The Joint Commission's mission 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. More than 80 percent of the hospitals in the United States use Joint Commission standards to assure the delivery of safe, quality care. A Joint Commission-accredited organization proudly displays its Joint Commission Gold Seal of Approval™ and strives continuously to provide the quality health care exemplified by the seal.

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Improving America’s Hospitals
A Report on Quality and Safety

Introduction from The Joint Commission President
Introduction from The Joint Commission President

In its landmark report, *Crossing the Quality Chasm*, the Institute of Medicine (IOM) described an American health care system that is performing below its potential. The report emphasized that health care effectiveness could be improved by consistently providing treatments and following practices found on the basis of scientific evidence to result in the best results or outcomes. The IOM also encouraged the ongoing tracking of performance in providing “evidence-based” treatments in meeting patient safety goals.

Since *Crossing the Quality Chasm* was published in 2001, health care organizations have worked to track and improve health care quality and patient safety, and have actively participated in efforts to disseminate performance information both to professional and general audiences. These latter efforts allow health care consumers to get more health care performance information faster through the Internet and other communication channels than ever before. But even as the availability of this information has grown, it is clear that consumers want even more specific and credible information about the best and safest treatments, medications, hospitals, and other dimensions of health care.

The first of what will become an annual report, *Improving America’s Hospitals: A Report on Quality and Safety*, presents how America’s accredited hospitals performed against evidence-based quality measures relating to the care of heart attacks, heart failure, and pneumonia, and to surgical infection prevention during the 2005 year. These measures are the product of the Joint Commission’s Hospital Core Measure Initiative that sought to create a set of standardized national measures that would permit comparisons across organizations. Subsequently, The Joint Commission collaborated with other organizations, including the Centers for Medicare and Medicaid Services (CMS) and the National Quality Forum (NQF), to align these measures with other measurement efforts in order to ease data collection efforts by hospitals and to ensure that the measure data were gathered and calculated in a consistent way in all organizations. These measures are also utilized for the “Hospital Quality Alliance: Improving Care through Information” initiative, a voluntary public reporting initiative led by the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges. These data are reported on the CMS Hospital Compare website.
This report also presents hospital performance in complying with the requirements of The Joint Commission 2005 National Patient Safety Goals. These performance results in particular show both where improvements have been made and where future opportunities for improvement still lie. While consumers may obtain information based on measurements or ratings of health care quality and safety from many sources, this report is based on scientifically credible data.

Compiled and published by The Joint Commission, this report presents a compelling portrait of hospital quality and safety. Although this report provides a rich array of comparative data, it does not provide a comprehensive portrayal of health care quality and patient safety in America's hospitals. It is, however, one of several initiatives that are designed to drive continuing improvement in health care quality and safety and to empower consumers with information that encourage them to become more active participants in their health care. Another one of these initiatives – our Quality Check website (www.qualitycheck.org) – gives consumers the ability to see how a specific accredited health care organization, such as a local hospital for example, has performed against the same quality and safety standards presented in this report.

By evaluating health care organizations against specific standards, The Joint Commission helps to improve the quality and safety of the care they provide to the public. This is our mission and our mandate. Our promise to the public is that we will continue to collect and publish accurate, helpful, critical information that will ultimately help patients. This report is part of that promise.

Sincerely,

Dennis S. O’Leary, M.D.
President
The Joint Commission
Improving America's Hospitals
A Report on Quality and Safety

Executive Summary
Executive Summary

U.S. hospitals have significantly improved the quality of care provided for heart attack, heart failure and pneumonia, according to performance data provided by more than 3,000 hospitals accredited by The Joint Commission. The Joint Commission’s mission is to improve health care quality and safety through accreditation and related services that support performance improvement.

Results consistently improved from year to year, with few exceptions, on 15 individual measures of performance quality analyzed from 2002 through 2005. Seven of the 15 measures applied to heart attack care, four to heart failure care and four to pneumonia care. This quality improvement strongly supports continual measurement of hospital performance against standard measures, as well as the reporting of the performance results back to hospitals and to the public.

This report updates a paper on 2002-2004 quality measures published by The Joint Commission in the New England Journal of Medicine in 2005. ¹

This report also identifies 2005’s top compliance issues – quality standards that were the most difficult for hospitals to meet – and performance data measuring hospital compliance with The Joint Commission 2005 National Patient Safety Goals and requirements.

WHY THIS REPORT IS IMPORTANT

This report is important because it shows the following:

• HOSPITALS ARE IMPROVING HEALTH CARE QUALITY AND SAFETY

_The magnitude of national improvement on individual measures ranged from 1.1 percent to 42.8 percent over this four-year period._ Hospital performance improved the fastest on measures where performance was lowest in 2002. For example, the largest and fastest improvement occurred in providing smoking cessation advice to pneumonia patients. In 2005, hospital staff advised pneumonia patients to stop smoking in 80 percent of the situations where providing this advice was recommended by national guidelines. There was an expectation to provide this advice 100 percent of the time. In 2002, pneumonia patients were given this advice in only 37.2 percent of these situations.

EXECUTIVE SUMMARY

- **Fourteen individual measures tracked whether or not hospitals provided “evidence-based” treatments** – practices shown by scientific evidence to be effective. In addition, a 15th measure tracked inpatient mortality for heart attack patients, which was reported as the average percentage of patients dying during their hospital stay. Scientific evidence shows a correlation between providing evidence-based treatments to heart attack patients and lower mortality.

- **Hospitals also improved their results on “composite” measures of quality for heart attack, heart failure and pneumonia care.** Composite measures combine the results of all individual measures into a single percentage rating calculated by adding or “rolling up” the number of times recommended care was provided to patients and dividing this sum by the total number of opportunities to provide this care. From 2002 to 2005, all three composite measures of quality improved: 86.9 percent to 90 percent for heart attack care, 60.7 percent to 76 percent for heart failure care, and 72.3 percent to 81 percent for pneumonia care.

*Each year, The Joint Commission identifies top compliance issues – quality standards that were the most difficult for hospitals to meet.* This report covers the compliance rates – ranging from 90 to 59 percent – that hospitals achieved for the 14 issues identified for 2005. The Joint Commission continually monitors compliance and annually updates the top issues list.

*This report illustrates national performance data measuring the compliance of Joint Commission accredited hospitals* with the 16 requirements of The Joint Commission 2005 National Patient Safety Goals. For example, the requirement relating to health care-associated infection was achieved by 100 percent of hospitals.* Several other goal requirements were achieved by nearly 100 percent of hospitals.* On other goal requirements, a significant percentage of hospitals fell short of compliance standards. Each year, goals and requirements are retired as hospitals achieve compliance, and new goals and requirements are identified. Data regarding compliance with The Joint Commission National Patient Safety Goals should be interpreted with caution; compliance often requires significant behavioral and/or systemic change and lower rates can be due to a variety of factors. For each of these requirements, The Joint Commission is seeking out well-performing organizations to understand what approaches work well and, with many of them, what approaches failed before they found success.

*The 1,573 hospitals that underwent on-site surveys during 2005.*
EXECUTIVE SUMMARY

• PERFORMANCE IMPROVEMENT PROCESSES SAVE LIVES – AND MUCH MORE

Quality and safety improvement in hospitals contributes to saved lives, better health and quality of life for many patients, and lower health care costs. On the other hand, when hospitals do not consistently provide standard evidence-based treatments, they increase the risk of adverse outcomes for patients. This enhanced risk may result in new or continued illnesses, unnecessary hospitalization, increased costs, time away from work, reduced life quality, or even death.

• The results covered by this report are significant because they support continuous quality and safety measurement and reporting, show the strides in quality and safety hospitals have made, and identify opportunities for further improvement. Since the 1980s, The Joint Commission has advocated and advanced performance measurement and several years ago implemented a standard process for continuous quality improvement, measurement and reporting that hospitals are now required to follow.

• THERE’S STILL MUCH ROOM FOR IMPROVEMENT

While the data presented in this report show good progress, they also demonstrate that there’s room for improvement on most measures. For example, hospitals are currently achieving 90 percent performance or higher on only about half of the measures tracked since 2002. Hospitals are performing at less than 65 percent on two measures tracked since 2002: providing pneumococcal screening and vaccination to pneumonia patients, and providing discharge instructions to heart failure patients.

Percent of Hospitals With 2005 Performance Rates Exceeding 90 Percent
• There is still considerable variability in the performance of hospitals by state on most measures, reflecting significant inconsistencies in the care provided. This variability has been known within the hospital industry for a long time. For example, statewide performance of hospitals on the measure of providing discharge instructions to heart failure patients ranges from 33.5 percent to 89 percent. On the measure of providing pneumococcal screening and vaccination, performance ranges from 48.3 percent to 84.3 percent. There are exceptions to this variability; on providing aspirin at arrival to heart attack patients, performance ranges from 93.5 percent to 98.3 percent.

• THERE ARE SIGNIFICANT DIFFERENCES BETWEEN THE HIGHEST- AND LOWEST-PERFORMING HOSPITALS

The data shows that some hospitals perform better than others in treating particular conditions. Detailed results for specific hospitals can be found at www.qualitycheck.org. Health care consumers can assure the best care for themselves and their families by comparing hospital quality and safety, asking doctors questions, considering options and making informed decisions.

• HOW THE JOINT COMMISSION MEASURES QUALITY AND SAFETY PERFORMANCE

*All of the quality measures described in this report were chosen because they provide concrete data about the best kinds of treatments or practices for common conditions.* In implementing these measures, The Joint Commission worked closely with clinicians, health care providers, hospital associations, performance measurement experts and health care consumers across the nation. Scientific evidence shows these treatments lead to the best outcomes for patients.

• Hospitals submit data on all measures of performance within specific sets they choose to third-party vendors, which compile and provide data to The Joint Commission each quarter. Hospitals can obtain feedback reports through The Joint Commission’s hospital extranet.
• The Joint Commission is in the early stage of tracking performance on 21 additional quality of care measures, for which improvement results will be available next year. In this report, the baseline 2005 results for these 21 measures are included. Two of the additional measures relate to heart attack care, three to pneumonia care and 16 to surgical infection prevention. As the performance tracking continues, hospitals continue to receive regular quarterly feedback they can use to drive quality improvement.

• Joint Commission National Patient Safety Goals are determined each year by reviewing the latest information on serious adverse events, known as “sentinel events,” reported by hospitals across the country, as well by reviewing other pertinent data and research. A Sentinel Event Advisory Group – composed of physicians, nurses, pharmacists, risk managers and other safety experts – works with Joint Commission staff and organizations representing key stakeholders to identify potential new National Patient Safety Goals and requirements for review and comment. Recommended goals and requirements are finally approved each year by The Joint Commission’s Board of Commissioners.

FOR MORE DETAILED INFORMATION

This report features detailed information on all performance results, as well as additional background on how the performance measures were determined. To find specific information, please refer to the Table of Contents.
Improving America’s Hospitals
A Report on Quality and Safety

Joint Commission Accreditation:
How Performance Measurement Supports
Quality Improvement and Patient Safety
Joint Commission Accreditation
How Performance Measurement Supports Quality Improvement and Patient Safety

“The mission of The Joint Commission 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.”

The fundamental goal of Joint Commission accreditation is performance improvement. Four major sets of activities support Joint Commission accreditation services: information dissemination, public policy initiatives and two others given special focus in this report – performance measurement and patient safety.

The Joint Commission has been involved in performance measurement since 1986, viewing it as a critical way to extend the reach and sophistication of the accreditation process. The Joint Commission’s 1990 publication, The Primer on Clinical Indicator Development and Applications—its all-time best-selling technical book—created a readily-adaptable template for performance measure development that is still in wide use today and established The Joint Commission as a leader in this arena.

The Joint Commission continues this leadership through initiatives such as the creation of a performance measure data network. Today, this network of 47 measurement systems, all under contract to The Joint Commission, is the source of all quality-related data on The Joint Commission’s Quality Check Web site (www.qualitycheck.org) and provides 92 percent of the data displayed on the Centers for Medicare and Medicaid Services’ (CMS) Hospital Compare Web site.

In the early 2000s, The Joint Commission established National Patient Safety Goals (NPSGs) and related requirements. NPSGs were soon accompanied by additional standards encouraging organizations to establish internal patient safety programs, to undertake proactive risk analyses, and to be transparent in sharing information about adverse events with patients and their families. Today, well over 50 percent of The Joint Commission’s standards relate directly to patient safety.

The Joint Commission continues to issue “lessons learned” advisory Sentinel Event Alerts in response to serious adverse events and updates all adverse event and root cause data in its Sentinel Event database. The Sentinel Event Policy encouraging the reporting and requiring the root cause analysis of sentinel events began in response to a series of serious adverse events in hospitals that captured national public attention in 1995.

In 2005, the World Health Organization (WHO) designated The Joint Commission and Joint Commission International as a Collaborating Centre for Patient Safety Solutions as part of the broader World Alliance for Patient Safety.

To improve health care quality and safety, The Joint Commission continues to disseminate pertinent and necessary information and to serve as an advocate for improved public policies.
Improving America’s Hospitals
A Report on Quality and Safety

Medical Conditions Relating to Performance Measures
Medical Conditions Relating to Performance Measures

This report includes performance results relating to heart attack, heart failure and pneumonia care and to surgical infection prevention. The next several pages provide background information on these four conditions.

HEART ATTACK

What is a heart attack?

- A heart attack occurs when the supply of blood and oxygen to an area of heart muscle is blocked. This blockage can lead to an irregular heartbeat that causes a severe decrease in the heart’s pumping function and may bring about sudden death. If the blockage is not treated within a few hours, the affected heart muscle will die and be replaced by scar tissue.  

- The signs and symptoms of a heart attack include chest and/or upper body discomfort, shortness of breath, cold sweat, nausea or vomiting, and light-headedness or dizziness. Chest discomfort can last for more than a few minutes, or it may go away and come back, and can feel like pressure, squeezing, fullness, or pain. Discomfort in other areas of the upper body can include pain or numbness in one or both arms or in the back, neck, jaw, or stomach.  

- Some people may have no symptoms with their heart attack; this is called a “silent” heart attack.

