The Joint Commission

Statement of

Jonathan Perlin, M.D., Ph. D, M.S.H.A
President and Chief Executive Officer
The Joint Commission

Before the

Senate Committee on Veterans' Affairs
May 11, 2022

INTRODUCTION

Good afternoon, Chairman Tester, Ranking Member Moran, and distinguished members of the Committee. Thank you for the opportunity to speak to you about The Joint Commission's accreditation program for Veterans' hospitals. I am Dr. Jonathan Perlin, President and CEO of The Joint Commission.

I am testifying not just as the new head of The Joint Commission, but as a person who has devoted a significant portion of my life to Veterans' care. Many of you know that I have a long-standing affiliation with the Department of Veterans Affairs, and the mission of service to those who have served is a labor of love for me. My career started in academia and eventually gave me the privilege of leading clinical operations, a one of the largest health systems in the private sector and, of course, the tremendous privilege of serving as VA's Under Secretary for Health. This set of experiences and my work in health IT, data science, and clinical performance improvement allowed me to hit the ground running at The Joint Commission on a wide range of quality issues. But this unique expertise also means that I can look with fresh eyes at The Joint Commission's accreditation work with Veterans' care. While I may not know all the answers, I do know the right questions to ask to improve care for Veterans.

Veterans using the VA for care tend to have greater health needs than the population at large. They frequently have unique healthcare challenges from serving in one of the highest-risk occupations – military service – and those unique occupational risks needs are driving the use of the healthcare services they require.

We applaud the Department of Veterans Affairs' focus on continually trying to meet the needs of Veterans wherever that care is delivered, in VA settings or in the community, to ensure that Veterans receive the timeliest, highest quality and safest care possible. But we need to appreciate that the Veterans Health Administration (VHA) faces the same challenges in delivering care that are confronting private sector health care systems -- maintaining an adequate workforce, coordinating care, and keeping pace with new delivery methods such as telehealth--and facing some of its own challenges, such as implementing a new health information system that can capture and transmit timely, accurate and useful data to coordinate an understanding of care needs over the life of the Veteran, from military service to present, and across all of the settings in which services may be provided.

THE JOINT COMMISSION

Founded in 1951, The Joint Commission is the nation's oldest and largest standard-setting and accrediting body for health care. We are an independent, not-for-profit organization with significant global reach. Although well-known as accrediting the majority of our nation's hospitals, including those of the Departments of Veterans Affairs and Defense, The Joint Commission accredits across the continuum of care. More than a dozen of our programs are relied upon by the Federal government, and every state depends upon our reviews for either a portion or all their hospital licensure requirements.

As part of our mission to continuously improve the quality of care provided to patients across every healthcare setting, we are deeply committed to the care Veterans receive. To accomplish our mission, we evaluate health care organizations through accreditation surveys and specialty program review. The Joint Commission couples the rigorous accreditation process with a breadth of services to assist hospitals in their journey toward excellence and to keep pace with developments in quality and safety.

Moreover, just as we expect our healthcare organizations to continuously assess the outcomes they obtain and improve what they do, we expect the same of ourselves. We are serious about our obligation to be a learning organization. In recent years we have incorporated into our oversight programs, meaningful enhancements to their effectiveness. The added rigor combined with machine learning algorithms allows us to make more in-depth and consistent judgments about compliance across thousands of hospitals, while more clearly informing hospital leaders about their relative safety risks. And please be assured that I am introducing several initiatives to further strengthen The Joint Commission's capacity to evaluate healthcare organizations and foster improvement.

Accreditation is an essential part of the evaluation armamentarium that complex systems should have to understand how well they are managing multifaceted and difficult issues in contemporary health care. Our accreditation is based on a set of Federal clinical, operational and leadership requirements that healthcare organizations must demonstrate to serve Medicare patients and enhanced by an even larger set of evidence-informed requirements that we add to foster safe and effective operation. There isn't any other organization with as much pragmatic knowledge about hospital assessment as the Joint Commission. With "boots on the ground", at one-third of our nation's hospitals annually, we see what works and what doesn't. We can observe both good practices and identify which system failures lead to poor outcomes. Importantly, this information is not only

translated into our standards and survey process but used to provide feedback to the organizations we survey.

Let me provide a brief overview of The Joint Commission's accreditation program as it relates to evaluating hospitals.

