Joint Commission Annual Report on Quality and Safety Shows Hospitals Improving

Hospitals accredited by The Joint Commission continue to improve quality of patient care, according to Improving America’s Hospitals: The Joint Commission’s Annual Report on Quality and Safety 2009, released in January 2010. The report aggregates core performance measure data from all Joint Commission–accredited hospitals submitting ORYX data. Five new measures were introduced in 2008, bringing the total number of Joint Commission measures covered in this report to 31. All of the measures described in this report were chosen because they provide concrete data about the best kinds of treatments or practices for common conditions for which Americans enter the hospital and seek care. Hospitals that performed well are those that consistently provide “evidence-based” treatments—practices demonstrated by scientific evidence to lead to the best outcomes.

The fourth annual report shows continual improvement over the seven-year period 2002–2008 on 12 quality measures reflecting the best evidence-based treatments—practices demonstrated by scientific evidence to lead to the best outcomes. The magnitude of national improvement on these measures ranged from 4.9% to 58.8%. Hospital performance also improved on 13 other measures. Since their inception as core measures in 2002, pneumococcal vaccination and smoking cessation advice measures have shown the greatest rates of improvement.

“In addition to saving lives and improving health, improved quality reduces health care costs by eliminating preventable complications,” says Mark R. Chassin, M.D., M.P.P.,

Continued on page 10
April Deadline for 2010 Eisenberg Award Applications

The Joint Commission and the National Quality Forum (NQF) are currently accepting applications/nominations for the 2010 John M. Eisenberg Patient Safety and Quality Award. The award recognizes major domestic and international achievements of individuals and organizations in improving patient safety and health care quality. Eligible projects must have clear implications for improving patient safety and health care quality beyond the setting where the study was performed.

Information about the award, descriptions of past award recipients, and application/nomination forms are available on http://www.jointcommission.org/PatientSafety/EisenbergAward or http://www.qualityforum.org. The deadline for submissions is April 12, 2010. Applicants must describe the patient safety and/or the health care quality–related research achievement and the importance of the achievement, including the specific impact on patient safety and/or health care quality. The 2010 Eisenberg Awards will be presented at NQF’s annual conference in the fall.

The Centers for Medicare and Medicaid Services (CMS) has named The Joint Commission a national designating authority for advanced imaging services, providing an estimated 7,000 health care organizations that utilize advanced diagnostic imaging with a way to meet a new Medicare accreditation requirement. CMS’ designation announcement appears in the January 26, 2010, Federal Register.

“The Joint Commission has been a long-standing accreditor for imaging services,” says Michael Kulczycki, executive director of the ambulatory care accreditation program at The Joint Commission. “We are pleased to be part of this federal effort to further improve care for Medicare beneficiaries.” While The Joint Commission has accredited imaging services since 1975, and currently accredits nearly 100 providers representing more than 800 sites of care, this is the first time CMS has designated an accreditor of advanced diagnostic imaging centers, which must now be accredited to qualify for Medicare reimbursement payments.

CMS requires accreditation standards that are as stringent as the legislation requires, particularly as those standards relate to imaging quality, the qualifications of imaging professionals, and patient safety. The Joint Commission’s standards for advanced diagnostic imaging focus on the following issues:

- Qualifications of medical personnel and medical directors
- Quality assurance and quality control programs to ensure the safety, reliability, clarity, and accuracy of diagnostic imaging

The April 2010 issue of Perspectives will include newly approved ambulatory care requirements for advanced imaging services.

Who Must Be Accredited?

Under a new rule that is part of the Medicare Improvements for Patients and Providers Act of 2008, Medicare suppliers that bill for the technical component of advanced diagnostic imaging modalities under the physician fee schedule must become accredited by a CMS-designated accrediting organization, such as The Joint Commission, by January 1, 2012. CMS considers advanced imaging services to be magnetic resonance imaging (MRI), computerized tomography (CT), positron emission tomography (PET), and nuclear medicine imaging services for Medicare beneficiaries on an outpatient basis. (CMS can expand the list to other modalities as it sees fit.)