What’s important to know about heart attack

- Every year, more than 1 million Americans have heart attacks. About half die from the heart attack, and about half of those who die do so within one hour of the start of symptoms and before reaching the hospital.

- Most people do not seek medical care for two hours or more after symptoms begin. Many people wait 12 hours or longer to seek treatment. Prompt treatment of a heart attack can help prevent or limit lasting damage to the heart and can prevent sudden death.

For more information about heart attack

- American Heart Association: www.americanheart.org
- American College of Cardiology: www.acc.org
- National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov

HEART FAILURE

What is heart failure?

• Heart failure occurs when the heart loses its ability to pump enough blood through the body. Usually, the loss in pumping action is a symptom of an underlying heart problem, such as coronary artery disease. 13

• Heart failure usually develops slowly, often over years, as the heart gradually loses its pumping ability and works less efficiently. 13

• There are two types of heart failure – systolic and diastolic:
  
  ◆ Systolic heart failure happens when the heart cannot pump with enough force to push blood into circulation. Blood coming into the heart from the lungs may back up and cause fluid to leak into the lungs, a condition known as pulmonary congestion.
  
  ◆ Diastolic heart failure happens when the heart cannot properly fill with blood because the muscle has become stiff, losing its ability to relax. This may lead to fluid accumulation, especially in the feet, ankles, and legs. Some patients may have lung congestion. 13

• Symptoms of heart failure include shortness of breath; fatigue or easy tiring; fluid accumulation in the feet, ankles, legs and, occasionally, the abdomen; and persistent coughing. 13

What’s important to know about heart failure

• About one in every 100 people over the age of 65 has chronic heart failure. 12

• Heart failure affects 2 to 3 million Americans, and 400,000 new cases are diagnosed each year. 13

• Heart failure causes 39,000 deaths each year and is a contributing factor in another 225,000 deaths. 13

• From 1999 to 2002, almost 5 million Americans were diagnosed with heart failure, and deaths from heart failure increased 35.3 percent. 12

• In 2005, the estimated cost of heart failure in the United States was $27.9 billion. 12

13 NHLBI Heart Failure: www.medhelp.org/NHLib/GF-272.html.
• One study showed that during the past 20 years, heart failure has not declined, but survival after being diagnosed has increased. 12

• Between 1970 and 2000, the death rate for heart failure patients more than doubled, from about 9 percent in 1970 to more than 19 percent in 2000. 14

For more information about heart failure
• American Heart Association:  www.americanheart.org
• American College of Cardiology:  www.acc.org
• National Heart, Lung, and Blood Institute:  www.nhlbi.nih.gov

PNEUMONIA CARE

What is pneumonia?
• Pneumonia is mainly caused by viruses, bacteria or a combination of both. Pneumonia can also be caused by inhaling food, liquid, gases, or dust, and by fungi. Certain diseases, such as tuberculosis, can also cause pneumonia. 21

• Half of all pneumonia cases are caused by viruses. Most viral pneumonia occurs in the very young. The symptoms of viral pneumonia are similar to influenza—fever, dry cough, headache, muscle pain, weakness, and breathlessness. 21

• Bacterial pneumonia can cause serious damage to the lungs, bloodstream and brain. About 40,000 deaths each year are attributed to bacterial pneumonia. 22
What's important to know about pneumonia

• Approximately 5 million cases of pneumonia occur annually. 21

• Pneumonia is the cause of nearly 55 million days of restricted activity, 31.5 million bed days, and 1.3 million hospitalizations each year. 23

• Inpatient treatment for pneumonia amounts to more than $7.5 billion annually. 24

For more information about pneumonia

• American Lung Association: www.lungusa.org

• National Institute of Allergy and Infectious Diseases: www3.niaid.nih.gov

SURGICAL INFECTION

What is an infection and what is a surgical site infection?

• An infection is a condition where a harmful organism—either a parasite, a virus, or bacteria—invades the human body or its tissues and causes disease.

• A surgical site infection is a condition where a harmful organism invades the human body or its tissues through the opening on the skin at the site of surgery.

What’s important to know about surgical infection

• Surgical site infections are not contagious and cannot be transferred from one person to another. However, these infections can have devastating effects on the patient and their families.

• Surgical site infections are the second most common hospital-acquired infections in the United States. 37

• Of 40 million operations performed in the United States annually, 0.8 million to 2 million are associated with surgical site infections. 38

37 Bratzler, D.W., Houck, P.M., for the Surgical Infection Prevention Guidelines Writers Workgroup. Antimicrobial Prophylaxis for Surgery: An Advisory Statement from the National Surgical Infection Prevention Project.
38 Bratzler, D.W. Updates from the Surgical Infection Prevention Project Presentation.
• Surgical site infections prolong hospital stays by an average of 7.5 days. 38
• Surgical site infections cost the nation between $130 million to $845 million each year. 38
• It is estimated that 40 percent to 60 percent of surgical site infections could be prevented. 38
• In about 25 percent to 50 percent of operations, overuse, underuse, improper timing, and inappropriate use of antibiotics occur. 38

For more information about surgical infection

• Surgical Care Improvement Project:  www.medqic.org/scip
• Centers for Disease Control and Prevention:  www.cdc.gov
• Association for Professionals in Infection Control and Epidemiology:  www.apic.org
• Association of periOperative Registered Nurses:  www.aorn.org
• Agency for Healthcare Research and Quality:  www.ahrq.gov/consumer/surgery.htm
• Consumer Reports:  www.consumersunion.org/campaigns/stophospitalinfections/learn.html

38 Bratzler, D.W. Updates from the Surgical Infection Prevention Project Presentation.
Quality and Safety Key Performance Results

Hospital Performance

Hospital performance improved on individual measures of quality.

Between 2002 and 2005, hospitals consistently improved the quality of care provided for heart attack, heart failure and pneumonia, according to an analysis of 15 individual measures of performance quality by The Joint Commission. Quality improvement in hospitals contributes to saved lives, better health and quality of life for patients, and lower health care costs. This report updates a paper on 2002-2004 quality measures published by The Joint Commission in the New England Journal of Medicine in 2005.¹

The results lend support to the use of performance measurement as a means for encouraging improvement in hospitals, as advocated and advanced by The Joint Commission since the 1980s. Long before the Institute of Medicine called for performance measurement in its 2001 report, The Joint Commission had implemented a standard process for continual quality measurement, reporting and improvement that hospitals are required to follow. This report covers the results of that process.

The magnitude of national improvement on individual evidence-based measures ranged from 1.1 percent to 42.8 percent, and improvement has increased steadily since 2002. The performance of hospitals improved the fastest on measures where performance was lower at the beginning of the tracking period. All improvements in performance are statistically significant. Many of the smaller percentage improvements occurred within large patient populations, meaning that significantly more patients received a treatment. In some cases, performance was already quite high and there was less room for improvement.

Importantly, hospitals improved the inpatient mortality rate for heart attack patients. In 2005, 8.5% of these patients died during their hospital stay, compared with 9.2% in 2002. This is significant because scientific evidence shows a correlation between providing evidence-based treatments to heart attack patients and lower mortality.

There were some dramatic improvements over the four-year period of data collection, especially in providing smoking cessation advice. For example, hospitals provided this advice to 92.1 percent of patients in 2005 compared with 66.6 percent in 2002. Hospitals also showed greatly improved results from 2002 to 2005 in providing this advice to heart failure (to 83.8 percent from 42.2 percent) and pneumonia patients (to 80.0 percent from 37.2 percent).

Other strong improvements included providing discharge instructions to heart failure patients (to 59.2 percent from 30.9 percent) and providing pneumococcal screening and vaccination to pneumonia patients (to 62.8 percent from 30.2 percent).

For more detail on these results, see the Quality Performance Detail section of this report, beginning on page 41.

¹ New England Journal of Medicine, 2005;353;3; 28-37.
QUALITY AND SAFETY KEY PERFORMANCE RESULTS

PERFORMANCE IMPROVEMENT ON INDIVIDUAL MEASURES, 2002-2005

Heart Attack Care: National Rates By Year

Heart Failure Care: National Rates By Year

Pneumonia Care: National Rates By Year

Key to abbreviations: ACEI: Angiotensin converting enzyme inhibitor, ARB: angiotensin receptor blocker, LVF: Left ventricular function. See Glossary for definitions.
The graph above shows the relationship between overall performance on the Acute Myocardial Infarction (AMI) measures and AMI mortality during 2005. As compliance increased across all of the AMI measures, the mortality rate decreased.

**Composite of AMI Measures:**
- Aspirin within 24 hours of arrival
- Aspirin prescribed at discharge
- Beta blocker within 24 hours from arrival
- Beta blocker prescribed at discharge
- ACEI for LVSD prescribed at discharge
- Smoking cessation counseling/advice
- Thrombolysis within 30 minutes
- PCI within 120 minutes

**N = 1,946**
Approximately 195 hospitals in each decile
Hospitals also improved on “composite” measures showing how consistently they provided “evidence-based” care.

Composite measures combine the results of all individual measures into a single percentage rating calculated by adding or “rolling up” the number of times recommended care was provided to patients and dividing this sum by the total number of opportunities to provide this care. From 2002 to 2005, all three composite measures of quality improved: 86.9 percent to 90 percent for heart attack care, 60.7 percent to 76 percent for heart failure care, and 72.3 percent to 81 percent for pneumonia care.

Evidence-based treatments are practices shown by scientific evidence to lead to the best outcomes for patients. The data showing improvements demonstrate that patients are more consistently receiving such treatments, increasing the likelihood of better outcomes and reducing the risk of adverse outcomes such as further illness, hospitalization, disability and death.

**PERFORMANCE IMPROVEMENT ON COMPOSITE MEASURES, 2002-2005**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2002</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing evidence-based heart attack</td>
<td>86.9%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Providing evidence-based pneumonia care</td>
<td>72.3%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Providing evidence-based heart failure</td>
<td>59.7%</td>
<td>76.0%</td>
</tr>
</tbody>
</table>
PERFORMANCE SUMMARY

Composite and Individual Measures

Each set’s results are ranked by 2002-2005 improvement. All improvements in performance are statistically significant. Many of the smaller percentage improvements occurred within large patient populations, meaning that significantly more patients received a treatment. In some cases, performance was already quite high and there was less room for improvement.

<table>
<thead>
<tr>
<th>Performance measure</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2002-2005 improvement (percentage points)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heart attack care composite</strong></td>
<td>86.9%</td>
<td>89.8%</td>
<td>91.5%</td>
<td>90.0%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Providing smoking cessation advice</td>
<td>66.6%</td>
<td>76.2%</td>
<td>84.2%</td>
<td>92.1%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Prescribing ACE inhibitor/ARB at discharge</td>
<td>75.8%</td>
<td>78.5%</td>
<td>79.9%</td>
<td>83.6%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Prescribing a beta blocker at discharge</td>
<td>87.3%</td>
<td>90.3%</td>
<td>92.5%</td>
<td>94.8%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Prescribing a beta blocker at arrival</td>
<td>85.0%</td>
<td>88.2%</td>
<td>90.0%</td>
<td>92.2%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Prescribing aspirin at discharge</td>
<td>92.0%</td>
<td>93.7%</td>
<td>94.5%</td>
<td>95.6%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Providing aspirin at arrival</td>
<td>93.0%</td>
<td>94.3%</td>
<td>94.7%</td>
<td>95.4%</td>
<td>2.4%</td>
</tr>
<tr>
<td>* Providing thrombolytic therapy within 30 minutes of arrival</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>38.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>* Providing PCI balloon therapy within 120 minutes of arrival</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>68.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>** Inpatient mortality (see below)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Heart failure care composite</strong></td>
<td>59.7%</td>
<td>66.3%</td>
<td>71.2%</td>
<td>76.0%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Providing smoking cessation advice</td>
<td>42.2%</td>
<td>56.8%</td>
<td>69.7%</td>
<td>83.8%</td>
<td>41.6%</td>
</tr>
<tr>
<td>Providing discharge instructions</td>
<td>30.9%</td>
<td>42.4%</td>
<td>49.6%</td>
<td>59.2%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Providing left ventricular function assessment</td>
<td>81.5%</td>
<td>84.5%</td>
<td>87.5%</td>
<td>90.8%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Prescribing ACE inhibitor/ARB at discharge</td>
<td>74.2%</td>
<td>75.8%</td>
<td>76.3%</td>
<td>83.0%</td>
<td>8.8%</td>
</tr>
<tr>
<td><strong>Pneumonia care composite</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing smoking cessation advice</td>
<td>72.3%</td>
<td>76.1%</td>
<td>79.9%</td>
<td>81.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Providing pneumococcal screening &amp; vaccination</td>
<td>37.2%</td>
<td>50.2%</td>
<td>65.5%</td>
<td>80.0%</td>
<td>42.8%</td>
</tr>
<tr>
<td>Measuring oxygen in the bloodstream</td>
<td>30.2%</td>
<td>37.6%</td>
<td>48.8%</td>
<td>62.8%</td>
<td>32.6%</td>
</tr>
<tr>
<td>Taking a blood test before giving antibiotics</td>
<td>95.0%</td>
<td>97.2%</td>
<td>98.6%</td>
<td>99.3%</td>
<td>4.3%</td>
</tr>
<tr>
<td>* Providing antibiotics within four hours of arrival</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>74.5%</td>
<td>N/A</td>
</tr>
<tr>
<td>* Providing antibiotics to intensive care unit patients within 24 hours of arrival</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>50.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>* Providing antibiotics to non-intensive care unit patients within 24 hours of arrival</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>83.9%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* 2005 was the first year this measure was tracked. 2005 was also the first year measures relating to surgical infection prevention were tracked. See pages 91-97 for details.

** Because inpatient mortality doesn’t itself constitute a specific process of care, this result is not included in the composite measure. Still, the data reflect an overall improvement in quality, with the hospitals reporting 8.5 percent of heart attack patients dying during their hospital stay in 2005, compared with 9.1 percent in 2004, 9.4 percent in 2003 and 9.2 percent in 2002. Scientific evidence shows a correlation between providing evidence-based treatments to heart attack patients and lower mortality.
Hospital performance at the state level varies significantly, but there is still much room for improvement.

