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Hearing on

Oversight of VA Quality
Management Activities

Before the

U.S. Senate Committee on Veterans' Affairs

June 24, 2009

Testimony by

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The Joint Commission

Introduction
Mr. Chairman, Ranking Member and Members of the Committee, on behalf of The Joint Commission, I want to thank you for the opportunity to testify at this very important hearing on the Oversight of VA Quality Management Activities. Founded in 1951, The Joint Commission is an independent, not-for-profit organization whose 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.

While The Joint Commission has its roots in hospital accreditation, over the years it has developed evaluation programs for a diverse array of health care settings. Today, The Joint Commission evaluates and accredits approximately 16,000 health care organizations and programs in the United States, including ambulatory care, behavioral health services, durable medical equipment providers and suppliers, home care, hospices, hospitals, laboratories, and long term care facilities.

The Joint Commission accredits approximately 146 Department of Veterans' Affairs organizations, including all of its hospitals. In partnership with the Veterans Health Administration, the Joint Commission strives to ensure that our nation's veterans are receiving high quality and safe care. We take situations such as the improper cleaning or reprocessing of colonoscopy equipment at VA medical centers very seriously and are working with the VA to identify the causes that contributed to this problem and to develop solutions so that these problems do not occur again.

The Joint Commission's Accreditation Process

Joint Commission accreditation is a risk-reduction process. The Joint Commission's accreditation process is designed to assist healthcare organizations in reducing the ubiquitous safety risks that are an integral part of the delivery of the high quality health care found in the United States and to then assess the level of the organization's success. While risk will never be completely removed, organizations can be highly successful in substantially reducing, though not eliminating, errors.

The delivery of health care is complex and is fundamentally a human endeavor. The role of The Joint Commission is to help organizations decrease errors through compliance with state of the art standards that focus on a "systems approach" to delivering care. The Joint Commission emphasizes to health care organizations the importance of having all staff work together to create a culture of safety, and establishing and maintaining a strong commitment from leadership to evolve toward high reliability organizations such as those found in the high risk industries of nuclear power and commercial aviation.

Systems Approach and Culture of Safety

Joint Commission efforts to improve patient safety in all types of health care organizations are based upon a recognition of the need for organization leaders and health care practitioners to adopt a "systems approach" to managing risk and keeping inevitable human error from reaching patients. For example, to help reduce the possibility of acquiring and transmitting an infection, organizations need to establish a robust, systematic infection prevention and control program that starts with strong expectations from organizational leadership and emphasizes communication and collaboration among all parts of the organization. Attempting to eliminate healthcare associated infections (HAIs) within health care settings requires attention to the entire care delivery process and involves everyone, from physicians and nurses to housekeeping and receptionists.

This systems approach requires organizations to establish a just culture in which people feel safe to systematically identify and report errors and near misses so that these events serve as important learning experiences for the organization and its staff. The Joint Commission recognizes that the VA is a leader in American medicine in creating such a culture and has spent a great deal of time and effort in creating and maintaining it. A safety-focused learning environment is one in which safety is always top of mind and in which there is constant vigilance by the organization's leaders and staff to identify and eliminate risks. The Joint Commission's standards, survey process, and other quality and safety improvement initiatives are designed to stimulate and facilitate the creation of a culture of safety within accredited organizations.

Accreditation Methods

The Joint Commission has created a framework to enhance patient safety. The critical components needed to achieve lasting improvement in organizational performance include:

• Evidenced-Based Standards and National Patient Safety Goals: Standards describe the successful operation of administrative and other critical systems of the health care organization (e.g., medication management, infection control and prevention, and leadership), while National Patient Safety Goals focus on specific high risk processes that directly impact the quality and safety of care delivered to patients (e.g., reduction of central line infections, safe use of

anticoagulation medications, reduction of wrong site surgery). These requirements are developed in collaboration with experts and key stakeholders with final review carried out by a nation-wide field engagement.

