

Quality Collaborative

Joint Commission Q&A

Send your questions for the Joint Commission to e-news@nahq.org.

Question: Is a freestanding home care or hospice able to obtain a Disease-Specific Care Certification from the Joint Commission? The guidelines seem to focus on hospitals.

Joint Commission: Yes. Freestanding home care or hospice programs are perfectly suited to pursue Disease-Specific Care Certification for programs they provide for the care of patients with chronic illnesses. Certified programs improve the quality of patient care through reduced variation, use of evidence-based processes, and continuous performance measurement and improvement. Requirements for Disease-Specific Care Certification are applicable to clinical programs in any setting: inpatient, long-term care, home care, outpatient clinics, or physician practice settings. The requirements can be applied to care coordination programs as well. Examples of some nonhospital-certified programs include wound management, pediatric asthma, migraine headache, diabetes, low back pain, and heart failure.

The 28 consensus-based standards that form the foundation of Disease-Specific Care Certification were originally based on the chronic care model developed by Ed Wagner, MD, in the mid-1990s. They focus on key structural components necessary for safety and quality, including delivery of clinical care, leadership and program management, patient self-management, clinical information management, and performance improvement. Organizations seeking certification are required to demonstrate compliance with the standards, actively use evidence-based clinical practice guidelines, and commit to collecting data on a minimum of four performance measures, as well as use them actively in performance improvement activities. More information about Disease-Specific Care Certification is available on the Joint Commission Web site at www.jointcommission.org/CertificationPrograms/Disease-SpecificCare/.

AHRQ: *C. difficile* Infection Doubles Among Hospital Patients

The number of hospital patients stricken by an infection that can lead to diarrhea, blood poisoning, and even death increased by 200% from 2000 to 2005, according to the Agency for Healthcare Research and Quality (AHRQ). The sharp upturn follows a 74% increase in the number of cases from 1993 to 2000. The infection—*Clostridium difficile* or *C. difficile*—associated disease—results after previous antibiotic therapy suppresses the normal bacteria of the colon. This allows growth of *C. difficile* following exposure by unwashed hands or infected surfaces such as bedpans, toilet seats, or floors. Symptoms can range from mild to severe diarrhea. This is a life-threatening illness that in its most severe form can be treated only by completely removing the colon.

AHRQ's analysis also found that

- there were over 2 million cases of *C. difficile* in U.S. hospitals between 1993 and 2005.
- two out of three infected hospital patients in 2005 were elderly.

- on average, patients with *C. difficile* were hospitalized almost three times longer than uninfected patients. The in-hospital death rate for patients with *C. difficile* was 9.5%, compared with 2.1% overall.
- the highest rate of *C. difficile* infection in hospital patients was in the Northeast (144 stays per 100,000 population), and the lowest rate was in the West (67 stays per 100,000 population).

This AHRQ News & Numbers summary is based on data in Clostridium difficile-associated Disease in U.S. Hospitals, 1993–2005. The report uses statistics from a database of hospital inpatient stays that is nationally representative of inpatient stays in all short-term, nonfederal hospitals. The data are drawn from hospitals that comprise 90% of all discharges in the United States and include all patients, regardless of insurance type, as well as the uninsured. For more information, or to speak with an AHRQ data expert, contact Joyce Middleton at Joyce.Middleton@ahrq.hhs.gov or call 301/427-1862.