Hospitals are currently achieving a national average of 90 percent performance or higher on only about half of the measures tracked since 2002. Hospitals are performing at less than 65 percent nationwide on two measures tracked since 2002: providing pneumococcal screening and vaccination to pneumonia patients, and providing discharge instructions to heart failure patients. The Joint Commission encourages all hospitals to strive for 100 percent performance on all measures.

On measures tracked for the first time in 2005, performance is generally lower and more variable than on the performance for measures tracked since 2002, showing a correlation between performance measurement and quality.

Significant differences exist in the performance of hospitals by state. For example, the performance of hospitals in different states on the measure of providing smoking cessation advice to heart attack patients ranged from a high of 96.8 percent performance in the highest-performing state to a low of 67.6 percent in the lowest-performing state. The following table compares the low and high ranges of state performance to national averages. More illustrations of hospital performance by state can be found in the Quality Performance Detail section of this report, beginning on page 41.
STATE PERFORMANCE VARIABILITY COMPARED TO NATIONAL AVERAGES

Each individual measure within set is ranked according to state performance variability, which shows the difference between the highest-performing and lowest-performing states.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heart attack care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Providing PCI balloon therapy within 120 minutes of arrival</td>
<td>68.3%</td>
<td>46.9%</td>
<td>86.9%</td>
<td>40.0%</td>
</tr>
<tr>
<td>* Providing thrombolytic therapy within 30 minutes of arrival</td>
<td>38.6%</td>
<td>18.2%</td>
<td>54.5%</td>
<td>36.3%</td>
</tr>
<tr>
<td>Providing smoking cessation advice</td>
<td>92.1%</td>
<td>67.6%</td>
<td>96.8%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Prescribing ACE inhibitor/ARB at discharge</td>
<td>83.6%</td>
<td>71.7%</td>
<td>91.1%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Providing beta blocker at arrival</td>
<td>92.2%</td>
<td>86.0%</td>
<td>97.5%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Prescribing beta blocker at discharge</td>
<td>94.8%</td>
<td>90.9%</td>
<td>98.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Prescribing aspirin at discharge</td>
<td>95.6%</td>
<td>92.7%</td>
<td>99.2%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Providing aspirin at arrival</td>
<td>95.4%</td>
<td>93.5%</td>
<td>98.3%</td>
<td>4.8%</td>
</tr>
<tr>
<td>** Inpatient mortality</td>
<td>8.5%</td>
<td>10.2%</td>
<td>4.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>Heart failure care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing discharge instructions</td>
<td>59.2%</td>
<td>33.5%</td>
<td>89.0%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Prescribing ACE inhibitor/ARB at discharge</td>
<td>83.0%</td>
<td>58.5%</td>
<td>94.2%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Providing left ventricular function assessment</td>
<td>90.8%</td>
<td>74.0%</td>
<td>96.3%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Providing smoking cessation advice</td>
<td>83.8%</td>
<td>76.5%</td>
<td>89.6%</td>
<td>13.1%</td>
</tr>
<tr>
<td><strong>Pneumonia care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing pneumococcal screening and vaccination</td>
<td>62.8%</td>
<td>48.3%</td>
<td>84.3%</td>
<td>36.0%</td>
</tr>
<tr>
<td>* Providing antibiotics for intensive care unit patients within 24 hours of arrival</td>
<td>50.1%</td>
<td>36.1%</td>
<td>70.6%</td>
<td>34.5%</td>
</tr>
<tr>
<td>Providing smoking cessation advice</td>
<td>80.0%</td>
<td>60.9%</td>
<td>89.7%</td>
<td>28.8%</td>
</tr>
<tr>
<td>Taking a blood test before giving antibiotics</td>
<td>83.1%</td>
<td>70.4%</td>
<td>89.5%</td>
<td>19.1%</td>
</tr>
<tr>
<td>* Providing antibiotics within four hours of arrival</td>
<td>74.5%</td>
<td>66.1%</td>
<td>86.2%</td>
<td>20.1%</td>
</tr>
<tr>
<td>* Providing antibiotics for non-intensive care unit patients within 24 hours of arrival</td>
<td>83.9%</td>
<td>78.3%</td>
<td>90.3%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Measuring oxygen in the bloodstream</td>
<td>99.3%</td>
<td>97.5%</td>
<td>100.0%</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

* New measures in 2005

** Because the inpatient mortality measure reports an adverse event (and the other measures are positive events), the higher percentage (10.2%) is reported as the low state performance, with 4.5% reported as the high state performance.
There are significant differences in performance between the highest- and lowest-performing hospitals.

The data shows that some hospitals perform better than others in treating particular conditions. The following chart shows that a significant percentage of hospitals are still not providing care consistent with evidence-based measures. More than 90 percent of the nation’s hospitals are achieving 90 percent performance on only one measure. More information on this chart can be found on page 98.

Detailed results for specific hospitals can be found at www.qualitycheck.org. Health care consumers can assure the best care for themselves and their families by comparing hospital quality and safety, asking doctors questions, considering options, and making informed decisions. Quality Check® is provided as a tool to help educate the public about the choices available to them. The Joint Commission strives to make the information provided on Quality Check as understandable and clear as possible so that people can make more informed decisions about their care.
The Joint Commission has had a longstanding commitment to providing meaningful information about the comparative performance of accredited organizations to the public. In 1994, the Joint Commission first published organization-specific Performance Reports and in 1996, Quality Check became available on the website. In 2004, Quality Reports replaced Performance Reports. The improvements have continued in 2005 and 2006 with a redesign of Quality Check. The process included extensive testing and input from consumer focus groups and stakeholders, including four advisory groups and state hospital associations. An online survey was also posted on the Joint Commission website. The feedback was used to refine and clarify Quality Reports for both health care professionals and the public.

Health care consumers can search by hospital name, zip code or state at www.qualitycheck.org.
Results for a specific hospital can be viewed online, or a Quality Report can be printed.
Each year, The Joint Commission identifies top compliance issues – standards that were the most difficult for hospitals to meet. In 2005, 14 issues were identified due to suboptimal compliance rates ranging from 90 to 59 percent.

1.) Once the hospital has prioritized its goals, strategies must be implemented to achieve these goals.

- 90 percent compliant
- 10 percent non-compliant

2.) There is a process for granting, renewing, or revising setting-specific clinical privileges.

- 90 percent compliant
- 10 percent non-compliant

3.) All the prescriptions or medication orders are reviewed for appropriateness.

- 89 percent compliant
- 11 percent non-compliant

4.) The hospital manages safety risks.

- 89 percent compliant
- 11 percent non-compliant

5.) The leaders develop and implement policies and procedures for care, treatment, and services.

- 87 percent compliant
- 13 percent non-compliant

6.) The hospital defines in writing the time frame(s) for conducting the initial assessment(s).

- 87 percent compliant
- 13 percent non-compliant

7.) The hospital has a complete and accurate medical record for every patient assessed or treated.

- 85 percent compliant
- 15 percent non-compliant
8.) When pain is identified, the patient is assessed and treated by the hospital or referred for treatment.

- 85 percent compliant
- 15 percent non-compliant

9.) Designated qualified personnel accept and transcribe verbal orders from authorized individuals.

- 83 percent compliant
- 17 percent non-compliant

10.) Medication orders are written clearly and transcribed accurately.

- 80 percent compliant
- 20 percent non-compliant

11.) Newly constructed and existing environments of care are designed and maintained to comply with the Life Safety Code®.

- 79 percent compliant
- 21 percent non-compliant

12.) Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

- 70 percent compliant
- 30 percent non-compliant

13.) Medications are properly and safely stored throughout the hospital.

- 63 percent compliant
- 37 percent non-compliant

14.) The hospital has processes in place to effectively manage information, including the capturing, reporting, processing, storing, retrieving, disseminating, and displaying of clinical/service and non-clinical data and information.

- 59 percent compliant
- 41 percent non-compliant
Understanding the Quality of Care Measures

*Why they were created, what they report and why the results are important*

*Improving America's Hospitals: A Report on Quality and Safety* was created to present the overall performance of America’s accredited hospitals on quality of care measures relating to the care they provide to patients for heart attack, heart failure, pneumonia and for the prevention of surgical infection. These are among the most common reasons that Americans enter the hospital and for which they are treated. Hospitals that performed well are those that consistently provide “evidence-based” treatments – practices demonstrated by scientific evidence to lead to the best outcomes.

The results are important because they show that hospitals have improved. The results identify additional opportunities for further improvement, and support continual measurement and reporting. Quality improvement in hospitals contributes to saved lives, better health and quality of life for many patients, and lower health care costs.

**Why These Measures?**

The Joint Commission worked closely with clinicians, health care providers, hospital associations, performance measurement experts, and health care consumers across the nation to identify the quality measures. This collaborative process identified measures that reflect the best “evidence-based” treatments for heart attack, heart failure and pneumonia and for surgical infection prevention. The measures are common to the Centers for Medicare and Medicaid Services (CMS) and are endorsed by the National Quality Forum (NQF). This commonality minimizes data collection and allows the data to be used for valid comparative performance measurement across different types of hospitals.

**Data Collection Methods.** The Joint Commission requires most hospitals to select three measure sets. Hospitals choose sets best reflecting their patient population and report on all the applicable measures in each of the sets they choose. A hospital needs to have a range of at least 60 to 78 eligible patients per reporting quarter in each chosen measure set, depending on the measure set. Hospitals submit monthly data to third-party vendors, which compile and provide data to The Joint Commission each quarter. Hospitals can obtain a feedback report through The Joint Commission hospital extranet.
**Note on Calculations and Methodology.** For the three measure sets tracked continuously from 2002 to 2005 (heart attack care, heart failure care, and pneumonia care), a composite measure was created. This measure is calculated by adding or “rolling up” the number of times recommended care was provided over all the process measures in the given measure set and dividing this sum by the total number of opportunities for providing this recommended care, determined by summing up all of the process measure populations for this same set of measures. The composite measure shows the percentage of the time that recommended care was provided.

For example, if a heart attack patient receives each treatment included in the heart attack measure set, that’s a total of eight treatments in eight opportunities. If 60 patients receive all eight treatments, that’s 480 treatments in 480 opportunities – 100 percent composite performance. However, if some of the 60 patients don’t receive all eight treatments, and the treatments given to the 60 patients add to a total of 432, the composite score is 90 percent.

Composite performance measures are useful in integrating performance measure information in an easily understood format that gives a summary assessment of performance for a given area of care in a single rate. The three composite measures in this report are based on combining all of the process rate-based measures in the measure set. For a performance measure, each patient identified as falling in the measure population can be considered an opportunity to provide recommended care.

**Inclusions and Exclusions.** This report only includes data about patients considered “eligible” for one of the evidence-based treatments or measures. “What one should know about the data” information is included in the Performance Detail section of this report for each measure. This information describes the kinds of patients whose results are excluded from this report’s data. It’s important to understand that not every patient gets – or should get – a treatment. Often, patients have health care conditions or factors that influence the effectiveness of treatments, or whether or not a provider orders a particular treatment. Also, a patient may choose to refuse treatment or not follow the instructions of his or her care plan.
National Patient Safety Goals

Joint Commission 2005 National Patient Safety Goals

Each year, health care providers must meet the requirements of the Joint Commission’s National Patient Safety Goals as part of the accreditation process. In 2005, eight goals and 16 requirements were identified and the compliance assessment results are displayed below. "Compliance" means consistent performance of the requirement. When an organization is found to be "non-compliant," it does not mean that the organization is failing to do what is required at all; it means that the organization is not meeting the requirement consistently.

Hospitals must do more than simply perform specified tasks to achieve compliance with Joint Commission National Patient Safety Goals. To assure safe health care environments, hospitals must continually analyze fundamental work systems and redesign those systems as needed. Hospitals must also go beyond the tasks of removing a dangerous medication from a patient care unit or requiring a specific safety feature on a medical device. They must achieve goals such as “improve the accuracy of patient identification” by changing how individuals caring for patients do their jobs. Achieving this kind of behavioral change among providers takes time, motivation, reinforcement, reward, patience, and support.

The Joint Commission conceptually supports the National Quality Forum’s 30 consensus safe practices for health care organizations. However, The Joint Commission believes it is important to focus on a smaller number of goals to leverage real change in organization culture and real investment in system redesign that are integral to any effort to keep inevitable human error from reaching the patient.

The compliance rates below are derived from 1,573 on-site surveys at Joint Commission accredited hospitals during 2005.

Goal 1: Improve the accuracy of patient identification.

Requirement 1A: Use at least two patient identifiers (neither to be the patient’s room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

95.3% compliance

Requirement 1B: Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

4.7% non-compliance
Goal 2: Improve the effectiveness of communication among caregivers.

Requirement 2A: For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read-back” the complete order or test result.

87.7% compliance

Requirement 2B: Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.

61.4% compliance

Requirement 2C: Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

90.5% compliance

Goal 3: Improve the safety of using medications.

Requirement 3A: Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.

98.6% compliance
Requirement 3B: Standardize and limit the number of drug concentrations available in the organization.

98.5% compliance

Requirement 3C: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

97.6% compliance


Requirement 4A: Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.

95.5% compliance

Note: This requirement is surveyed under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

Requirement 4B: Implement a process to mark the surgical site and involve the patient in the marking process.

96.7% compliance

Note: This requirement is surveyed under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.
Goal 5: Improve the safety of using infusion pumps.

**Requirement 5A:** Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.9%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Goal 6: Improve the effectiveness of clinical alarm systems.

**Requirement 6A:** Implement regular preventive maintenance and testing of alarm systems.

**Requirement 6B:** Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

*Note: Because of continued high compliance rates, this Goal was retired after 2004, along with its two requirements.*

Goal 7: Reduce the risk of health care-associated infections

**Requirement 7A:** Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>96.4%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

**Requirement 7B:** Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

<table>
<thead>
<tr>
<th>Compliance</th>
<th>Non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Goal 8: Accurately and completely reconcile medications across the continuum of care.

Requirement 8A: During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

99.9% compliance

Requirement 8B: A complete list of the patient’s medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

99.7% compliance

Goal 9: Reduce the risk of patient harm resulting from falls.

Requirement 9A: Assess and periodically reassess each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen, and take action to address any identified risks.

