thing, I think you're right down the centre of the road, aren't' you?

DR. DENNIS O'LEARY: Well we are, primary care is outpatient care. So by definition we're not picking it up and this report is only about inpatients.

REPORTER: No, but I'm thinking in terms of a community hospital that's not a referral centre but it's got 750 beds.

DR. DENNIS O'LEARY: Okay, that's secondary care.

REPORTER: All right. I've always thought of that as a primary care hospital. All right, have you compared secondary care hospital, large secondary care with tertiary care hospitals?

STEVEN SCHMALTZ: Not yet.

REPORTER: Okay and would you be willing to release your findings that you've reached so far?

JEROD LOEB: Well, the findings that we've got so far, as I said earlier, is we literally this morning got the paper which pertains the volume thresholds and performance measures accepted. I'm assuming that will appear in probably early to mid 2008 because it was just accepted. We still continue to work on cutting the data in a variety of ways.

I don't think I'm telling a tale that in all the work that we published in the past, this is not organizational specific. We aggregate at a point where we can provide important communication messages but not organizational specific information. However, having said that, as you heard Dr. O'Leary mention earlier, the data are there. On our website you can actually do data downloads now with quarterly data points. So anybody that has the inclination and the academic wishes can go ahead and do the very same kind of analyses that we can do. So I mean they're there for the taking. They're available literally today.

REPORTER: Right, I was referring to access to the underlying data not to your paper, not to volume of facts and that sort of thing; just compliance based on geography and bed size and that sort of thing.

JEROD LOEB: Well, I expect that downstream the report that you're looking at today is going to be richer. And particularly, as you may know, one of the important decisions that our Board made last year which has been realized as of just a week ago, is The Joint Commission gaining access to what we have formerly called Anonymous Patient Level

Data, we now call Hospital Clinical Data, to the extent that we could do a lot more sophisticated drill down than we've ever been able to do before.

So, I think if you're sort of watching the radar screen from this organization, it's going to light up downstream with respect to our ability to do all kinds of innovative cuts.

DR. DENNIS O'LEARY: I think you raise a good point and I mean if you knew the names of the hospitals you wanted to look at what Jerod said is right, you can go to the website, you can download the hospitals and get the information that you want.

If you want a more sophisticated study, somebody has to commission that so that you know we would do under a contract for somebody.

The other possibility is to wait until we cut out future reports and start doing the additional slicing and dicing which each of the reports is going to become more sophisticated.

But those are really the options because it takes a certain amount of work and then you have to...it's easy to say well, teaching hospitals versus non-teaching hospitals or academic centre, academic health centers as a subset of teaching hospitals, you need to know who's included in and who's included out. And the secondary care hospitals, there are secondary care hospitals of 75 beds and higher and then there are secondary care hospitals that go down to an average daily census of one.

So it really depends upon how you want to define the characteristics of the populations that you want to compare. That's all doable, but it's all work.

CATHY BARRY-IPEMA: I'd like to thank everyone for participating in today's call. Again, this information is all available up on our website at www.jointcommission.org and, having said that, thank you again for joining us and have a good day. Good bye.