This requirement does not apply to advanced diagnostic imaging services provided by hospital inpatient or outpatient centers billing under the inpatient or outpatient prospective payment system. Rather, it does apply when the following circumstances exist:

- Suppliers bill Medicare for the technical component of advanced diagnostic imaging services, that is, MRI, CT, PET, and nuclear medicine procedures
- Such procedures are supplied to Medicare beneficiaries on an outpatient basis
- Such procedures are billed to Medicare under the physician fee schedule

According to a 2005 Medicare Payment Advisory Commission (MedPAC) report, diagnostic imaging services paid under Medicare’s physician fee schedule grew more rapidly than any other type of physician service between 1999 and 2003, and at approximately double the rate of all other physician services.

Providers that have a current accreditation status as of January 1, 2012, will not need to be reaccredited until the term of accreditation expires. For more information, please visit http://www.jointcommission.org/AdvImaging2012.
CORRECTION: Scoring Impact and Criticality for Accreditation Requirements

We inadvertently misprinted some scoring criticality tiers in the articles “Approved: New and Revised Hospital EPs to Improve Patient-Provider Communication” (pages 5–6) and “Approved: Staffing Effectiveness Requirements for Hospitals and Long Term Care Organizations” (page 7) in the January 2010 issue of The Joint Commission Perspectives.

At the following requirements where it shows a patient care impact of ▲, it should be a △:
- PC.02.01.0X*, elements of performance (EPs) 1 and 2 (effective no sooner than January 1, 2011) for hospitals

At the following requirements where it shows ▲, there should not be a triangle (that is, tier 4):
- RL.01.01.01, EPs Y and Z* (effective no sooner than January 1, 2011), for hospitals
- PI.02.01.01, EPs 12, 13, and 14 (effective July 1, 2010), for hospitals and long term care

In addition, scoring categories were inadvertently left out of the print version of the Comprehensive Accreditation Manuals for Hospitals for three requirements in the “Leadership” chapter, which are correct in the E-dition:
- LD.04.03.01, EP 26, should be scoring category A
- LD.04.03.07, EPs 1 and 2, should be scoring category A

We regret these errors.

* Please note: Where X, Y, or Z appear in a standard or EP number, the final enumeration will be determined before publication in 2011.

A Perspective on the Current Health Care System from National Health Care Leaders


The article states that the U.S. health care system is essentially a cottage industry of nonintegrated, dedicated artisans who avoid standardization. According to the article, “services are often highly variable, performance is largely unmeasured, care is customized to individual patients, and standardized processes are regarded skeptically.”

“Expert guidelines and meaningful outcome measures will transform us from high-variation clinicians to a more streamlined, consistent community of care, since improvement in care delivery will necessitate integration and cooperation,” the article continues. “We see the public reporting of outcomes and adherence to standardized care processes as key tactics for driving health care improvement.”

The article provides the example of how the public reporting of performance measures by The Joint Commission is helping to assess, manage, and systematically improve processes (see the article on page 1 of this issue). The article concludes that “good doctors should see process improvement as part of their core work. Rather than undermining health care, public reporting on the performance of standardized care processes and outcomes will be the key to converting our isolated cottages into integrated, continually improving communities.”

During the revision of the 2010 National Patient Safety Goals, the language of NPSG.03.04.01 on labeling medications was modified to include the preparation date in addition to the expiration dates and times that were required in the existing requirement. This addition unintentionally increased the scope of the goal and places a burdensome additional requirement on health care organizations. As such, NPSG.03.04.01, EP 3, has been modified as indicated with strikethrough text in the box below. The change is effective immediately and affects ambulatory care, critical access hospital, hospital, and office-based surgery organizations.

Furthermore, the word “prevention” was inadvertently omitted from the 2010 version of NPSG.07.03.01, EP 3, on preventing infections related to multidrug-resistant organisms. This goal applies to critical access hospitals and hospitals. The correct language for NPSG.07.03.01 appears in underline text in the box below.

### Correction to Two National Patient Safety Goals

**APPLICABLE TO AMBULATORY CARE, CRITICAL ACCESS HOSPITALS, HOSPITALS, AND OFFICE-BASED SURGERY**

**Effective Immediately**

**NPSG.03.04.01**

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

**Note:** Medication containers include syringes, medicine cups, and basins.

**Elements of Performance for NPSG.03.04.01**

A 3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:

- Medication name
- Strength
- Quantity
- Diluent and volume (if not apparent from the container)
- Preparation date
- Expiration date when not used within 24 hours
- Expiration time when expiration occurs in less than 24 hours

**Note:** The date and time are not necessary for short procedures, as defined by the [organization].

**APPLICABLE TO CRITICAL ACCESS HOSPITALS AND HOSPITALS**

**Effective Immediately**

**NPSG.07.03.01**

Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in [acute care hospitals/critical access hospitals].