• Ongoing Collection of Data: The Joint Commission initiated the first national standardized data collection program for hospitals. This program has formed the basis for Medicare's current pay-for-reporting program; the VA has been an active participant in this program since its inception. The data collected on each organization reflect the degree to which the organization routinely delivers safe and quality health care. Data on sentinel events, patient complaints, past survey results, and performance measures are collected on every Joint Commission-accredited healthcare organization and help The Joint Commission focus and drive the onsite assessment.

• Periodic Onsite Survey Process: Unannounced onsite surveys emphasize the need for organizations to be in continuous compliance with all accreditation standards. The organization's annual self-assessment augments the onsite survey process. Additionally, the availability of data about the performance of an organization gives the Joint Commission surveyors an informed method to pick patients in the organization whose experience can highlight how the organization is performing in its delivery of quality and safe medical care; this data allows the surveyors to use the important "tracer methodology" tool. By starting with a specially selected patient and then "tracing" that patient's experience through the organization, a surveyor is able to both understand the care directly delivered to patients and the integration of systems within the organization. For example, a patient with a hospital acquired MRSA infection in the ICU will not only reveal how an infectious patient is treated, but will also lead the surveyor to appreciate the healthcare organization's entire infection prevention and control program.

• Completion of an Annual Self-Assessment Tool: In addition to being assessed for compliance with standards during the onsite survey, every health care organization is required to complete an annual self-assessment of compliance with all standards. Part of that process is an opportunity to discuss questions and concerns with Joint Commission staff about the organization's approach to compliance with the accreditation requirements.

• Ready Public Access to a Robust Complaint Process: As a way to receive ongoing information about the delivery of care at all of the accredited organizations, there exists a toll-free complaint hotline, the confidentiality of which is maintained for those who report concerns about an accredited organization. This hotline is available to patients, families, staff, or anyone else who might have concerns about the care provided at an organization. There is a team that investigates all complaints and has the resources to do an onsite visit if required. Also, this information becomes part of the data used by the Joint Commission to focus the onsite survey.

Raising the Bar

The Issue of Infection Prevention and Control

Infection prevention and control remains one of the most important issues challenging the safe delivery of health care, and the approach to eliminating infections is constantly changing and improving. The Joint Commission is aware of this and strives to remain on the cutting edge of initiatives and advancements in this area of health care. Since there are numerous ways in which errors may occur in delivering health care, The Joint Commission helps organizations to focus on priority areas. For example, The Centers for Disease Control and Prevention (CDC) estimates that tens of thousands of central line-associated bloodstream infections occur annually; 12-25% of patients with these infections die. The Joint Commission created a National Patient Safety

Goal requiring organizations to implement best practices to prevent central line-associated bloodstream infections. These requirements specify steps an organization must take and are based on evidenced-based national guidelines (Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, found at www.shea-online.org/about/compendium.cfm). A March 2008 GAO report underscores the importance of providing such explicit implementation guidance to hospitals trying to reduce the transmission of infections. For example, the GAO stated that the CDC has over 13 guidelines for hospitals on infection control and prevention containing almost 1200 recommended practices. However, these practices are not framed for easy implementation and in a manner that provides a blueprint for action. The Joint Commission recognizes that many of these practices are vague or framed as contingencies (e.g., if this, then maybe that). To help to address the GAO's concern, The Joint Commission was active in the development of the Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals. The Compendium addresses these implementation issues to help hospitals be successful in a complex area.

In regard to the VA's situation pertaining to the use of colonoscopes, because of the complexity of disinfection and sterilization of equipment, the process can be error-prone. Though the number of infections resulting from these processes is not as high as other sources of HAIs, disinfection and sterilization remains a current area of focus.

The need to decrease the number and seriousness of healthcare associated infections remains a focus of Joint Commission accreditation. In the last several years, The Joint Commission has worked closely with both government (e.g., CDC) and professional organizations (e.g., SHEA, APIC) to identify the most effective way to use scarce resources to mitigate the continuing problem of HAIs. Four infections are responsible for the majority of HAIs. The National Patient Safety Goals identify the most dangerous of those infections and create the expectation that the organization develops processes to significantly lower their incidence in the hospital.

