

PHYSICIAN LEADER MONTHLY



March 2018

Updated sentinel event statistics for 2017

For 2017, The Joint Commission reviewed a total of 805 reports of sentinel events. The Top 10 most frequently reported types of sentinel events are shown in the table. [See more updated stats.](#)

Top 10 most frequently reported sentinel events for 2017

Unintended retention of a foreign body	116
Fall	114
Wrong-patient, wrong-site, wrong-procedure	95
Suicide	89
Delay in treatment	66
Other unanticipated event*	60
Criminal event	37
Medication error	32
Operative/postoperative complication	19
Self-inflicted injury	18

*Includes asphyxiation, burn, choked on food, drowned, or being found unresponsive.

Center for Transforming Healthcare, Huron partner on high reliability

A series of workshops on high reliability strategies for health care organizations will be available starting in April, thanks to a new partnership between the Joint Commission Center for Transforming Healthcare and global professional services firm Huron. The [first workshop](#) is April 11 in Minneapolis. [Read more.](#)



Seeking comments on proposed requirements

Proposed are a new credentialing and privileging requirement and revisions to credentialing and privileging standards for contract services. [Comment](#) deadline is March 21.

Proposed new requirements for pediatric emergency equipment and supplies for



hospitals, critical access hospitals and ambulatory care facilities that provide pediatric services.

[Comment](#) deadline is. March 27.

March JQPS: Learn how 10 health centers used electronic health record (EHR) analysis to identify patients potentially suffering from hypertension to improve their diagnoses.

See the Table of Contents.

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ORIGINAL ARTICLES

Care Processes

115 Applying Population Health Approaches to Undiagnosed Hypertension

S.D. Pencill

A population health strategy driven by electronic health record data is a practical approach to improving the diagnosis of hypertension in health centers that provide care to underserved underserved populations and communities. Clinicians have responsibility for the health needs not just to the patients in their care but for the whole group of patients who have previously sought care.

117 Improving Identification and Diagnosis of Hypertensive Patients Hiding in Plain Sight (HIPS) in Health Centers

M. Maslow, J.A. Osheoff, R. Reider

Many safety-net patients with hypertension are not formally diagnosed and may remain untreated and at increased risk for cardiovascular events. Algorithmic logic and other clinical decision support-enabled care process improvements were used to identify and engage patients at risk for undiagnosed hypertension at 10 health centers with high hypertension prevalence. After the intervention, the prevalence of diagnosed hypertension increased significantly from 38.5% to 36.7% ($p = 0.05$). Of the tracked patients, 65.2% completed a follow-up evaluation, of which 31.0% received a hypertension diagnosis. Identifying all hypertensive patients is a key step to ensure that hypertension control efforts yield maximal improvements to population cardiovascular health.

Patient and Family Engagement

130 Empowering Informal Caregivers with Health Information OpenNotes as a Safety Strategy

H. Chlanowicz, M. Gerold, A. Foss, F. Bourgeois, S.K. Bell

Enabling family/friend caregivers with access to visit notes may help avoid errors, delayed diagnoses, or other ambulatory safety risks. The impact of the OpenNotes initiative—which entails the sharing of providers' notes with patients through computer portals—was assessed by patient surveys. Of 24,722 portal accounts accessed during the study, 7,058 (29%) surveys were returned, with 150 (2%) of participants identified as caregivers. For patients who had sons and sisters, reading notes helped caregivers, for example, understand the reason for the test (80%) or referral (82%), remember to get patient seen/done (55%), to check (82%) and understand (82%) results, and remember patient appointments (69%). Access to patient health information may better support and help engage patients and families in safety efforts.

Adverse Events

137 When Clinicians Drop Out and Start Over after Adverse Events

J. Rodriguez, S.D. Scott

The impact of adverse clinical events on health care workers has become a growing topic of research. An exploratory study developed a 30-question survey and assessed the experiences of 77 health care providers who changed career paths as a consequence of an adverse clinical event. The participating clinicians reported a paucity of adequate social support after the event. Many of the clinicians felt less joy and meaning in their new clinical roles, but others thrived by solidifying their careers towards implementing patient safety initiatives and enhancing peer support networks. They reported a desire for more transparency and support to help them recover. The study findings highlight the need to develop better support systems for clinicians who are involved in an adverse clinical event.

Performance Measures

146 Meeting Quality Measures for Adolescent Preventive Care Assessing the Perspectives of Key Stakeholders

S.R. Panzararajan, S.L. Johnson, D. Magnusson, T. King

Health plans are increasingly implementing quality improvement strategies aimed at meeting adolescent clinical quality measures, yet clinics often struggle to meet these measures. A qualitative study was conducted to explore how efforts to meet the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS) performance measure for adolescent well-care visits were perceived by a multidisciplinary group of stakeholders. In the depth, semistructured interviews, the stakeholder group—clinical staff with direct patient contact, health care institutional leaders, and representatives of a payer organization—diverged in their opinions regarding strategies for achieving adolescent quality measures. For example, in contrast to a relationship-based approach to reaching adolescent patients, stakeholders with no direct patient contact emphasized that building performance measures in an efficient manner was a marker of high-quality well-care delivery for patients.

JUST PUBLISHED

[Getting an ROI from Robust Process Improvement \(RPI\):](#) The Center for Transforming Healthcare team frequently hears from organizations struggling to bring their leadership fully on board with high reliability.

[New requirements assess pregnant mothers' infectious disease status upon delivery room admission:](#) Assessing pregnant women's status for HIV, syphilis, hepatitis B, and group B strep (GBS) is about to get much more comprehensive — even if it doesn't take place until the delivery room.

[AHRQ focuses on ASC patient safety resources:](#) Despite the trend of more surgical care being provided in ambulatory care settings, the majority of patient safety efforts to date have focused on the inpatient setting.

RESOURCES

TST® for Hand Hygiene mobile app simplifies observations

Users of the Targeted Solutions Tool® (TST®) for Hand Hygiene can now record their hand hygiene

observations on any mobile device or tablet. Download the mobile app from Google Play or .Apple app store. [Learn more](#)



Podcast details **Emergency Management standards updates**

Recent updates to the Emergency Management standards were made in response to the Centers for Medicare & Medicaid Services' final rule on emergency preparedness. [Listen in](#) to the [discussion with Field Director Jim Kendig. [4:46

INDUSTRY NEWS

NPDB NATIONAL PRACTITIONER DATA BANK

NPDB launches new hospital attestation initiative: The National Practitioner Data Bank launched a new initiative for U.S. hospitals to complete their federally mandated hospital attestation when renewing their registrations with the NPDB. Hospitals will be joining a growing group that includes State Licensing Boards and health centers that complete attestation when they renew their registration with the NPDB every two years. Learn more in [NPDB Insights](#).



Five minute video: HFMA President and CEO Joseph J. Fifer, FHFMA, CPA, discusses variations in health care prices and why physicians and other stakeholders should focus on providing price information that is accurate, timely, and individualized. [Watch the video](#).

THE JOINT COMMISSION IN THE NEWS

[In disaster response, physician leaders must inspire and emphathize | AAPL](#)

[Intensive, well-resourced antibiotic stewardship found best in small hospitals | CIDRAP](#)

[Suicide-screening toolkit can help identify youths at high risk for suicide | Psychiatry Advisor](#)



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