**Note:** This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococcus (VRE), and multidrug-resistant gram-negative bacteria.

**Elements of Performance for NPSG.07.03.01**

C 3. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection prevention strategies.
The Joint Commission and Joint Commission Resources (JCR), The Joint Commission's not-for-profit affiliate and official publisher, have co-authored a new book, *The Smart Parent's Guide to Getting Your Kids Through Checkups, Illnesses, and Accidents: Expert Answers to the Questions Parents Ask Most*, with Jennifer Trachtenberg, M.D., a nationally renowned parenting expert and board-certified pediatrician. RealAge, a health company that features interactive online health and wellness quizzes and advice, also contributed to the book. *The Smart Parent's Guide* was published by Free Press, a division of Simon and Schuster, and is now available wherever books are sold.

*The Smart Parent's Guide* features “insider” recommendations about how to protect your child’s health—in the emergency department, pediatrics unit, pharmacy, and doctor's exam room and at home. It provides guidance in choosing the right pediatrician, the right hospital (make sure it’s Joint Commission accredited), and the right emergency department for your child. The book also provides detailed information on navigating the emergency department and a hospital stay with your child and ensuring that your child gets the best care. It includes expert answers to commonly asked questions by parents about medications, healthy diets, infection prevention, sleep habits, vaccinations, and more. There is also a chapter on dealing with the health care system for parents of children with chronic illnesses and special needs.

The book emphasizes the importance of looking for the Joint Commission’s Gold Seal of Approval™ when choosing a health care organization for your child and for your family. Specific reference is made in the book to Joint Commission Sentinel Event Alerts, National Patient Safety Goals, the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™, the Speak Up™ campaign, and Quality Check®.

Trachtenberg, or “Dr. Jen,” is the author of *Good Kids, Bad Habits: The RealAge Guide to Raising Healthy Children* and serves as chief pediatric officer for RealAge.com and maintains a successful private pediatric practice in New York City. She is also assistant clinical professor in pediatrics at The Mount Sinai Medical Center, a fellow of the American Academy of Pediatrics, and a mother of three children.


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**General Book Information**

**Title:** The Smart Parent's Guide to Getting Your Kids Through Checkups, Illnesses, and Accidents: Expert Answers to the Questions Parents Ask Most

**Authors:** Jennifer Trachtenberg, M.D., The Joint Commission, and RealAge

**Publisher:** Free Press, a division of Simon and Schuster

**Price:** $16.00 U.S.

To prevent pregnancy-related deaths and severe illness, The Joint Commission issued its 44th issue of Sentinel Event Alert. Pre-existing medical conditions such as high blood pressure are putting women at greater risk for death during or shortly after pregnancy, according to the Alert released January 26, 2010.

Federal and state governments have begun stepping up efforts to identify and prevent the causes of maternal deaths. The most current statistics from the Centers for Disease Control and Prevention show 13.3 maternal deaths per 100,000 live births, well over the target of 3.3 maternal deaths per 100,000 live births set as part of the U.S. government’s Healthy People 2010 initiative. Common preventable causes that lead to maternal deaths include uncontrolled high blood pressure, undiagnosed fluid build-up in the lungs of women with pre-eclampsia, failure to pay attention to vital signs after a Cesarean section, and hemorrhage following a Cesarean section.

“It is a profound tragedy whenever a mother dies in childbirth. Fortunately, these are rare events,” says Mark R. Chassin, M.D., M.P.P., M.P.H., president of The Joint Commission. “Achieving our national goal of reducing their frequency even further requires organizations and caregivers to have a thorough understanding of the underlying causes of maternal deaths and a disciplined focus on assuring consistent excellence in the early recognition and management of complications of delivery.”

The Joint Commission suggests that hospitals take a series of several specific actions to prevent such tragedies, as listed in the Alert which begins to the right. In addition to the specific recommendations in the Alert, the Joint Commission urges hospitals to use its accreditation standards to improve safety for pregnant women. The “Provision of Care, Treatment, and Services” Standard PC.02.01.19 requires hospitals to have a process for recognizing and responding as soon as a patient’s condition appears to be worsening and to develop written criteria for early warning signs that a patient’s condition is deteriorating. The standard also addresses staff response to concerns about a patient’s condition and educating patients and families about how to get help if they have concerns.