Simply knowing about problems will not immediately remedy the situation, but it is the first step. Usually, an epidemic triggers an investigation and the results of that investigation uncover system failures or process breakdowns. For example, an outbreak of Hepatitis in Nevada led to an investigation which uncovered the reusing of syringes or needles in clinics. In the VA situation, there is no known epidemic; the performance improvement process is working. The VA self-identified a process problem, conducted an investigation, and is implementing improvements. The lapses that happened within the VA system are probably typical of what may be occurring within health care organizations outside of the VA system. The Joint Commission will actively disseminate what is being learned from this situation to other health care organizations.

The Infection Prevention and Control Standards stress the fact that everyone who works in the organization has a role in infection prevention and control; must be given the tools and training necessary to fulfill that role; and must be held accountable for following procedures that minimize risks to patients. In addition, the Infection Prevention and Control Standards require the creation of a program that addresses the specific risks to the organization and which must be re-evaluated and modified on a yearly basis.

A standard part of any infection control and prevention program is the proper processing of equipment, devices, and supplies. This would include all surgical instruments, scopes, and other equipment. While the frequency of infections directly associated with poorly cleaned equipment is not well established (compared to, for example, those associated with the insertion of devices in the body), the control and prevention of HAIs nevertheless remains an integral part of all infection control and prevention programs. The Joint Commission expects organizations to use evidence-based national guidelines when developing infection prevention and control activities. The two widely recognized guidelines pertaining to cleaning, disinfecting, and sterilizing equipment are the Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee's Guideline for Disinfection and Sterilization in Healthcare Facilities (http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf, and The Society for Healthcare Epidemiology of America's Multi-society Guidelines for Reprocessing Flexible Gastrointestinal Endoscopes (http://www.shea-online.org/Assets/files/position_papers/SHEA_endoscopes.pdf).

It is important to emphasize that, as part of every accreditation survey, the surveyors will examine disinfection and sterilization processes. Surveyors are trained to ask health care workers about manufacturer's instructions and how they process medical equipment; observe medical equipment being processed; and review information about parametric, chemical, and biologic indicators. Surveyors are well prepared to review how an organization manages the processing of medical equipment. Surveyors receive ongoing training on the proper management and processing of medical equipment, and they also have access to infection prevention and control experts within The Joint Commission who can guide them while conducting the onsite review.

A combination of cleaning, decontamination, disinfection, and sterilization methods are used in handling medical equipment. Regardless of the methods required, organizations are expected to follow the manufacturer's guidelines. Additionally, organizations are expected to have an on-going quality control process that ensures that proper medical equipment handling protocols are being followed. In a large hospital, there will be many procedures requiring disinfection and sterilization in which many staff are involved. So, while not every type of sterilization procedure is reviewed, the overall process of how the organization manages this portion of its infection control and prevention program is always part of an accreditation survey.

The Joint Commission's Experience with the VA
How the VA Differs from Other Health Care Systems
The Joint Commission has been asked to comment on how the VA health care organizations perform in relation to private health care organizations. Because of issues such as confidentiality and limited resources, The Joint Commission does not routinely conduct such data analyses. However, because of the way the VA is uniquely organized (for example, the integration of care for a single episode is generally unique to the VA system), the opportunity exists to achieve high quality, safe care when compared to other health care organizations. Among the VA's positive attributes are the following:

- A single medical record for each patient across all care settings supporting coordination of care
- A centralized, integrated health care system allowing coordination of care
- A standardized credentialing and privileging process for the appointment of medical staff

• The capability to achieve enhanced epidemiology through the integrated medical record
• The ability to standardize medical equipment through centralized purchasing
• Leadership's commitment to and support of performance improvement and the encouragement of a culture of safety that impacts the entire delivery system

The power of the VA's unique environment was demonstrated through its ability to reach out to the entire hospital membership once the process breakdown in the colonoscopy cleaning process was discovered. That more than a dozen organizations stepped up to describe similar process breakdowns in their own facilities is unusual in an industry that too often is seen as hiding these types of problems. The advantage of the VA's medical record system was demonstrated through the identification of all of the potentially infected veterans and the seeming ease with which the VA contacted those patients with proper next steps.