95.5% compliance

For more detail, see The Joint Commission 2005 National Patient Safety Goals Performance Detail section of this report, beginning on page 105.
The following chart illustrates trends in National Patient Safety Goal compliance from 2003-2005. The compliance rates are derived from on-site surveys at Joint Commission hospitals during those years. The trends in the data should be interpreted with caution. At first glance, it looks like performance may be deteriorating. However, the more likely explanation is that Joint Commission surveyors are becoming more sophisticated in assessing and identifying non-compliance.

For example, the 2004 hospital compliance rate for conducting a “time out” before surgery was 92 percent, compared to 83 percent in 2005. When the “time out” requirement was first implemented, it was surveyed primarily in the operating rooms. In these areas, performance of the “time out” is generally quite consistent. But “time out” is not just an OR requirement; it applies wherever invasive procedures are done. More recently, surveyors are finding non-compliance with the "time out" requirement in endoscopy suites, catheterization labs, and even at bedside procedures.

Also, some requirements call for significant behavioral change. For example, the “do not use” abbreviations requirement asks practitioners to stop doing what they were taught to do in medical school and residency training. Writing out full names of medicines is seen as less efficient than using abbreviations and other “concise” notations.

National Patient Safety Goal Compliance Trends for the Hospital Accreditation Program (January 1, 2003 – December 31, 2005)

The numbers represent percentages, except the second row, which represents the number of surveys conducted.

<table>
<thead>
<tr>
<th>Goal</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A Two patient identifiers</td>
<td>96.2</td>
<td>95.9</td>
<td>95.3</td>
</tr>
<tr>
<td>1B “Time out” before surgery*</td>
<td>91.1</td>
<td>92.0</td>
<td>82.7</td>
</tr>
<tr>
<td>2A Read back verbal orders</td>
<td>92.6</td>
<td>91.8</td>
<td>87.7</td>
</tr>
<tr>
<td>2B “Do not use” abbreviations</td>
<td>76.5</td>
<td>75.2</td>
<td>61.4</td>
</tr>
<tr>
<td>2C Reporting critical test results</td>
<td>--</td>
<td>--</td>
<td>90.5</td>
</tr>
<tr>
<td>3A Restrict concentrated electrolytes</td>
<td>97.0</td>
<td>98.1</td>
<td>98.6</td>
</tr>
<tr>
<td>3B Standardize drug concentrations</td>
<td>99.4</td>
<td>99.1</td>
<td>98.5</td>
</tr>
<tr>
<td>3C Look-alike, sound-alike drugs</td>
<td>--</td>
<td>--</td>
<td>97.6</td>
</tr>
<tr>
<td>4A Preoperative verification process*</td>
<td>98.5</td>
<td>94.6</td>
<td>95.5</td>
</tr>
<tr>
<td>4B Surgical site marking*</td>
<td>93.8</td>
<td>95.4</td>
<td>96.7</td>
</tr>
<tr>
<td>5A Infusion pump free-flow protection</td>
<td>99.7</td>
<td>99.9</td>
<td>99.9</td>
</tr>
<tr>
<td>6A Maintain and test alarm systems**</td>
<td>98.6</td>
<td>99.9</td>
<td>--</td>
</tr>
<tr>
<td>6B Alarms set properly and audibly**</td>
<td>97.9</td>
<td>98.3</td>
<td>--</td>
</tr>
<tr>
<td>7A CDC hand hygiene guidelines</td>
<td>--</td>
<td>98.8</td>
<td>96.4</td>
</tr>
<tr>
<td>7B Health-care associated infection</td>
<td>--</td>
<td>99.9</td>
<td>100</td>
</tr>
<tr>
<td>8A Medication list reconciliation</td>
<td>--</td>
<td>--</td>
<td>99.9</td>
</tr>
<tr>
<td>8B Transfer/discharge reconciliation</td>
<td>--</td>
<td>--</td>
<td>99.7</td>
</tr>
<tr>
<td>9A Fall risk assessment</td>
<td>--</td>
<td>--</td>
<td>95.5</td>
</tr>
</tbody>
</table>

-- The requirement was implemented in later years or was not applicable that year.
* Beginning in 2005, this requirement was surveyed under the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™, except for 1B for the home care, laboratory, and long term care programs.
** These requirements were retired after 2004.
How National Patient Safety Goals Are Determined

The Joint Commission Sentinel Event database maintains an active repository of information on serious adverse events reported by hospitals across the country. A Sentinel Event Advisory Group – composed of physicians, nurses, pharmacists, risk managers and other safety experts – works with Joint Commission staff to review these and other data and literature to identify potential new National Patient Safety Goals and requirements on a continuing basis. As part of this development process, potential Goals and requirements are sent to organizations representing providers, consumers, purchasers and other interested parties for review and comment each year.

To determine its priority Goals and requirements each year, the Advisory Group considers evidence respecting measuring their potential overall impact on patient safety, as well as the cost and practicality of implementation. The proposed Goals and requirements are then presented to the Joint Commission’s Board of Commissioners for final review and approval. The Advisory Group may also recommend the retirement of selected Goals and requirements each year.
Improving America’s Hospitals
A Report on Quality and Safety

Quality Performance Detail
Quality Performance Detail

This section of the report includes background information, important facts and statistics, and results for each performance measure in four sets (heart attack care, heart failure care, pneumonia care and surgical infection prevention). This section also identifies the top compliance issues – standards that are the most difficult for hospitals to meet.

A “What one should know about the data” section for each measure includes information about the kinds of patients whose results are excluded from this report’s data. It’s important to understand that not every patient gets – or should get – a treatment. Often, patients have health care conditions or factors that influence the effectiveness of treatments, or whether or not a provider orders a particular treatment. Also, a patient may choose to refuse treatment or not follow the instructions of his or her care plan.

This report only includes data about patients considered “eligible” for one of the evidence-based treatments or measures.

Heart Attack Care Performance Detail

Composite Measure

What this information tells us
The graph on the next page illustrates the “composite” measure of how consistently hospitals provided evidence-based care in 2005. The number of hospitals (left axis) is shown in relation to the composite measure rate (bottom axis) for the eight evidence-based heart attack treatments or measures evaluated in this report. Data represented by this illustration were reported by 2,726 total hospitals.

Results
During 2005, the national average for providing the eight evidence-based heart attack treatments or measures evaluated in this report was 90 percent, an improvement of 3.1 percentage points from 2002, when The Joint Commission began tracking performance on heart attack measures. The bars on the chart on the next page show the approximate number of hospitals achieving varying composite measure rates, which are plotted on a scale of 30 to 100 percent in 2.5 percent intervals. For example, the highest bar shows that more than 400 hospitals achieved a composite measure rate of more than 90 percent in 2005.
What one should know about the data
Hospitals were required to have a minimum of 30 patients over a 12-month period for whom to report data. The expansion of the measures in 2005 resulted in a lower composite rate.

Heart Attack Care Graph #1
Aspirin at Arrival: 2005 State Rates

What this information tells us
These data report the percentage of heart attack patients who both needed and received aspirin within 24 hours before or after arriving at the hospital.
What’s important to know about aspirin and heart attack treatment

- The American Heart Association recommends aspirin use for patients who have had a heart attack (unless the patient has other conditions that prevent him or her from safely taking aspirin.)  

- For certain types of heart attack, aspirin is beneficial because it reduces the tendency of blood to clot in blood vessels of the heart and improves the chance a patient will survive.

- National guidelines strongly recommend the early administration of aspirin for some heart attack patients. Some patients are allergic to aspirin, or are taking medicines that cannot be taken with aspirin, among other reasons.

- Do not start aspirin therapy without first consulting your doctor; the risks and benefits vary for each person.

Results

- In 2005, Joint Commission-accredited hospitals achieved average performance of 95.4 percent in providing heart attack patients with aspirin within 24 hours of arriving at the hospital – an improvement of 0.7 percentage points from 2004, of 1.1 percentage points from 2003, and of 2.4 percentage points from 2002.

- Performance rates among states ranged from 93.5 and 98.3 percent.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient did not receive aspirin due to an allergy to aspirin or other medical reasons;
- The patient was younger than 18 years of age;
- The patient was transferred to another acute care or federal hospital on the day of arrival;
- The patient was transferred from another acute care hospital, including another emergency department;
- The patient was discharged on the same day of arrival at the hospital;
- The patient died on the day of arrival at the hospital; or
- The patient left against medical advice on the day of arrival.

Heart Attack Care Graph #2
Aspirin Prescribed at Discharge: 2005 State Rates

What this information tells us

These data report how often aspirin was prescribed to some heart attack patients when they left the hospital.

What’s important to know about taking aspirin after having a heart attack

• The American Heart Association recommends aspirin use for patients who have had a heart attack (unless the patient has other conditions that prevent him or her from safely taking aspirin.)

• For certain types of heart attack, aspirin is beneficial because it reduces the tendency of blood to clot in blood vessels of the heart and improves the chance a patient will survive.

• National guidelines strongly recommend that some heart attack patients continue to take aspirin to prevent another heart attack. Some patients are allergic to aspirin, or are taking medicines that cannot be taken with aspirin, among other reasons.

• Do not start aspirin therapy without first consulting your doctor; the risks and benefits vary for each person.
Results

- In 2005, Joint Commission-accredited hospitals achieved national average performance of 95.6 percent in prescribing aspirin to heart attack patients at hospital discharge – an improvement of 1.1 percentage points from 2004, of 1.9 percentage points from 2003, and of 3.6 percentage points from 2002.

- Performance rates among states ranged from 92.7 to 99.2 percent.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient did not receive aspirin due to an allergy to aspirin or other medical reasons;
- The patient was younger than 18 years of age;
- The patient was transferred to another acute care or federal hospital;
- The patient died;
- The patient left against medical advice; or
- The patient was discharged to hospice.
Heart Attack Care Graph #3
ACEI/ARB Prescribed at Discharge: 2005 State Rates

What this information tells us
These data report the percentage of heart attack patients (those with problems in a certain part of the heart’s left ventricle) who received a prescription for a medicine called an ACE inhibitor or an ARB when they were discharged from the hospital. ACE stands for angiotensin converting enzyme. ARB stands for angiotensin receptor blocker. ACE inhibitors, also called ACEIs, and ARBs are medicines taken by mouth that reduce blood pressure and strengthen the heart beat.

What’s important to know about ACE inhibitors, ARBs, and heart attack
• Studies show that heart attack patients who are treated with an ACE inhibitor and ARB medicine live longer than patients who do not take these medications. 5
• National guidelines strongly recommend ACE inhibitor and ARB medicines for heart attack patients. 6
Results

• In 2005, Joint Commission-accredited hospitals achieved national average performance of **83.6 percent** in prescribing an ACE inhibitor or ARB medication to heart attack patients discharged from the hospital – an improvement of **3.7 percentage points** from 2004, of 5.3 percentage points from 2003, and of 7.8 percentage points from 2002.

• Performance rates among states ranged from 71.7 to 91.1 percent.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient did not receive an ACE inhibitor or ARB medication due to an allergy to these medications or other medical reasons;
- The patient was younger than 18 years of age;
- The patient was transferred to another acute care or federal hospital;
- The patient died;
- The patient left against medical advice; or
- The patient was discharged to hospice.
Heart Attack Care Graph #4
Smoking Cessation Advice: 2005 State Rates

What this information tells us
These data report the percentage of heart attack patients who were given advice or counseling about quitting smoking.

What’s important to know about smoking and heart attack
• More than 25 percent of adult American men and 20 percent of adult American women are smokers. 7
• Studies show that smokers are more likely to quit smoking if a doctor advises them to do so. 6
• One year after quitting smoking, a person's risk of heart disease decreases by 50 percent. 7
• National guidelines strongly recommend smoking cessation counseling for heart attack patients who smoke. 9
Results

• In 2005, Joint Commission-accredited hospitals achieved **national average performance of 92.1 percent** in advising heart attack patients to quit smoking – **an improvement of 7.9 percentage points** from 2004, of 15.9 percentage points from 2003, and of 25.5 percentage points from 2002.

• There is significant variability across the nation, with performance rates among states ranging from 67.6 to 96.8 percent.

What one should know about the data

Some heart attack patients received smoking cessation advice but were excluded from these data for one or more of the following reasons:

• The patient was younger than 18 years of age;
• The patient was transferred to another acute care or federal hospital;
• The patient died;
• The patient left against medical advice; or
• The patient was discharged to hospice.

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1 Heart Disease and Stroke Statistics—2005 Update. American Stroke Association and American Heart Association, Chapter 9, Risk Factors, p 33.


What this information tells us
These data report the percentage of some heart attack patients who received a prescription for a medicine called a beta blocker when they were discharged from the hospital.

What’s important to know about beta blockers after heart attack

• Beta blocker medicine has been shown to reduce further heart damage. ¹⁰

• Beta blocker medicine protects the heart by slowing the heart and helping the heart use less energy to pump blood. ⁵

• National guidelines strongly recommend that heart attack patients continue taking beta blocker medicine to prevent another heart attack. ⁶
Results

- In 2005, Joint Commission-accredited hospitals achieved national average performance of **94.8 percent** in prescribing beta blocker medication to heart attack patients at hospital discharge – **an improvement of 2.3 percentage points** from 2004, of 4.5 percentage points from 2003, and of 7.5 percentage points from 2002.

- Performance rates among states ranged from 90.9 to 98.3 percent.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patients did not receive a beta blocker medicine due to an allergy to the medication or other medical reasons;
- The patient was younger than 18 years of age;
- The patient was transferred to another acute care or federal hospital;
- The patient died;
- The patient left against medical advice; or
- The patient was discharged to hospice.
Heart Attack Care Graph #6
Beta Blocker at Arrival: 2005 State Rates

What this information tells us
These data report the percentage of heart attack patients who received a medicine called a beta blocker within 24 hours after arriving at the hospital.

What’s important to know about beta blockers and heart attack
- Beta blocker medicine has been shown to reduce further heart damage. 10
- National guidelines strongly recommend that heart attack patients receive beta blocker medicine soon after having a heart attack. 6
Results

• In 2005, Joint Commission-accredited hospitals achieved national average performance of 92.2 percent in providing patients with beta blocker medication within 24 hours after arriving at the hospital – an improvement of 2.2 percentage points from 2004, of 4 percentage points from 2003, and of 7.2 percentage points from 2002.