Sentinel Event Alert Issue 44, along with previously released Alerts, can be found on The Joint Commission Web site at http://www.jointcommission.org/SentinelEvents/SentinelEventAlert.

Sentinel Event Alert Issue 44: Preventing Maternal Death

The goal of all labor and delivery units is a safe birth for both newborn and mother. A previous Alert reviewed the causes of death and injury among newborns with normal birth weight and suggested risk reduction strategies. This Alert addresses the equally tragic loss of mothers. Unfortunately, current trends and evidence suggest that maternal mortality rates may be increasing in the U.S., despite the rarity of the incidence of maternal death—deaths that occur within 42 days of birth or termination of pregnancy. Since 1996, a total of 84 cases of maternal death have been reported to The Joint Commission’s sentinel event database, with the largest numbers of events reported in 2004, 2005, and 2006. According to the National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC), in 2006, the national maternal mortality rate was 13.3 deaths per 100,000 live births. “Although the current maternal mortality rate may reflect increased identification of women who died during or shortly after pregnancy, there clearly has been no decrease in maternal mortality in recent years, and we are not moving toward the U.S. government’s Healthy People 2010 target of no more than 3.3 maternal deaths per 100,000 live births,” says William M. Callaghan, M.D., M.P.H., senior scientist, Division of Reproductive Health, Centers for Disease Control and Prevention.

Leading Causes and Prevention of Maternal Death

According to a study by the CDC of pregnancy-related mortality in the U.S. between 1991 and 1997, the leading causes of maternal death are: hemorrhage, hypertensive disorder, pulmonary embolism, amniotic fluid embolism, infection, and pre-existing chronic conditions (such as cardiovascular disease). The study—conducted with state health departments and the American College of Obstetricians and Gynecologists—also indicated a four-fold increased risk of pregnancy-related death for black women, and increased risks for older women and women with no prenatal care. Whether due to better management, increased awareness, or quality improvement, the numbers of deaths related to hemorrhage are declining, while deaths attributable to other medical conditions—including mortality in the U.S. between 1991 and 1997, the leading causes of maternal death are: hemorrhage, hypertensive disorder, pulmonary embolism, amniotic fluid embolism, infection, and pre-existing chronic conditions (such as cardiovascular disease). The study—conducted with state health departments and the American College of Obstetricians and Gynecologists—also indicated a four-fold increased risk of pregnancy-related death for black women, and increased risks for older women and women with no prenatal care. Whether due to better management, increased awareness, or quality improvement, the numbers of deaths related to hemorrhage are declining, while deaths attributable to other medical conditions—including
Preventing Maternal Death (continued)
Continued from page 7

(cardiovascular, pulmonary, and neurologic problems—have significantly increased.4

Individual state health departments and researchers nationally are examining the possible role of pre-existing medical conditions in contributing to maternal death. Pre-pregnancy obesity, with its related health implications, is an example. “Obesity is a growing epidemic in this country which impacts all age groups, including women of child-bearing age. Obesity can lead to hypertensive disorders, diabetes, and other medical conditions, and thus can directly and indirectly present significant health risks for pregnant women,” says Janet Hardy, Ph.D., M.Sc., M.P.H., perinatal epidemiologist and assistant professor, Departments of Medicine, Obstetrics/Gynecology and Pediatrics, University of Massachusetts Medical School. “Heightened practitioner awareness and screening of pre-pregnant and pregnant women with pre-existing conditions and associated risk factors should be optimized. Improving access to prenatal care environments where specialized services and support are available for these women should be considered.” It is only by taking a thorough medical and social history that underlying factors can be revealed.