The Joint Commission's Process with the VA

The Joint Commission's Office of Quality Monitoring is working with the VA to assist with the organizations that are experiencing issues with colonoscope cleaning. According to the responses from the organizations to date, no definitive connection between the equipment and the positive diagnoses found in patients has been made. In addition, prior survey history and prior complaint history were absent any indication of infection control or equipment management problems at any of the three facilities. While the organizations' responses were thorough and credible, ongoing guidance with Joint Commission management and leadership was sought related to whether any alternative approaches should be considered due to the common theme among these events and with the knowledge that the situation was being addressed by the VA at a leadership level. The Joint Commission is continually in communication with the VA regarding this matter, and will ensure through survey and other means that follow-up is successful.

What The Joint Commission is Doing

Complexity of Health Care

There are a number of industries operating within complex environments that have been more successful in avoiding the number and variety of errors that continue to plague the delivery of medical care. Industries such as commercial aviation and nuclear power have had similar types of challenges and have been more successful in creating safe environments known as High Reliability Organizations. While a complete discussion of what constitutes a High Reliability Organization is beyond the scope of this document, it is important to at least list the characteristics that are generally associated with organizations that have achieved such a status. These five characteristics are:
• Preoccupation with failure
• Reluctance to simplify interpretations
• Sensitivity to operations
• Commitment to resilience
• Deference to expertise

For an organization to incorporate these characteristics into its fabric, an attitude of safety must exist through all levels of an organization. While that achievement is quite difficult, at a minimum an expectation that the organization will remain safe through the use of established tools must be solidly part of the leadership's attitudes. The expectation that health care

organizations continually move towards achieving this state of high reliability is at the core of The Joint Commission's accreditation process and its components.

The Joint Commission continues to work with the VA in a collaborative and collegial fashion to resolve the VA's infection prevention and control issues. The Joint Commission's pledge to help health care organizations help patients by providing them with useful guidelines and tools (such as the Standards and National Patient Safety Goals) drives The Joint Commission to constantly evolve and grow. In addition to disseminating all lessons learned through its interaction with the VA, The Joint Commission will:

- Survey health care organizations using state-of-the-art standards;
- Guide and educate these organizations on the most critical of issues through the National Patient Safety Goals;
- Launch the Center for Transforming Healthcare which will allow The Joint Commission to directly partner with the most innovative and advanced organizations in the country to address the most critical health care issues facing the industry today;
- Regularly introduce new initiatives to the health care industry, such as the forthcoming hand hygiene initiative:
- Help health care organizations to reach the same high reliability status as the commercial aviation and nuclear power industries;
- Share with the health care industry all lessons learned;
- Help organizations to provide the highest quality, safest care possible; and
- Serve and protect patients.

Conclusion

The delivery of health care is a complex undertaking with numerous intricate and complicated processes that fundamentally depend upon human beings, which tends to make these processes error-prone. The Joint Commission began a number of years ago to help organizations become safer environments for patients and staff by moving organizations towards establishing cultures of safety that are characterized by encouraging the reporting of problems and unsafe practices; prospectively wrapping envelopes of safety systems around high risk processes; and involving all parts of the organization in keeping safety top of mind.

The Joint Commission is pleased that the VA has moved expeditiously in this direction and has spent significant resources on creating the safety infrastructure that can take them into the future. We note that it was a VA employee who identified the risk to patients and the VA leadership took appropriate action to minimize risks for patients being treated at other VA facilities. These types of actions are critical to the evolution of a culture of safety.

On behalf of The Joint Commission, I would like to thank you again for this opportunity to testify. We are firmly committed to working with all of our partners—public and private—to ensure continuous improvement in the delivery of safe, quality health care.