

QUALITY COLLABORATIVE

NQF Launches New Project to Improve Coordination of Healthcare

The National Quality Forum (NQF) has launched a yearlong project to improve patient safety and reduce waste by promoting practices and measures that better coordinate a notoriously fragmented healthcare system. According to NQF, at least \$15 billion in Medicare spending is wasted each year in treating patients who, because of poor care coordination, become sicker after their discharge and must be readmitted.

Through the project, NQF will endorse practices and measures to ensure that critical information follows the patient when he or she leaves the hospital or a provider's office and is shared among all of the patient's providers throughout his or her lifetime. The practices and measures that NQF will endorse over the coming year will complement NQF's endorsed care coordination framework that focuses on five key dimensions in healthcare: healthcare home, plan of care and follow-up, communication, information systems, and transitions or handoffs.

Care coordination was identified by the National Priorities Partnership in November 2008 as one of six national priorities for healthcare reform with the greatest potential to improve America's healthcare. The other priorities were patient and family engagement, population health, safety, palliative and end-of-life care, and overuse. NQF is both the convener and a member of this diverse coalition, which is composed of 28 major national organizations representing those who pay for, receive, provide, and evaluate healthcare. These organizations are in a prime position to transform healthcare from the inside out—where it has the best chance to succeed.

NQF is currently convening a steering committee of experts for the care coordination project and has issued a call for preferred practices to be considered for endorsement. NQF anticipates opening a call for measures in February 2009 and expects to complete the project in late 2009.

Strategies to Reduce Medical Residents' Fatigue-Related Errors and Improve Training

To improve patient safety and the training environment, fatigued medical residents need protected sleep periods and increased supervision of work-hour limits, according to a new Institute of Medicine (IOM) report funded by the U.S. Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ).

The report is the result of a 15-month study by an IOM committee that reviewed the relationship between residents' work schedules, their performance, and the quality of care they provide. The study confirms scientific evidence showing that acute and chronically fatigued residents are more likely to make mistakes.

The IOM committee recommends several changes to the existing 80-hour-per-week limit on work hours, including protected sleep periods for residents. The current rules of the Accreditation Council for Graduate Medical Education allow residents to work a maximum 30-hour shift. In this time, they may treat patients for 24 hours and engage in training or transition activities for the other 6 hours. The IOM recommends a change to allow residents who complete a 30-hour shift to treat patients for a maximum of 16 hours. Then they must have a 5-hour protected sleep period between 10 p.m. and 8 a.m., during which time other nonsleeping residents or additional staff members can take over patient care.

"The Institute of Medicine study provides the clear evidence to prove what we have long believed is true—fatigue increases the chance for human error," said AHRQ director Carolyn M. Clancy, MD. "Most importantly, this report provides solid recommendations that can improve patient safety, as well as increase the quality of the resident training experience."

Other recommendations in the report, *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*, include increased supervision of work hours, stronger moonlighting restrictions,

guaranteed days off to permit adequate recovery after working long shifts, reasonable on-call periods, safe transportation provided by hospitals for residents who are too fatigued to drive home, increased resident training on better communication during handoffs, and increased involvement of residents in patient safety activities and adverse event reporting.

AHRQ has free resources to help residents and other healthcare providers implement recommendations related to patient safety training and adverse event reporting. For information, visit www.iom.edu/CMS/3809/48553/60449.aspx or contact AHRQ's office of communications at 301/427-1859 or 301/427-1865.

Joint Commission Q&A

Question: Are major scoring changes coming in 2009?

Joint Commission: Yes, but the changes have made scoring easier to understand! Effective January 1, 2009, new scoring and decision processes for all accreditation and certification programs are in place that better reflect an organization's performance regarding compliance with Joint Commission standards and elements of performance (EPs). The processes are based on the premise that some requirements are more critical than others. A requirement has a "direct impact" if noncompliance is likely to create an immediate risk to patient safety and quality of care. Direct Impact requirements are typically implementation-based requirements. Indirect Impact requirements are typically planning- and evaluation-based requirements in which there is initially less immediacy of risk to patient safety and quality of care as the result of noncompliance. However, failure to resolve noncompliance with the Indirect Impact requirements increases the risk.