• Performance rates among states ranged from 86 to 97.5 percent.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

• The patient did not receive a beta blocker medicine due to an allergy to the medication or other medical reasons;

• The patient was younger than 18 years of age;

• The patient was transferred to another acute care or federal hospital on the day of arrival at the hospital;

• The patient was transferred from another acute care hospital, including another emergency department;

• The patient was discharged on the same day of arrival at the hospital;

• The patient died on the day of arrival at the hospital; or

• The patient left against medical advice on the day of arrival.

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**Heart Attack Care Graph #7**

*Thrombolytic Therapy Received Within 30 Minutes of Hospital Arrival: 2005 State Rates*

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**What this information tells us**

These data report the percentage of heart attack patients who received a medicine called thrombolytic therapy within 30 minutes of arriving at the hospital. While thrombolytic therapy is not appropriate for all heart attack patients, national guidelines establish a 30-minute optimum timeframe for getting this medicine to patients who might benefit from it.

**What's important to know about thrombolytic therapy and heart attack**

- Thrombolytic therapy is only used in certain types of heart attacks. 11
- Thrombolytic therapy breaks up blood clots, which increases blood flow to the heart. If blood flow is returned to the heart muscle quickly during a heart attack, the risk of death is decreased. 2
- It is important that this medicine be given quickly after a heart attack is diagnosed. 4
- Studies show that each hour of delay in providing thrombolytic therapy costs nearly two lives per 1,000 heart attack patients. 11
- National guidelines recommend that thrombolytic therapy be given within 30 minutes of arrival at the hospital to patients who are having the type of heart attack that thrombolytic therapy helps. 4
QUALITY PERFORMANCE DETAIL

Results

• In 2005, Joint Commission-accredited hospitals achieved a national average performance of 38.6 percent in providing thrombolytic therapy within 30 minutes of the patient's arrival at the hospital. Beginning in 2005, this measure changed from one where “time to thrombolytic therapy” was measured and recorded to one where “the percent of patients receiving thrombolytic therapy within 30 minutes of arrival” was measured and recorded.

• Performance rates among states ranged from 18.2 to 54.5 percent.

• While this measure had poor performance nationwide, only 33 individual hospitals were able to publicly report data on this measure because a minimum of 30 patients was required to report data.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

• The patient was younger than 18 years of age; or

• The patient was transferred from another acute care hospital, including another emergency department.

Thrombolytic therapy is only done at certain hospitals since it is a specialized service requiring trained personnel.

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2 National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov
Heart Attack Care Graph #8
PCI Received Within 120 Minutes of Hospital Arrival: 2005 State Rates

What this information tells us
These data report the percentage of heart attack patients with a clogged heart artery who received PCI (percutaneous coronary interventions) balloon therapy within 120 minutes of arriving at the hospital. National guidelines establish a 120-minute optimum timeframe for getting this treatment after having a heart attack. 6

What’s important to know about PCI balloon therapy and heart attack
• PCI balloon therapy involves threading a small balloon into a blood vessel in the heart to open up a clogged artery that keeps the blood from flowing to the heart muscle. 2
• PCI can open a clogged artery, thereby increasing blood flow to the heart and reducing heart damage. A lack of blood supply to the heart muscle can cause lasting heart damage. 2
• It is important that this therapy be given quickly after a heart attack is diagnosed. 4
• PCI balloon therapy is used in certain types of heart attacks. 6
• National guidelines recommend that PCI balloon therapy be given promptly to patients who are having the type of heart attack that PCI balloon therapy helps. 6
Results

• In 2005, Joint Commission-accredited hospitals achieved a national average performance of 68.3 percent in providing PCI balloon therapy within 120 minutes of the patient’s arrival at the hospital. Beginning in 2005, this measure changed from one where “time to PCI balloon therapy” was measured and recorded to one where “the percent of patients receiving PCI balloon therapy within 120 minutes of arrival” was measured and recorded.

• Performance rates among states ranged from 46.9 to 86.9 percent.

What one should know about the data

Some heart attack patients received this treatment but were excluded from these data for one or more of the following reasons:

• The patient was younger than 18 years of age;
• The patient was transferred from another acute care hospital, including another emergency department;
• The patient was given thrombolytic therapy (a medication that breaks up blood clots, which increases blood flow to the heart).

PCI balloon therapy is only done at certain hospitals since it requires special resources and training.

The small number of patients receiving PCI balloon therapy allows for the wide degree of variability in the results for this measure.

5 National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov
Heart Attack Care Graph #9
Inpatient Mortality: 2005 Risk - Adjusted State Rates

What this information tells us
These data report the percentage of heart attack patients who died during their hospital stay. These data take into account that some patients are sicker or have other pre-existing medical conditions that make death more likely.

What’s important to know about death from heart attack
• In 2002, more than 225,000 Americans died from a heart attack. 12
Results

• In 2005, Joint Commission-accredited hospitals reported a national average of **8.5 percent of heart attack patients dying during their hospital stay**. In 2004, the national average reported was 9.1 percent; in 2003 it was 9.4 percent; and in 2002 it was 9.2 percent.

• The state mortality rates ranged from 4.5 to 10.2 percent.

What one should know about the data

These data take into account that some patients are sicker or have other pre-existing medical conditions that make death more likely. This is called “risk adjustment.” Risk adjustment provides a more fair comparison between different hospitals and different states.

Some heart attack patients were excluded from these data for one or more of the following reasons:

• The patient died in the emergency department;

• The patient was younger than 18 years of age;

• The patient was transferred to another acute care or federal hospital;

• The patient was transferred from another acute care hospital; or

• The patient was discharged to hospice.
Heart Attack Care Graph #10: National Rates by Year

The following graph shows national data for heart attack measures at Joint Commission-accredited hospitals. (This is the same graph used in the “Quality and Safety Performance Results” section.)

[Graph showing national rates for heart attack measures over four years]

Key to abbreviations: ACEI: Angiotensin converting enzyme inhibitor, ARB: angiotensin receptor blocker. See Glossary for definitions.

What this information tells us
These data show the national performance rates of Joint Commission accredited hospitals over the course of four consecutive years (2002, 2003, 2004, and 2005) for six of the nine heart attack measures evaluated in this report.

What's important to know about heart attack
• Every year, more than 1 million Americans have heart attacks. About half die from the heart attack, and about half of those who die do so within one hour of the start of symptoms and before reaching the hospital.

• Most people do not seek medical care for two hours or more after symptoms begin. Many people wait 12 hours or longer to seek treatment. Prompt treatment of a heart attack can help prevent or limit lasting damage to the heart and can prevent sudden death.
Results

• Joint Commission-accredited hospitals reported steady improvement over the course of the study in six of eight heart attack measures. The most significant improvement was in providing smoking cessation advice to heart attack patients.

• The best rates of performance were for:
  
  • Providing aspirin at discharge improved from 92 percent in 2002, to 93.7 percent in 2003, to 94.5 percent in 2004, to 95.6 percent in 2005.
  
  • Providing aspirin at arrival improved from 93 percent in 2002, to 94.3 percent in 2003, to 94.7 percent in 2004, to 95.4 percent in 2005.
  
  • Providing beta blocker at discharge improved from 87.3 percent in 2002, to 90.3 percent in 2003, to 92.5 percent in 2004, to 94.8 percent in 2005.

• In 2002, only 66.6 percent of accredited hospitals were providing smoking cessation advice to heart attack patients—the lowest percentage of activity compared to the other heart attack measures. In 2005, there was significant improvement, with 92.1 percent of hospitals providing smoking cessation advice to heart attack patients.

• The greatest need for improvement is for the two measures in which the measuring and recording methodology changed in 2005: PCI balloon therapy received within 120 minutes of arrival—with 68.3 percent national performance; and thrombolytic therapy received within 30 minutes of arrival—with 38.6 percent national performance. This thrombolytic therapy measure had the lowest national performance of all the measures in this report.

What one should know about the data

These data measure specific “processes” of care for heart attack. In this instance, the study counts the number patients receiving the recommended care for heart attack.

While improvement sometimes is less than 1 percentage point, these are statistically significant improvements because of the larger number of hospitals that reported these data during the time period covered in this graph.

² National Heart, Lung, and Blood Institute: www.nhlbi.nih.gov
Heart Failure Care Performance Detail

Composite Measure

What this information tells us

The graph below illustrates the “composite” measure of how consistently hospitals provided evidence-based care for heart failure in 2005. The number of hospitals (left axis) is shown in relation to the composite measure rate (bottom axis) for the four evidence-based heart failure treatments or measures evaluated in this report. Data represented by this illustration were reported by 3,120 total hospitals.

Results

During 2005, the national average for providing the four evidence-based heart failure treatments or measures evaluated in this report was 76 percent, an improvement of 15.3 percentage points from 2002, when The Joint Commission began tracking performance on heart attack measures. The bars on the chart below show the approximate number of hospitals achieving varying composite measure rates, which are plotted on a scale of 0 to 100 percent in 2.5 percent intervals. For example, the highest bars show that many hospitals achieved composite measure rates between roughly 70 and 90 percent in 2005.

What one should know about the data

Hospitals were required to have a minimum of 30 patients for whom to report data.
Heart Failure Care Graph #1
Discharge Instructions: 2005 State Rates

What this information tells us
These data report the percentage of heart failure patients who are given specific discharge instructions about their condition and care when they leave the hospital.
What’s important to know about heart failure after being hospitalized

• One study showed that during the past 20 years, heart failure has not declined, but survival after being diagnosed has increased. 12

• Patient education about activities, diet, follow-up, medicines, worsening symptoms, and monitoring weight can prevent further hospitalization. National guidelines strongly support patient education. 15

Results

• In 2005, Joint Commission-accredited hospitals achieved national average performance of 59.2 percent in providing discharge instructions to heart failure patients – an improvement of 9.6 percentage points from 2004, of 16.8 percentage points from 2003, and of 28.3 percentage points from 2002.

• Performance rates among states ranged from 33.5 to 89 percent.

What one should know about the data

Some heart failure patients received discharge instructions but were excluded from these data for the following reason:

• The patient was younger than 18 years of age.

Heart Failure Care Graph #2
Left Ventricular Function Assessment: 2005 State Rates

What this information tells us
These data report the percentage of heart failure patients who received an in-depth evaluation of the function of the main pumping chamber of the heart (the left ventricle) during their hospitalization, or during pre-admission to, or after discharge from, the hospital.

What’s important to know about heart failure and left ventricular function assessment

- The left ventricle is the thickest muscle of the heart and carries the major workload of the heart.  
- Left ventricular heart failure is one of the most common forms of heart failure in the United States. It is a condition in which the muscles of the left side of the heart (left ventricle) become weakened and have to work harder to pump blood. This type of heart failure often causes breathing difficulties.
• The tests that can help determine left ventricular function include echocardiograms, radionuclide angiography and cardiac catheterizations. If the test shows that the left ventricle is not pumping blood effectively, the condition is known as left ventricle systolic dysfunction (LVSD). \(^{17}\)

• National guidelines promote left ventricular function assessment as the single most important test for heart failure patients. \(^{17}\)

Results

• In 2005, Joint Commission-accredited hospitals achieved **national average performance of 90.8 percent** in providing a left ventricular function assessment to heart failure patients – **an improvement of 3.3 percentage points** from 2004, of 6.3 percentage points from 2003, and of 9.3 percentage points from 2002.

• Performance rates among states ranged from 74 to 96.3 percent.

What one should know about the data

Some heart failure patients had their left ventricular function assessed but were excluded from these data for one or more of the following reasons:

• The patient was younger than 18 years of age;
• The patient was transferred to another acute care or federal hospital;
• The patient died;
• The patient left against medical advice; or
• The patient was discharged to hospice.

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\(^{17}\) AHA Guidelines for the Evaluation and Management of Heart Failure.
Heart Failure Care Graph #3
Smoking Cessation Advice: 2005 State Rate

What this information tells us
These data report the percentage of heart failure patients who were given advice or counseling about quitting smoking.

What's important to know about heart failure and smoking
• More than 25 percent of adult American men and 20 percent of adult American women are smokers. 7
• Studies show that smokers are more likely to quit smoking if a doctor advises them to stop. 8
• One year after quitting smoking, a person’s risk of heart disease decreases by 50 percent. 7
• National guidelines strongly recommend smoking cessation counseling for heart failure patients who smoke. 9
Results

• In 2005, Joint Commission-accredited hospitals achieved national average performance of 83.8 percent in advising heart failure patients to quit smoking – an improvement of 14.1 percentage points from 2004, of 27.0 percentage points from 2003, and of 41.6 percentage points from 2002.

• Performance rates among states ranged from 76.5 to 89.6 percent.

What one should know about the data

Some heart failure patients received smoking cessation advice but were excluded from these data for one or more of the following reasons:

• The patient was younger than 18 years of age;
• The patient was transferred to another acute care or federal hospital;
• The patient died;
• The patient left against medical advice; or
• The patient was discharged to hospice.

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Heart Failure Care Graph #4
ACEI/ARB Prescribed at Discharge: 2005 State Rates

What this information tells us
These data report the percentage of heart failure patients who received a prescription for medicine called an ACE inhibitor or an ARB when they were discharged from the hospital. ACE stands for angiotensin converting enzyme. ARB stands for angiotensin receptor blocker. ACE inhibitors, also called ACEIs, and ARBs are medicines taken by mouth that reduce blood pressure and strengthen the heart beat.

What’s important to know about ACE inhibitors, ARBs, and heart failure
• ACE inhibitor and ARB medicines improve the heart’s ability to pump blood to the body. 18
• Heart failure patients who take ACE inhibitor and ARB medicine have fewer symptoms, are physically better, and reduce their risk of returning to the hospital. 19, 20
• National guidelines strongly recommend ACE inhibitor and ARB medicine for heart failure patients. 15
**Results**

- In 2005, Joint Commission-accredited hospitals achieved national average performance of 83 percent in prescribing ACE inhibitor and/or ARB medication of heart failure patients when they were discharged from the hospital – an improvement of 6.7 percentage points from 2004, of 7.2 percentage points from 2003, and of 8.8 percentage points from 2002.