SURVEY PROCESS AND ACCREDITATION STANDARDS

Our survey process depends upon the strength and interdependence of three domains that comprise an effective evaluation: first, the use of state-of-the-art standards; second, their application by expertly trained and experienced surveyors who can provide contemporaneous feedback about good practices during the onsite survey; and third, an assessment process that is discerning, systematic, risk-based, and engages hospital staff and patients.

Joint Commission accreditation standards set us apart among other hospital accreditors. We go beyond basic Federal requirements to address emerging, critical issues in health care, such as our recent standards on maternal morbidity and mortality, workplace violence, and suicide prevention. Our standards are evidence-based and developed in partnership with leading experts, reviewed by practicing clinicians, and honed through a public field review. Recently VA staff were invaluable to our technical expert panel on suicide prevention and contributed to changes to accreditation standards for all healthcare organizations, as well as to the creation of a related National Patient Safety Goal on suicide prevention.[1]

By keeping our standards up to date, our nation's Veterans benefit from the application of the latest knowledge about care delivery practices. Our standards set expectations for organizational performance that are reasonable, achievable, and surveyable. They also set a floor for expectations of competency for safe operations and assist a hospital in focusing on those important processes and organizational functions that are essential to providing safe, high-quality care. Furthermore, the standards seek to build organizational learning around these requirements and expectations.

The survey measures consistency with a robust set of standards by a highly trained survey team. Traditional, triennial surveys *are unannounced* and occur onsite at any time during an interval of 18-36 months from the previous survey. The goal of periodic but

[1] https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf.

unannounced surveys is that hospitals don't just study for an exam but, learn – and own – the material. We also conduct "for cause" surveys under circumstances that arise from a precipitating event, such as a serious complaint submitted by Veterans, families, health care providers; through state and Federal agency reports; or through information taken from the media. Such "for cause" surveys are an in-depth look into a specific concern and provide an extensive, deep view on a specific issue in a manner that cannot be accomplished during the triennial survey. If the triennial survey is like a general physical exam to assure basic health, a "for cause" survey is like a specialist visit for a suspected, life-threatening problem, such as heart disease.

The survey process is fundamental to ascertaining whether a hospital has the necessary structures and processes in place to undergird the provision of quality care. This includes sampling records and reviewing policy and process to assess among other things, whether the hospital has a properly credentialed workforce, a safe physical environment, and the systems in place to address healthcare-associated risks such as infection prevention. Surveys and any follow-up activities are intended to encourage organizations to embed accreditation expectations into routine operations with the goal of continuously maintaining clinical and operational excellence.

Starting with a common framework, the standard elements are matched to the services offered by a particular organization. Notably, a portion of the survey will determine whether the organization is delivering services as intended by its own policies. There are numerous components to a survey, but some salient features are that surveyors:

- trace the full experience of selected Veterans during their hospital stay,
- focus on evaluating the underlying systems of care delivery,
- observe the performance of medical and surgical procedures,
- interview staff and patients,
- evaluates standards of safety related to the facility's physical environment, and
- engage in daily communication with the hospital leadership on what is being found during the survey.

The survey team's composition is driven by the size and complexity of the organization and the scope of services provided. All hospital surveys include clinical and non-clinical staff, including but not limited to physicians, masters or doctoral-level nurses, and pharmacists. Non-clinical survey team members are individuals with expertise in facilities management, engineering, and fire protection. Surveyors receive annual education and training specific to the operations of VA hospitals.

Tracer Methodology and the SAFER® Matrix Tool

I would like to highlight two cornerstones of our survey process. The first is our ***tracer methodology***. Tracers assess standards compliance by following all the care and services a patient encountered during a hospital stay -- from admission to discharge, including expectations for follow-up services. Such patient-specific tracers provide a critical view into an organization's ability to achieve patient-centered and high-quality care. And, technically, they trace whether a patient's experience was consistent with the standards for care quality that are part of all standard surveys, as well as assessing whether a patient's care was consistent with the hospitals own policies.

During our survey, these individual patient tracers are complemented by system tracers, which assess how successful the underlying functions of a hospital are at supporting the entire organization's service delivery. For example, a system tracer may evaluate how the organization manages its data privacy, maintains infection prevention, or utilizes HR policy.

A second cornerstone is our *SAFER® Matrix* tool, which plots the likelihood of a violated standard causing harm to a patient, staff member or visitor against the scope of risk, from isolated to widespread. The introduction of this tool changed survey results from amplifying numerous negligible risks to placing focus on the most severe risks: those with high likelihood of harm, especially if widespread. The SAFER matrix allows for synthesizing views of common risks, especially among hospitals or in a system.