Although the three-point EP scoring scale (satisfactory compliance = 2, partial compliance = 1, and insufficient compliance = 0) will be retained, numerous scoring changes are being made for 2009, including the following:

- Bulleted lists of expectations have been minimized.
- Compliance problems previously cited as supplemental findings will be cited as requirements for improvement.
- EPs will be divided into two scoring categories: A and C. Scoring category B will be eliminated.
 - Category A EPs are usually related to structural requirements (for example, policies or plans) that either exist or do not exist, and are scored either 0 or 2. They may also be related to a Medicare Condition of Participation that must always be fully compliant.
 - Category C EPs are scored according to the number of times an organization does not meet a particular EP. They are scored 2 if there are one or no occurrences of noncompliance; they are scored 1 if there are two occurrences of noncompliance; and they are scored 0 if there are three or more occurrences of noncompliance.
- All findings of less than full compliance require resolution through an Evidence of Standards Compliance (ESC) submission. The timeline for completing the ESC submission will depend on the criticality of findings and immediacy of risk.
 - If one or more Direct Impact EPs under a standard are found to be partially or insufficiently compliant, then all EPs under that standard that have been found to be partially or insufficiently compliant must be addressed in an ESC submission within 45 days.
 - If no Direct Impact EPs under a standard are found to be partially or insufficiently compliant, then all EPs under that standard that have been found to be partially or insufficiently compliant must be addressed in an ESC submission within 60 days.

Also effective January 1, the use of “thresholds” was eliminated as a determinant of Conditional Accreditation (CA) and Preliminary Denial of Accreditation (PDA) decisions. Program-specific thresholds serve only as “screens” for identifying organizations whose survey findings should be subject to a more intensive review by Joint Commission central office staff, rather than serve as “automatic” determinants of CA and PDA decisions. This review is in addition to the review conducted for organizations that meet a Situational Decision Rule for an adverse accreditation decision or for which an Immediate Threat to Life has been declared.

The internal review of survey findings focuses on identifying and resolving instances in which “situational” rules for CA or PDA were actually met at the time of survey but were not recognized at that time. The revised process will also evaluate the magnitude and nature of the survey findings to determine whether “systemic” problems exist across the organization (that is, similar issues were identified across multiple department or key systems), or whether the findings would result in a “condition”-level deficiency in programs for which the Joint Commission has been granted deeming authority by the Centers for Medicare and Medicaid Services. Organizations are still held accountable for addressing any requirements for improvement (RFIs) through the ESC process.

The screens for the central office review are based on the number of not-compliant Direct Impact standards and are adjusted for differences in size and complexity of surveyed organizations (“bands”). The bands are based on survey length (number of surveyor days). Organizations that meet or exceed the program-specific screens are “statistical outliers” based on the number of not-compliant Direct Impact standards identified at their organization versus the average number identified within their peer group. The “bands” and “screens” (numbers of not-compliant Direct Impact Standards) for the hospital program are below.

Band	Surveyor Days	Screens
1	1-4	7
2	5-6	8
3	7-9	9
4	10-13	11
5	More than 14	13

Using the Summary of Survey Findings Report, the Joint Commission central office staff will compare the RFIs, if any, to establish screens and take one of the following three actions:

- Issue an Accreditation Survey Findings Report with or without RFIs; all RFIs must be addressed by the organizations through the ESC process. On the basis of past experience and recent modeling of the new accreditation process, the vast majority of organizations will fall into this category.
- If the number of RFIs cited exceeds the established screens and if the magnitude and severity of the survey findings are thought to warrant intensive follow-up with the organization, including a focused follow-up survey, a recommendation of Conditional Accreditation will be proposed for consideration by the Joint Commission’s Accreditation Committee.
- If the number of RFIs cited exceeds the established screens and if an Immediate Threat to Life exists within the organization or a Situational Decision Rule was met as evidenced by the survey findings, a recommendation of Preliminary Denial of Accreditation will be proposed for consideration by the Accreditation Committee. Existing rules for Conditional Accreditation and Preliminary Denial of Accreditation are described in the “Accreditation Process” section of the Joint Commission’s *Comprehensive Accreditation Manual for Hospitals*.

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