- Performance rates among states ranged from 58.5 to 94.2 percent.

**What one should know about the data**

Some heart failure patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient did not receive an ACE inhibitor and/or ARB due to an allergy to the medicine or other medical reasons;

- The patient was younger than 18 years of age;

- The patient was transferred to another acute care or federal hospital;

- The patient died;

- The patient left against medical advice; or

- The patient was discharged to hospice.

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14 NHLBI Heart Failure: Heart Disease and Medications: wwwmedhelp.org/NIHLib/GF-272.html.


Heart Failure Care Graph #5: National Rates by Year

The following graph shows national data for heart failure measures at Joint Commission-accredited hospitals. (This is the same graph used in the “Quality and Safety Performance Results” section.)

Key to abbreviations: ACEI: Angiotensin converting enzyme inhibitor, ARB: angiotensin receptor blocker, LVF: Left ventricular function. See Glossary for definitions.

What this information tells us

These data show the national performance rates of Joint Commission accredited hospitals over the course of four consecutive years (2002, 2003, 2004, and 2005) for the four heart failure measures evaluated in this report.
What’s important to know about heart failure

- About one in every 100 people over the age of 65 has chronic heart failure. \(^{12}\)
- Heart failure affects 2 to 3 million Americans. \(^{13}\)
- From 1999 to 2002, almost 5 million Americans were diagnosed with heart failure. \(^{12}\)
- One study showed that during the past 20 years, heart failure has not declined, but survival after being diagnosed has increased. \(^{12}\)
- From 1999 to 2002, almost 5 million Americans were diagnosed with heart failure, and deaths from heart failure increased 35.3 percent. \(^{12}\)
- In 2005, the estimated cost of heart failure in the United States was $27.9 billion. \(^{12}\)

Results

- In 2005, Joint Commission-accredited hospitals reported steady improvement over the course of the study in all of the heart failure measures, with the most significant improvement in providing both discharge instructions and smoking cessation advice to heart failure patients.
- The best rates of performance were for:
  - Providing left ventricular function (LVF) assessment improved from 81.5 percent in 2002, to 84.5 percent in 2003, to 87.5 percent in 2004, to 90.8 percent in 2005.
  - Providing smoking cessation advice improved from 42.2 percent in 2002, to 56.8 percent in 2003, to 69.7 percent in 2004, to 83.8 percent in 2005.
  - Providing ACE inhibitor or ARB at discharge improved from 74.2 percent in 2002, to 75.8 percent in 2003, to 76.3 percent in 2004, to 83 percent in 2005.
  - There remains much room for improvement in heart failure care, especially in regard to providing discharge instructions, which now stands at 59.2 percent.

What one should know about the data

These data measure specific “processes” of care for heart failure. In this instance, the study counts the number patients receiving the recommended care for heart failure.

While improvement sometimes is less than 1 percentage point, these are statistically significant improvements because of the larger number of hospitals that reported these data during the time period covered in this graph.

\(^{13}\) NHLBI Heart Failure: www.medhelp.org/NIHlib/GF-272.html.
Pneumonia Care Performance Detail

Composite Measure

What this information tells us
The graph below illustrates the “composite” measure of how consistently hospitals provided evidence-based care for pneumonia in 2005. The number of hospitals (left axis) is shown in relation to the composite measure rate (bottom axis) for the five evidence-based pneumonia treatments or measures evaluated in this report. Data represented by this illustration were reported by 3,013 total hospitals.

Results
During 2005, the national average for providing the five evidence-based pneumonia treatments or measures evaluated in this report was 81 percent, an improvement of 8.7 percentage points from 2002, when The Joint Commission began tracking performance on pneumonia care measures. The bars on the chart below show the approximate number of hospitals achieving varying composite measure rates, which are plotted on a scale of 40 to 100 percent in 2.5 percent intervals. For example, the highest bars show that many hospitals achieved composite measure rates below 70 percent in 2005.

What one should know about the data
- Hospitals were required to have a minimum of 30 patients for whom to report data; and
- The expansion of the measures in 2005 resulted in a lower composite rate.
What this information tells us

These data report the percentage of pneumonia patients who had the amount of oxygen in their bloodstream measured.

What’s important to know about pneumonia and oxygenation assessment

- Giving oxygen has been shown to improve survival rates for pneumonia patients with low levels of oxygen. 25, 26
Results

• In 2005, Joint Commission-accredited hospitals achieved **national average performance of 99.3 percent** in measuring blood oxygen level in pneumonia patients – **an improvement of 0.7 percentage points** from 2004, of 2.1 percentage points from 2003, and of 4.3 percentage points from 2002.

• Performance rates among states ranged from 97.5 to 100 percent.

• Of all the measures covered in this report, hospitals showed the best performance on this particular treatment. This measure also showed the least variability, meaning it was provided more consistently at all Joint Commission accredited hospitals.

What one should know about the data

Some pneumonia patients had the oxygen in their bloodstream measured but were excluded from these data for one or more of the following reasons:

• The patient was transferred from another acute care or critical access hospital, including another emergency department;

• The patient was not diagnosed with pneumonia at the time of admission to the hospital;

• The patient received comfort care only; or

• The patient was younger than 18 years of age.

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Pneumonia Care Graph #2

Pneumococcal Screening and Vaccination: 2005 State Rates

What this information tells us

These data report the percentage of pneumonia patients ages 65 years and older who were screened and vaccinated to prevent pneumonia.

What’s important to know about pneumonia screening and vaccination

- It’s important to give pneumonia vaccine because of the increasing resistance of pneumonia bacteria to antibiotics. 27
- Studies show that vaccination is up to 60 percent effective in preventing bacterial infection. 28, 29
- National guidelines recommend that pneumococcal vaccine be given to all patients age 65 or older and younger patients who have medical conditions associated with increased risk for pneumonia. Revaccination is recommended after 5 to 7 years. 30, 31
Results

• In 2005, Joint Commission-accredited hospitals achieved national average performance of 62.8 percent in providing pneumococcal screening and vaccinating pneumonia patients—an improvement of 14 percentage points from 2004, of 25.2 percentage points from 2003, and of 32.6 percentage points from 2002.

• Performance rates among states ranged from 43.8 to 84.3 percent. There has been noticeable improvement over time, but there is room for improvement.

What one should know about the data

Some pneumonia patients received pneumococcal screening and vaccination but were excluded from these data for one or more of the following reasons:

• The patient was transferred from another acute care or critical access hospital, including another emergency department;
• The patient was not diagnosed with pneumonia at the time of admission to the hospital;
• The patient received comfort care only;
• The patient died;
• The patient left the hospital against medical advice;
• The patient was discharged to hospice;
• The patient was transferred to another general or federal hospital; or
• The patient was younger than 65 years of age.

Pneumonia Care Graph #3
Blood Cultures: 2005 State Rates

What this information tells us
These data report the percentage of pneumonia patients who had a blood test to check for the presence of bacteria before they were given antibiotics.

What’s important to know about pneumonia and blood cultures
• Pneumonia treatment guidelines recommend that blood tests be taken for all pneumonia patients to determine the most effective treatment. 32
Results

• In 2005, Joint Commission-accredited hospitals achieved national average performance of **83.1 percent** in taking a blood test of pneumonia patients before giving them antibiotics – an **improvement of 0.9 percentage points** from 2004, of 0.8 percentage points from 2003, and of 1.1 percentage points from 2002.

• Performance rates among states ranged from 70.4 to 89.5 percent, showing wide variability across the nation.

What one should know about the data

Some pneumonia patients were given a blood test before being given antibiotics but were excluded from these data for one or more of the following reasons:

• The patient was transferred from another acute care or critical access hospital, including another emergency department;

• The patient did not receive antibiotics or have a blood culture;

• The patient was not diagnosed with pneumonia at the time of admission to the hospital;

• The patient received comfort care only; or

• The patient was younger than 18 years of age.

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What this information tells us

These data report the percentage of pneumonia patients who were given advice or counseling about quitting smoking.

What’s important to know about pneumonia and smoking cessation advice

- More than 25 percent of adult American men and 20 percent of adult American women are smokers.  
- Studies show that smokers are more likely to quit smoking if a doctor advises them to stop. 
- One year after quitting smoking, a person’s risk of heart disease decreases by 50 percent. 
- National guidelines recommend smoking cessation counseling for pneumonia patients who smoke.
Results

- In 2005, Joint Commission-accredited hospitals achieved national average performance of 80 percent in advising pneumonia patients to quit smoking—an improvement of 14.5 percentage points from 2004, of 29.8 percentage points from 2003, and of 42.8 percentage points from 2002.

- Performance rates among states ranged from 60.9 to 89.7 percent, showing wide variability across the nation.

- Smoking cessation advice is the only measure provided for heart attack, heart failure and pneumonia care. Performance in providing smoking cessation advice to pneumonia and heart failure patients improved at a faster rate than advice provided to heart attack or heart failure patients.

What one should know about the data

Some pneumonia patients received smoking cessation advice but were excluded from these data for one or more of the following reasons:

- The patient was transferred from another hospital’s emergency department;
- The patient was not diagnosed with pneumonia at the time of their admission to the hospital;
- The patient received comfort care only;
- The patient died in the hospital;
- The patient left against medical advice;
- The patient was discharged to hospice;
- The patient was transferred to another federal or general hospital; or
- The patient was younger than 18 years of age.
Pneumonia Care Graph #5
Initial Antibiotic Received Within 4 Hours of Hospital Arrival: 2005 State Rates

What this information tells us
These data report the percentage of pneumonia patients who received an antibiotic within 4 hours of arriving at the hospital.

What’s important to know about pneumonia and antibiotics
• Studies show that pneumonia patients have better survival rates if they receive antibiotics within 3 to 8 hours of arriving at the hospital. 33, 34, 35, 36
Results

- In 2005, Joint Commission-accredited hospitals achieved a national average performance of 74.5 percent in providing antibiotics to pneumonia patients within 4 hours of arrival at the hospital. By 2005, this measure changed from one where “time to antibiotic” was measured and recorded to one where “the number of patients receiving antibiotics within 4 hours of arrival” was measured and recorded.

- Performance rates among states ranged from 66.1 to 86.2 percent.

What one should know about the data

Some pneumonia patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient was transferred from another acute care or critical access hospital, including another emergency department;
- The patient was not diagnosed with pneumonia at the time of admission to the hospital;
- The patient received comfort care only;
- The patient did not receive antibiotics within 36 hours from the time of hospital arrival;
- The patient received antibiotics within 24 hours prior to arriving at the hospital;
- The patient was involved in clinical trials; or
- The patient was younger than 18 years of age.

Pneumonia Care Graph #6
Initial Antibiotics Selection – Intensive Care Unit Patients: 2005 State Rates

What this information tells us
These data report the percentage of pneumonia patients (those with a certain type of pneumonia called Community Acquired Pneumonia) in the intensive care unit (ICU) who started taking antibiotics within 24 hours of arriving at the hospital.

What’s important to know about Community Acquired Pneumonia and antibiotics
• Studies show that pneumonia patients have better survival rates if they receive antibiotics within 3 to 8 hours of arriving at the hospital. 33, 34, 35, 36
QUALITY PERFORMANCE DETAIL

Results

• In 2005, Joint Commission-accredited hospitals achieved a national average performance of **50.1 percent** in starting ICU patients with Community Acquired Pneumonia on antibiotics within 24 hours of arrival at the hospital. This is a new measure for 2005, so there is no data for previous years.

• Performance rates among states ranged from 36.1 to 70.6 percent, showing wide variability across the nation.

What one should know about the data

Some pneumonia patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient was transferred from another acute care or critical access hospital, including another emergency department;
- The patient was not diagnosed with pneumonia at the time of admission to the hospital;
- The patient received comfort care only;
- The patient did not receive antibiotics while in the hospital or within 36 hours after arriving at the hospital;
- The patient’s immune system was already susceptible to infection;
- The patient was not in the ICU;
- The patient had a type of pneumonia called Health Care Associated Pneumonia;
- The patient was involved in clinical trials; or
- The patient was younger than 18 years of age.

What this information tells us

These data report the percentage of pneumonia patients (those with a certain kind of pneumonia called Community Acquired Pneumonia) who were not in the intensive care unit (ICU) and who started taking antibiotics within 24 hours of arriving at the hospital.

What’s important to know about Community Acquired Pneumonia and antibiotics

- Studies show that pneumonia patients have better survival rates if they receive antibiotics within 3 to 8 hours of arriving at the hospital. 53, 54, 55, 56
Results

- In 2005, Joint Commission-accredited hospitals achieved a national average performance of **83.9 percent** in starting patients with Community Acquired Pneumonia who were not in the ICU on antibiotics within 24 hours of arrival at the hospital. This is a new measure for 2005, so there is no data for previous years.

- Performance rates among states ranged from 78.3 to 90.3 percent.

What one should know about the data

Some pneumonia patients received this treatment but were excluded from these data for one or more of the following reasons:

- The patient was transferred from another acute care or critical access hospital, including another emergency department;
- The patient was not diagnosed with pneumonia at the time of admission to the hospital;
- The patient received comfort care only;
- The patient did not receive antibiotics while in the hospital or within 36 hours after arriving at the hospital;
- The patient’s immune system was already susceptible to infection;
- The patient was in the ICU;
- The patient had a type of pneumonia called Health Care Associated Pneumonia;
- The patient was involved in clinical trials; or
- The patient was younger than 18 years of age.

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Pneumonia Care Graph #8
National Rates by Year

The following graph shows national data for pneumonia measures at Joint Commission-accredited hospitals. (This is the same graph used in the “Quality and Safety Performance Results” section.)

See Glossary for definitions.

What this information tells us
These data show the national performance, or compliance, rates of Joint Commission accredited hospitals over the course of four consecutive years (2002, 2003, 2004 and 2005) for four of the seven pneumonia measures.

What’s important to know about pneumonia
• Approximately 5 million cases of pneumonia occur annually. 21
• Pneumonia is the cause of nearly 55 million days of restricted activity, 31.5 million bed days, and 1.3 million hospitalizations each year. 23
• Inpatient treatment for pneumonia amounts to more than $7.5 billion annually. 24
Results

• Joint Commission-accredited hospitals reported steady improvement during the course of the study for all but one of the pneumonia measures: taking blood cultures before giving the patient antibiotics showed slight improvement between 2002 and 2003, no change from 2003 to 2004, and some improvement from 2004 to 2005.