Survey Deficiencies: Requirements for Improvement:

Deficiencies identified during the survey result in *Requirements for Improvement* (RFIs) that represent breaches in standards. These RFIs are provided to the hospital leadership on the last day of a survey and are a compilation of the survey team's findings. We require plans of correction for each formal requirement with specified time frames for completion. The proposed corrective actions are reviewed in our central office for completeness and their likelihood to resolve the deficiencies. Some issues may require additional onsite visits or other touchpoints with the organization. However, evidence must be provided to The Joint Commission demonstrating that the plans of correction have resulted in compliance before the hospital receives an unrestricted accreditation decision.

Despite our sign off on a hospital's plan of correction, it is up to the facility to be accountable for change. We expect organizations to react to our findings in a positive and decisive manner, implementing new policies and practices to achieve the needed

changes to hospital operations. The most effective hospital systems have system-level control processes to assure timely, effective remediation of our Requirements for Improvement.

In those instances where we find that the organization has failed to institute change, despite our survey requirements, the organization is likely to be placed in a provisional status. Provisionally accredited organizations are displayed on our website with the reasons for not attaining full accreditation.

VHA Enterprise Summation

Each year, we conduct a summary review for VHA that provides an analysis of system-wide survey findings across the hospitals surveyed that year, as well as context from all surveys conducted by The Joint Commission. These summations have a wide attendance, including both system-level leadership, VISN leadership, as well as other quality and safety leaders.

Specifically, the summation offers: 1) an objective assessment of overall strengths and weaknesses found in the hospitals surveyed that year; 2) a summary of general accreditation findings across the surveyed organizations; and 3) benchmarking against both an internal and several external comparison groups. In reviewing the *internal* benchmarking data, we have seen that the overall number of requirements made for improvement have remained consistent over the last 5 years. However, the specific opportunities for improvements in meeting accreditation standards as well as the demonstrated strengths in delivering care will vary year to year. For example, mental health and suicide prevention programs, staffing issues, and infection control are currently at the forefront.

We believe that the information that we provide in these summations is valuable to the VA as an enterprise, and we hope that it results in additional sharing among all facilities and internal stakeholders with an expectation for appropriate actions. A notable best practice across all health systems is the sharing of issues, so that a risk found at one facility is presumed present elsewhere and is remediated at all sites of care operating within the system.

LIMITATIONS OF ACCREDITATION

In good conscience, I cannot tell you that accreditation can guarantee that bad things can never happen in an organization. Accreditation can, however, significantly help with risk reduction. The result of being awarded accreditation after a survey is analogous to getting a driver's license from the Motor Vehicle Administration. It is an assurance of safety if the rules-of-the-road are followed. Likewise, accreditation represents compliance with expectations for how the hospital will operate but cannot prevent all system failures or willful misconduct.

Another limitation of accreditation -- a limitation shared with all other evaluators -- is measuring the intangible, or unstructured aspects of care delivery and operations, such as effective communication or a culture that is conducive to safety and reliability. Like others who oversee quality and safety, we have more work to do in these areas if we are to effectively pick up signals that an organization is in trouble.

OBSERVATIONS ABOUT QUALITY AND SAFETY CHALLENGES

The pandemic has brought excruciating clarity to the difficulties in care delivery that face hospitals nationwide. The pandemic has critically exacerbated existing challenges such as workforce shortages, the need to improve the well-being of hospital staff, and the fragility of our supply chains. At the same time, hospitals are grappling with expansions in the use of virtual care, learning how to provide continuity for patients among care providers in multiple settings (including virtual), and seeking to measure performance and deliver increasingly higher-value healthcare. VA is not isolated from any of these challenges, and as care is more frequently provided to Veterans in community settings, coordination of information and care continuity is even more complex.

From my observations, and from looking at the peer reviewed, scientific literature, there are arenas where the VHA outperforms the private sector and areas where there is not sufficient information to make comparisons, because the metrics either do not exist or they are not systematically tracked. While there is no single metric that we can point to for making overarching comparisons, some peer reviewed studies in selected clinical areas have pointed to where the VHA has excelled over the private sector – such as in decreased mortality rates when critically ill patients are taken by ambulance to VHA hospitals, wound healing, and the rates of certain preventive health screenings. And many additional studies have shown the VA care to be on a par with the private sector, such as mortality after cardiac rehabilitation.

Next, I have observed that most VA staff are very dedicated to serving patients. Many staff and, indeed, leaders are themselves Veterans. VA leadership seeks to be responsive when quality issues arise, but as a system, VA is challenged with leadership turnover and stability. This is especially problematic, as whenever there are voids in leadership, additional, not fewer, competencies are needed to accomplish mission. While most bedside caregivers will still provide care, serve patients, and act with best intentions, they may not have the benefit of sophisticated guidance at every level of the organization that can quickly differentiate between expedient adaptations and bona fide best practice.

Lastly, the importance of proactively accounting for safety is more consequential than ever. Solutions do not include asking staff to try harder. Effective safety involves ensuring fidelity to well-designed processes that mitigate harm and that can keep mistakes from reaching patients by accounting for the inevitability of human factures and frailties. The Joint Commission and VHA have a shared responsibility to continuously examine where workarounds can create vulnerabilities in high-risk activities and where safety culture may be failing. It has been said that high-reliability organizations have a healthy paranoia about system risks and failure modes and an equally aggressive commitment to control systems and robust defenses against human error.

By control systems, I am referring to ongoing and internal audit processes to "check the math." Examples would be avid chart abstractions, proactive risk assessments, evaluations of internal metrics, large scale and even automated data review, and robust peer review systems. Furthermore, any identified risks should serve as signals to be actively shared among other VA facilities, because similar risks will assuredly confront other hospitals.

MOVING FORWARD

The issue at hand is how we create a better health care system. Working in tandem, I believe we can make more progress. Let me mention three of the more salient ways.

First, we stand ready to offer more support through The Joint Commission's Office of Quality and Patient Safety which helps hospitals conduct credible and unrelentingly thorough root cause analyses of serious patient safety events. This unique resource engages highly trained and experienced clinical staff in assisting a hospital in uncovering the system issues leading to an unexpected occurrence of a death or serious harm – what we call a Sentinel Event. The causes leading up to such serious adverse events almost always involve human factors interacting with multiple system failures. Our experts can

help a hospital understand where systems redesign and process improvement are needed to mitigate a similar occurrence in the future

Many hospitals voluntarily report Sentinel Events to us. Others go further: the Department of Defense has a regulation requiring such reporting.

Regardless of reporting, The Joint Commission requires that all hospitals experiencing a Sentinel Event immediately conduct a root cause type of investigation and develop a comprehensive response that includes a pathway to making the necessary preventative system changes. Nonetheless, we appreciate hospitals voluntarily reporting to us their Sentinel Events even if they do not wish assistance with root cause analysis. Such reporting informs The Joint Commission about the scope and frequency of safety events which then improves our accreditation programs and resources for all hospitals.

We appreciate that hospitals may have reticence to report, as it may trigger a "for-cause" survey. However, learning about Sentinel Events through other means may also do so in a less favorable context, as a working assumption is that the organization is not committed to transparency in addressing and remediating failure modes. Importantly, a for-cause survey is not meant to be punitive, but rather it is to provide assistance in remediating issues underlying a Sentinel Event. Voluntary reporting has informed our highly influential National Patient Safety Goals in areas such as infection control and wrong site surgery and has contributed to our issuing Safety Alerts, based on the unfortunate, if not tragic, learnings elsewhere. Cross-industry sharing of such information is critical in other fields that required high reliability, such as aviation and nuclear engineering.

Second, The Joint Commission can prepare customized reports for VHA's central office leadership on certain high-profile areas of interest. We have done this in the past when VHA asked that we conduct focused surveys in a short period of time so that leadership could get a more contemporaneous view of performance across all hospitals on selected quality issues.

Third, as I prepared for this testimony, I learned that The Joint Commission has had the opportunity to occasionally work with the VA's Office of the Inspector General, such as in a case where we shared information about problem spots in a particular facility. In that instance, parallel "for cause" investigations revealed similar concerns and deepened the understanding of failure modes, a key to implementing the effective remediation of critical issues. There is more potential here for collaboration with all elements of VA while assiduously guarding our respective obligations to provide VHA and Veterans with independent, reliable surveys and forthright findings.

CONCLUSION

In conclusion, The Joint Commission welcomes all opportunities to strengthen its partnership with the Federal government, and I believe there is additional ground to explore. We stand with you in commitment to building a safer system, and commit to being responsive to the Committee and to VA. As I noted earlier, I may not have all the answers, but I do know the right questions to ask to ascertain what needs remediation. I look forward to working with you in any manner that is constructive to our shared goals.

Thank you for inviting The Joint Commission to be here today.