• The best rates of performance were for:
  • Measuring oxygen in the bloodstream improved from 95 percent in 2002, to 97.2 percent in 2003, to 98.6 percent in 2004, to 99.3 percent in 2005.
  • Providing smoking cessation advice improved from 37.2 percent in 2002, to 50.2 percent in 2003, to 65.5 percent in 2004, to 80 percent in 2005.

• While performance in providing pneumococcal screening and vaccination and in providing smoking cessation advice is improving, there is still room for further improvement. In 2005, 62.8 percent of hospitals nationwide were providing pneumococcal screening and treatment to pneumonia patients, up from 48.8 percent in 2004. In 2005, 80 percent of hospitals nationwide were advising pneumonia patients to quit smoking compared to 65.5 percent in 2004.

What one should know about the data

While improvement sometimes is less than 1 percentage point, these are statistically significant improvements because of the larger number of hospitals that reported these data during the time period covered in this graph.

Surgical Infection Prevention Performance Detail

**Surgical Infection Prevention Care: 2005 National Rates**

**Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>CABG</th>
<th>Cardiac</th>
<th>Colon</th>
<th>Hip</th>
<th>Mastectomy</th>
<th>Knee</th>
<th>Vascular</th>
<th>Overall</th>
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<tbody>
<tr>
<td>100</td>
<td>105</td>
<td>71</td>
<td>174</td>
<td>209</td>
<td>269</td>
<td>247</td>
<td>93</td>
<td>358</td>
</tr>
</tbody>
</table>

Key to abbreviations: CABG: Coronary artery bypass graft surgery. See Glossary for definitions.

**What this information tells us**

These data report the percentage of surgical patients at Joint Commission-accredited hospitals throughout the nation who received an antibiotic within one hour before the first surgical cut. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut. The numbers at the top of each bar indicate the number of hospitals reporting data for that specific surgical procedure. *Note:* Not every surgery requires antibiotics and this measure reports on those selected surgeries where evidence or experts have identified that antibiotics would be helpful.

**What’s important to know about timing of antibiotics and surgical infection prevention**

- In about 25 percent to 50 percent of operations, overuse, underuse, improper timing, and inappropriate use of antibiotics occur. 38
- Overuse, underuse, inappropriate use, and improper timing of antibiotics could result in a surgical site infection, an increased risk of antibiotic resistance, an antibiotic shortage, and increased health care costs.
• Based on scientific evidence, health care personnel can take specific steps to prevent surgical site infections for some operations, including:

  • Selecting the antibiotics recommended by the Surgical Infection Prevention Project 37 specific to the type of surgery the patient is having.

  • Starting the preventive antibiotic within one hour of the first surgical skin cut (except for vancomycin or fluoroquinolone antibiotics, which should be given within two hours before the first surgical skin cut).

• Ways that the patient can prevent or minimize surgical infections are:

  • Stop smoking. Patients who smoke have significantly higher rates of surgical infections.

  • Wash your hands before touching your surgical site or any other open site, and ask that others do the same—including health care professionals. Hand washing is the single most important means of preventing infections.

Results

• In 2005, 358 Joint Commission-accredited hospitals reported data for this measure and achieved overall national average performance of 81.8 percent in providing surgical patients with antibiotics within one hour before the first surgical cut. This measure was introduced in 2004 and 2005 produced the first full year of data.

Joint Commission-accredited hospitals are required to collect and submit data to The Joint Commission on a minimum of three of the five core measure sets available based on the applicability of those measure sets to the services provided by the hospital and the patient populations served. The selection of measure sets is at the discretion of the hospital. However, hospitals receiving reimbursement from Medicare had a financial incentive in 2005 to submit data on 10 measures from the acute myocardial infarction, heart failure and pneumonia measure sets, or receive a lower payment if not reported. The smaller number of hospitals reporting on the surgical infection prevention measures may be a result of the majority of hospital selecting the acute myocardial infarction, heart failure, and pneumonia measures sets to meet both The Joint Commission requirement and receive the financial incentive. However, as requirements and incentives change, it is anticipated that a larger number of hospitals will select this set.
• Performance rates among the different types of surgical procedures ranged from 72.1 to 85.2 percent.

  • For coronary artery bypass graft (CABG) surgery, of the 105 hospitals reporting this data, 85.2 percent provided antibiotics within one hour before the first surgical cut.

  • For cardiac surgery (other than CABG), of the 71 hospitals reporting this data, 83.8 percent provided antibiotics within one hour before the first surgical cut.

  • For colon surgery, of the 174 hospitals reporting this data, 72.1 percent provided antibiotics within one hour before the first surgical cut.*

  • For hip joint replacement surgery, of the 209 hospitals reporting this data, 81.2 percent provided antibiotics within one hour before the first surgical cut.

  • For hysterectomy surgery, of the 269 hospitals reporting this data, 82.3 percent provided antibiotics within one hour before the first surgical cut.

  • For knee joint replacement surgery, of the 247 hospitals reporting this data, 85 percent provided antibiotics within one hour before the first surgical cut.

  • For vascular surgery, of the 93 hospitals reporting this data, 75.2 percent provided antibiotics within one hour before the first surgical cut.

* There were national shortages of the antibiotics recommended for patients undergoing colon surgery. However, there was a recommended alternative combination of antibiotics for these operations. Therefore, the lower rates of antibiotic usage for colon surgery may have been impacted by the antibiotic shortage, but there may be other reasons for the lower rate.
What one should know about the data

Some surgical patients received an antibiotic within one hour before the first surgical cut but were excluded from these data for one or more of the following reasons:

- The patient already had an infection or infectious disease;
- The patient was taking antibiotics within 24 hours before arriving at the hospital or having surgery (except colon surgery patients taking oral antibiotics as directed by their doctor);
- The patient was having colon surgery and was already taking oral antibiotics as directed by his or her doctor, and the patient received no other antibiotics during his or her hospital stay;
- The patient had another medical procedure that required anesthesia, and the anesthesia was administered within 24 hours before the surgery and during the same hospital visit; or
- During the same hospital stay, the patient had another medical procedure in which anesthesia was administered within 24 hours before the surgery measured here; or
- The patient was younger than 18 years of age.
**Surgical Infection Prevention Care: 2005 National Rates**  
**Prophylactic Antibiotic Discontinued Within 24 Hours After Surgical End Time**

![Bar chart showing percentages of surgical patients whose antibiotic was stopped within 24 hours after surgery.]

**Key to abbreviations:** CABG: Coronary artery bypass graft surgery. See Glossary for definitions.

**What this information tells us**

These data report the percentage of surgical patients at Joint Commission-accredited hospitals throughout the nation whose antibiotic was stopped within 24 hours after having surgery. Giving medicine that prevents infection for more than 24 hours after the end of surgery is not helpful unless there is a specific reason (for example, fever or other signs of infection). The numbers at the top of each bar indicate the number of hospitals reporting data for that specific surgical procedure. **Note:** Not every surgery requires antibiotics and this measure reports on those selected surgeries where evidence or experts have identified that antibiotics would be helpful.

**What’s important to know about surgical infection prevention**

- In about 25 percent to 50 percent of operations, overuse, underuse, improper timing, and inappropriate use of antibiotics occur. 

- Overuse, underuse, inappropriate use, and improper timing of antibiotics could result in a surgical site infection, an increased risk of antibiotic resistance, an antibiotic shortage, and increased health care costs.
• Based on scientific evidence, health care personnel can take specific steps to prevent surgical site infections for some operations, including:
  
  • Selecting the antibiotics recommended by the Surgical Infection Prevention Project specific to the type of surgery the patient is having.
  
  • Stopping the preventive antibiotic within 24 hours after the surgery (48 hours for cardiac surgery).
  
• Ways that the patient can prevent or minimize surgical infections are:
  
  • Stop smoking. Patients who smoke have significantly higher rates of surgical infections.
  
  • Wash your hands before touching your surgical site or any other open site, and ask that others do the same—including health care professionals. Hand washing is the single most important means of preventing infections.

Results

• In 2005, 357 Joint Commission-accredited hospitals reported data for this measure and achieved overall national average performance of 73.5 percent in stopping antibiotics within 24 hours after surgery. This is a new measure for 2005, so there is no data for previous years.

Joint Commission accredited hospitals are required to collect and submit data to The Joint Commission on a minimum of three of the five core measure sets available based on the applicability of those measure sets to the services provided by the hospital and the patient populations served. The selection of measure sets is at the discretion of the hospital. However, hospitals receiving reimbursement from Medicare had a financial incentive in 2005 to submit data on 10 measures from the acute myocardial infarction, heart failure and pneumonia measure sets, or receive a lower payment if not reported. The smaller number of hospitals reporting on the surgical infection prevention measures may be a result of the majority of hospital selecting the acute myocardial infarction, heart failure, and pneumonia measures sets to meet both The Joint Commission requirement and receive the financial incentive. However, as requirements and incentives change, it is anticipated that a larger number of hospitals will select this set.

• Performance rates among the different types of surgical procedures ranged from 61.5 and 88 percent.
  
  • For coronary artery bypass graft (CABG) surgery, of the 103 hospitals reporting this data, 70 percent stopped antibiotics within 24 hours after surgery.
• For cardiac surgery (other than CABG), of the 67 hospitals reporting this data, 63 percent stopped antibiotics within 24 hours after surgery.

• For colon surgery, of the 160 hospitals reporting this data, 61.5 percent stopped antibiotics within 24 hours after surgery.*

• For hip joint replacement surgery, of the 204 hospitals reporting this data, 69 percent stopped antibiotics within 24 hours after surgery.

• For hysterectomy surgery, of the 259 hospitals reporting this data, 88 percent stopped antibiotics within 24 hours after surgery.

• For knee joint replacement surgery, of the 246 hospitals reporting this data, 69.3 percent stopped antibiotics within 24 hours after surgery.

• For vascular surgery, of the 85 hospitals reporting this data, 65.4 percent stopped antibiotics within 24 hours after surgery.

What one should know about the data

Some surgical patients received an antibiotic within one hour before the first surgical cut but were excluded from these data for one or more of the following reasons:

• The patient already had an infection or infectious disease;

• The patient was taking antibiotics within 24 hours before arriving at the hospital or having surgery (except colon surgery patients taking oral antibiotics as directed by their doctor);

• The patient did not receive any antibiotics before or during surgery, within 24 hours after surgery, or any time during his or her hospital stay;

• The patient was diagnosed and treated for infection within two days after surgery;

• During the same hospital stay, the patient had another medical procedure in which anesthesia was administered within 24 hours after the surgery measured here; or

• The patient was younger than 18 years of age.

* There were national shortages of the antibiotics recommended for patients undergoing colon surgery. However, there was a recommended alternative combination of antibiotics for these operations. Therefore, the lower rates of antibiotic usage for colon surgery may have been impacted by the antibiotic shortage, but there may be other reasons for the lower rate.
Overall Reported Data and Results

The following graph shows the national performance rates for various measures for heart attack, heart failure, pneumonia, and surgical infection prevention at Joint Commission-accredited hospitals.

Percent of Hospitals With 2005 Performance Rates Exceeding 90 Percent


What this information tells us
These data report the percentage of hospitals that provided these treatments or practices most of the time* during 2005.

* “Most of the time” is defined here as 90 percent or better.
Results

• In 2005, 99.1 percent of Joint Commission-accredited hospitals throughout the United States reported that they provided an oxygenation assessment for pneumonia patients most of the time; 87.7 percent reported that they provided aspirin at arrival for heart attack patients most of the time.

• Five of the heart attack treatments or measures were performed consistently most of the time at between 69.8 and 87.7 percent of the accredited hospitals throughout the nation: beta blocker at arrival, smoking cessation advice, beta blocker at discharge, aspirin at discharge, and aspirin at arrival. Only oxygenation assessment for pneumonia patients was done most of the time at reporting hospitals, showing that there is room for improvement.

• Slightly more than 5 percent of accredited hospitals throughout the United States reported that they provided heart attack patients with PCI balloon therapy within 120 minutes of arrival, or pneumonia patients with an antibiotic within 4 hours of arrival, most of the time.

• None of the hospitals (those with 30 or more patients requiring thrombolytic therapy) exceeded 90 percent in providing heart attack patients with thrombolytic therapy within 30 minutes of arrival, or starting ICU patients with Community Acquired Pneumonia with antibiotics within 24 hours of arrival.

What one should know about the data

These data measure specific “processes” of care for heart attack, heart failure, pneumonia, and surgical infection prevention. In this instance, the study counts the number patients receiving the recommended care for heart attack, heart failure, pneumonia, or surgical infection prevention.
Top Standards Compliance Issues

While compliance with the standards at all times is the goal of Joint Commission-accredited organizations—and the intent behind accreditation—there are times when it is impossible to attain that high level of achievement consistently. That’s why we emphasize continuous improvement through accreditation.

Health care is changing daily; there are new, more effective treatments, medications, and processes of care, as well as emerging technologies and systems. Some health care organizations are challenged to find resources to keep up with the all of the demands for newer, better ways to deliver care. Joint Commission accreditation is changing to meet these needs.

We provide organizations with tools to help them track their performance complying with standards and measuring improvement. Each year, we publish the top standards compliance issues—those standards that are the most difficult for health care organizations to meet. The top standards compliance issues for hospitals during 2005 were:

1.) Once the hospital has prioritized its goals, strategies must be implemented to achieve these goals.

| 90 percent compliant | 10 percent non-compliant |

2.) There is a process for granting, renewing, or revising setting-specific clinical privileges.

| 90 percent compliant | 10 percent non-compliant |

3.) All the prescriptions or medication orders are reviewed for appropriateness.

| 89 percent compliant | 11 percent non-compliant |

4.) The hospital manages safety risks.

| 89 percent compliant | 11 percent non-compliant |
5.) The leaders develop and implement policies and procedures for care, treatment, and services.

- 87 percent compliant
- 13 percent non-compliant

6.) The hospital defines in writing the time frame(s) for conducting the initial assessment(s).

- 87 percent compliant
- 13 percent non-compliant

7.) The hospital has a complete and accurate medical record for every patient assessed or treated.

- 85 percent compliant
- 15 percent non-compliant

8.) When pain is identified, the patient is assessed and treated by the hospital or referred for treatment.

- 85 percent compliant
- 15 percent non-compliant

9.) Designated qualified personnel accept and transcribe verbal orders from authorized individuals.

- 83 percent compliant
- 17 percent non-compliant

10.) Medication orders are written clearly and transcribed accurately.

- 80 percent compliant
- 20 percent non-compliant
11.) Newly constructed and existing environments of care are designed and maintained to comply with the *Life Safety Code®*.

| 79 percent compliant | 21 percent non-compliant |

12.) Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

| 70 percent compliant | 30 percent non-compliant |

13.) Medications are properly and safely stored throughout the hospital.

| 63 percent compliant | 37 percent non-compliant |

14.) The hospital has processes in place to effectively manage information, including the capturing, reporting, processing, storing, retrieving, disseminating, and displaying of clinical/service and non-clinical data and information.

| 59 percent compliant | 41 percent non-compliant |
The Joint Commission’s Commitment to Safety

The Joint Commission’s commitment to patient safety is inherent in its mission. At its heart, accreditation is a risk-reduction activity and compliance with the standards is intended to reduce the risk of bad outcomes. The Joint Commission demonstrates its commitment to patient safety through other numerous efforts, including its *Sentinel Event Alert* patient safety newsletter and the establishment of annual Joint Commission National Patient Safety Goals.

Central to this work is the Sentinel Event Advisory Group, which was formed in February 2002. The Advisory Group recommends the National Patient Safety Goals to The Joint Commission Board of Commissioners each year; the first goals became effective in January 2003. The goals help accredited organizations address specific areas of concern in regards to patient safety.

The Joint Commission also conducts patient safety-related research, publishes books and organizes conferences on patient safety, evaluates complaints and reports of concerns about Joint Commission accredited health care organizations, and publicly discloses information about accredited organizations through Quality Reports (available at qualitycheck.org). Most recently, The Joint Commission has established a Center for Patient Safety, an entity that draws upon the patient safety expertise, resources and knowledge of both The Joint Commission and its not-for-profit subsidiary, Joint Commission Resources.
2005 National Patient Safety Goals
Performance Detail

Each year, health care providers must meet the requirements of the Joint Commission’s National Patient Safety Goals as part of the accreditation process. In 2005, eight goals and 16 requirements were identified and the compliance assessment results are displayed below. “Compliance” means consistent performance of the requirement. When an organization is found to be "non-compliant,” it does not mean that the organization is failing to do what is required at all; it means that the organization is not meeting the requirement consistently.

Hospitals must do more than simply perform specified tasks to achieve compliance with Joint Commission National Patient Safety Goals. To assure safe health care environments, hospitals must continually analyze fundamental work systems and redesign those systems as needed.

Hospitals must also go beyond the tasks of removing a dangerous medication from a patient care unit or requiring a specific safety feature on a medical device. They must achieve goals such as “improve the accuracy of patient identification” by changing how individuals caring for patients do their jobs. Achieving this kind of behavioral change among providers takes time, motivation, reinforcement, reward, patience, and support.

The Joint Commission conceptually supports the National Quality Forum’s 30 consensus safe practices for health care organizations. However, The Joint Commission believes it is important to focus on a smaller number of goals to leverage real change in organization culture and real investment in system redesign that are integral to any effort to keep inevitable human error from reaching the patient.

The 2005 National Patient Safety Goals for hospitals are listed on the following pages, as well as the percentage of hospitals (derived from 1,573 on-site surveys conducted in 2005) that were found to be in compliance with the specific requirements of each goal at the time of their on-site surveys.
Goal 1: Improve the accuracy of patient identification.

Requirement 1A: Use at least two patient identifiers (neither to be the patient’s room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

95.3% compliance 4.7% non-compliance

Requirement 1B: Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

82.7% compliance 17.3% non-compliance

Note: This requirement is surveyed as 1C under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

Goal 2: Improve the effectiveness of communication among caregivers.

Requirement 2A: For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read-back” the complete order or test result.

87.7% compliance 12.3% non-compliance

Requirement 2B: Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.

61.4% compliance 38.6% non-compliance
Requirement 2C: Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

90.5% compliance

Goal 3: Improve the safety of using medications.

Requirement 3A: Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.

98.6% compliance

Requirement 3B: Standardize and limit the number of drug concentrations available in the organization.

98.5% compliance

Requirement 3C: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

97.6% compliance


Requirement 4A: Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.

95.5% compliance

Note: This requirement is surveyed under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.
Requirement 4B: Implement a process to mark the surgical site and involve the patient in the marking process.

![96.7% compliance](3.3% non-compliance)

Note: This requirement is surveyed under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

Goal 5: Improve the safety of using infusion pumps.

Requirement 5A: Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

![99.9% compliance](0.1% non-compliance)

Goal 7: Reduce the risk of health care-associated infections

Requirement 7A: Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

![96.4% compliance](3.6% non-compliance)

Requirement 7B: Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

![100% compliance](0.0% non-compliance)
Goal 8: Accurately and completely reconcile medications across the continuum of care.

Requirement 8A: During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

99.9% compliance  0.1% non-compliance

Requirement 8B: A complete list of the patient’s medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

99.7% compliance  0.3% non-compliance

Goal 9: Reduce the risk of patient harm resulting from falls.

Requirement 9A: Assess and periodically reassess each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen, and take action to address any identified risks.

95.5% compliance  4.5% non-compliance
National Patient Safety Goal 1: Improve the accuracy of patient identification.

Requirement 1A: Use at least two patient identifiers (neither to be the patient’s room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing or providing any other treatments or procedures.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of using at least two patient identifiers (neither to be the patient’s room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 95.3 percent in using at least two patient identifiers.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 1: Improve the accuracy of patient identification.

Requirement 1B: Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

2005 State Rates

What this information tells us
These data report the percentage of hospitals** complying with the requirement of, prior to the start of any surgical or invasive procedure, conducting a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

Result
• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 82.7 percent in conducting a final verification or "time-out" process prior to surgery.

Note: This requirement is surveyed under The Joint Commission's Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.

** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 2: Improve the effectiveness of communication among caregivers.

Requirement 2A: For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read-back” the complete order or test result.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of, for verbal or telephone orders or for telephonic reporting of critical test results, verifying the complete order or test result by having the person receiving the order or test result “read-back” the complete order or test result.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 87.7 percent in verifying by reading back the complete order or test result.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 2: Improve the effectiveness of communication among caregivers

Requirement 2B: Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of standardizing the abbreviations, acronyms and symbols not to be used throughout the organization.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 61.4 percent in standardizing “do not use” abbreviations, acronyms and symbols.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.

** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 2: Improve the effectiveness of communication among caregivers

Requirement 2C: Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of measuring, assessing and, if appropriate, taking action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 90.5 percent in improving the timely reporting of critical test results and values.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.

** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 3: Improve the safety of using medications

Requirement 3A: Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of removing concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.

Result

- In 2005, Joint Commission-accredited hospitals** achieved national average performance of 98.6 percent in removing concentrated electrolytes from patient care units.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 3: Improve the safety of using medications.

Requirement 3B: Standardize and limit the number of drug concentrations available in the organization.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of standardizing and limiting the number of drug concentrations available in the organization.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 98.5 percent in standardizing and limiting drug concentrations.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 3: Improve the safety of using medications.

Requirement 3C: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of identifying and, at a minimum, annually reviewing a list of look-alike/sound-alike drugs used in the organization, and taking action to prevent errors involving the interchange of these drugs.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 97.6 percent in identifying and reviewing a list of look-alike/sound-alike drugs and taking action to prevent errors involving these drugs.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.

Requirement 4A: Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of creating and using a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 95.5 percent in creating and using a preoperative verification process to confirm the availability of appropriate documents.

Note: This requirement is surveyed under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.

Requirement 4B: Implement a process to mark the surgical site and involve the patient in the marking process.

What this information tells us

These data report the percentage of hospitals** complying with the requirement of implementing a process to mark the surgical site and involving the patient in the marking process.

Result

- In 2005, Joint Commission-accredited hospitals** achieved national average performance of 96.7 percent in implementing a process of surgical site marking and involving the patient in this process.

Note: This requirement is surveyed under The Joint Commission’s Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 5: Improve the safety of using infusion pumps.

Requirement 5A: Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of ensuring free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 99.9 percent in ensuring free-flow protection.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
**National Patient Safety Goal 7:** Reduce the risk of health care-associated infections.

**Requirement 7A:** Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

### 2005 State Rates

![Map showing state compliance rates for CDC hand hygiene guidelines in 2005.](image)

**What this information tells us**

These data report the percentage of hospitals** complying with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

**Result**

- In 2005, Joint Commission-accredited hospitals** achieved national average performance of 96.4 percent in complying with current CDC hand hygiene guidelines.

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* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
**National Patient Safety Goal 7: Reduce the risk of health care-associated infections.**

**Requirement 7B:** Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of managing as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.

Result

- In 2005, Joint Commission-accredited hospitals** achieved national average performance of 100.0 percent in managing as sentinel events all cases of unanticipated death or permanent function loss associated with health care-acquired function.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 8: Accurately and completely reconcile medications across the continuum of care.

Requirement 8A: During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of, during 2005, for full implementation by January 2006, developing a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 99.9 percent in developing a process for obtaining and documenting a complete list of a patient’s medications with the involvement of the patient.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 8: Accurately and completely reconcile medications across the continuum of care.

Requirement 8B: A complete list of the patient’s medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of communicating a complete list of the patient’s medications to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 99.7 percent in communicating a complete list of patient medications to the next provider of service.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
National Patient Safety Goal 9: Reduce the risk of patient harm resulting from falls.

Requirement 9A: Assess and periodically reassess each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen, and take action to address any identified risks.

2005 State Rates

What this information tells us

These data report the percentage of hospitals** complying with the requirement of assessing and periodically reassessing each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen, and taking action to address any identified risks.

Result

• In 2005, Joint Commission-accredited hospitals** achieved national average performance of 95.5 percent of assessing and periodically reassessing each patient’s risk for falling.

* Since in 2005 only one Montana hospital was surveyed by The Joint Commission, no state compliance percentage is provided.
** 1,573 hospitals underwent on-site surveys during 2005.
Improving America’s Hospitals
A Report on Quality and Safety

Glossary of Definitions and Abbreviations
Glossary of Definitions and Abbreviations

**ACE Inhibitors or ACEI.** ACE stands for “angiotensin converting enzyme.” ACE inhibitors are medicines that are used to treat heart failure and high blood pressure. These medicines block an enzyme in the body that is responsible for causing the blood vessels to narrow. If the blood vessels are relaxed, blood pressure is lowered and more oxygen-rich blood can reach the heart. ACE inhibitors also lower the amount of salt and water in the body, which helps to lower blood pressure.

**AMI – Acute Myocardial Infarction.** The medical term for "heart attack.” Acute myocardial infarction results from a blockage in one or more of the blood vessels leading to the heart. Damage to the heart muscle results, due to the lack of blood flow.

**Antibiotic timing.** The length of time from arrival at the hospital until antibiotics are given. Antibiotics are generally given as soon as possible to pneumonia patients to speed their recovery.

**ARB.** ARB stands for “angiotensin receptor blocker.” An ARB is a medicine taken by mouth that reduces blood pressure and strengthens the heart beat. ARBs are useful in the treatment of cardiac diseases such as heart attack and heart failure.

**At Arrival.** The time period lasting from 24 hours before to 24 hours after a patient arrives at a hospital.

**At Discharge.** The time during which a patient is preparing to leave the hospital. At discharge, patients often receive information and advice about medicines, diet, activities and signs to watch for to prevent further hospitalization.

**Beta blocker.** This type of medicine blocks the action of certain hormones on the heart. By blocking these hormones, beta blockers help to reduce the heart rate and blood pressure, thereby reducing the amount of oxygen needed by the heart.

**Blood cultures.** Blood tests that look for bacteria or fungi in the blood. These tests are given to pneumonia patients before antibiotics are administered.
**CABG.** CABG stands for coronary artery bypass graft surgery – an operation in which a section of vein or artery is used to bypass a blockage in a coronary artery, allowing enough blood to flow to deliver oxygen and nutrients to the heart muscles. CABG is performed to prevent myocardial infarction (heart attack) and to relieve angina.

**Composite measure.** A measure that combines the results of all process measures within a set into a single rating.

**Inpatient mortality.** Patient death during a hospital stay.

**LVF assessment.** An in-depth evaluation of heart muscle function that helps determine the correct treatment for heart failure. LVF stands for “left ventricular function.” An LVF assessment evaluates how well the left ventricle – the heart’s main pumping chamber – is functioning. Left ventricular diastolic dysfunction results when the heart chamber is not pumping all the blood out before it refills for the next heart beat. This results in high pressure within the heart and can produce heart failure.

**Joint Commission National Patient Safety Goals.** A series of specified actions that accredited organizations are expected to take in order to prevent medical errors.

**National Quality Improvement Goals.** Standardized performance measures that can be applied across accredited hospitals.

**Oxygenation assessment.** A test measuring the amount of oxygen in a patient’s bloodstream.

**PCI balloon therapy.** PCI stands for “percutaneous coronary interventions.” PCI balloon therapy is a coronary angioplasty procedure performed by a doctor who threads a small balloon into a clogged artery to open it, thereby improving blood flow to the heart. A lack of blood supply to the heart muscle can cause lasting heart damage. PCI balloon therapy is used as an alternative treatment to coronary artery bypass surgery (CABG).
**Pneumococcal screening and vaccination.** A vaccination and a series of tests that help to prevent pneumonia.

**Thrombolytic therapy.** Medication that dissolves blood clots. Breaking up blood clots increases blood flow to the heart. If blood flow is returned to the heart muscle quickly during a heart attack, the risk of death is decreased.

**Surgical Infection Prevention Care.** The use of indicated antibiotics to prevent infection during surgery. Infection is lowest when patients receive antibiotics to prevent infection within one hour before the skin is surgically cut and when antibiotics are stopped within 24 hours after surgery.
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