Attempts to identify preventable deaths and understand how to prevent them have yielded varying results; several studies determined that from 28 to 50 percent of maternal deaths were preventable. In 2008, Hospital Corporation of America (HCA) looked at individual causes of maternal deaths among 1.5 million births within 124 hospitals in the previous six years.6 The study concluded that the majority of maternal deaths are not preventable and that while some deaths can be prevented by better individual care, precise figures indicating the frequency of preventable deaths should be examined carefully and with caution. According to the HCA study, the most common preventable errors are:

- Failure to adequately control blood pressure in hypertensive women
- Failure to adequately diagnose and treat pulmonary edema in women with pre-eclampsia
- Failure to pay attention to vital signs following Cesarean section
- Hemorrhage following Cesarean section

“The data showed the individual causes of death to be very heterogeneous and that the only cause of maternal death amendable to nationwide systematic prevention efforts is pulmonary embolism,” says Steven L. Clark, M.D., medical director of women and newborn services, HCA. “Pregnancy is a known major risk factor for venous thrombosis and pulmonary embolism. HCA now advocates for the universal use of pneumatic compression devices for all pregnant women undergoing Cesarean section.” Many hospital systems in California have also adopted VTE prophylaxis measures, as well as comprehensive programs for addressing and responding to hemorrhage, according to Elliott Main, M.D., chairman and chief of obstetrics, Sutter Health’s California Pacific Medical Center, and the principal investigator for California Maternal Quality Care Collaborative (CMQCC). However, unlike nearly all other adult patients undergoing major surgery, pregnant women undergoing Cesarean delivery have traditionally not received prophylactic measures for the prevention of venous thromboembolism afforded similar surgical patients who lack this risk factor.

Main also serves as chair of the California Pregnancy-Related and Pregnancy Associated Mortality Review Committee which identifies causes for the increase and improvement opportunities that can be addressed by CMQCC. As California has over 550,000 annual births, its findings can serve as a model for the entire United States. “Too often we under-respond to abnormal vital signs and operate in a state of denial and delay,” Dr. Main says. “It is important to identify triggers and establish protocols that certain findings trigger a response. In California, hemorrhage and complications of pre-eclampsia have been the drivers of maternal mortality and both have significant prevention opportunities.”

“Maternal deaths are the tip of the iceberg for they are a signal that there are likely bigger problems beneath—some of which are preventable,” says Dr. Callaghan. “It is important to consider the women who get very, very sick and do not die, because for every woman who dies, there are 50 who are very ill, suffering significant complications of pregnancy, labor, and delivery.” For 1991 through 2003, the severe morbidity rate in the U.S. for severe complications and conditions associated with pregnancy was 50 times more common than maternal death. Understanding these experiences could affect how care is delivered as well as health policy.9

Existing Joint Commission Requirements

National Patient Safety Goal 16 (recognize and respond to changes in a patient’s condition) is most applicable to the care of women during labor and birth. During an extensive review of the National Patient Safety Goals during 2009, Goal 16 was deemed better suited as a standard and was moved to the 2010 standards for hospitals and critical access hospitals. The “Provision of Care, Treatment, and Services” Standard PC.02.01.19 requires the hospital to:

- Have a process for recognizing and responding as soon as a patient’s condition appears to be worsening.
• Develop written criteria describing early warning signs of a change or deterioration in a patient’s condition and when to seek further assistance.
• Based on the hospital’s early warning criteria, have staff seek additional assistance when they have concerns about a patient’s condition.
• Inform the patient and family how to seek assistance when they have concerns about a patient’s condition.

Joint Commission Suggested Actions

Each case of maternal death needs to be identified, reviewed, and reported in order to develop effective strategies for preventing pregnancy-related mortality and severe morbidity. To this end, The Joint Commission encourages participation by hospital physicians, including obstetrician-gynecologists, in state-level maternal mortality review and collaboration with such review committees in sharing data and records needed for review.

The following suggested actions can help hospitals and providers prevent maternal death:

1. Educate physicians and other clinicians who care for women with underlying medical conditions about the additional risks that could be imposed if pregnancy were added; how to discuss these risks with patients; the use of appropriate and acceptable contraception; and pre-conceptual care and counseling. Communicate identified pregnancy risks to all members of the health care delivery team.

2. Identify specific triggers for responding to changes in the mother’s vital signs and clinical condition and develop and use protocols and drills for responding to changes, such as hemorrhage and pre-eclampsia. Use the drills to train staff in the protocols, to refine local protocols, and to identify and fix systems problems that would prevent optimal care.

3. Educate emergency room personnel about the possibility that a woman, whatever her presenting symptoms, may be pregnant or may have recently been pregnant. Many maternal deaths occur before the woman is hospitalized or after she delivers and is discharged. These deaths may occur in another hospital, away from the woman’s usual prenatal or obstetrical caregivers. Knowledge of pregnancy may affect the diagnosis or appropriate treatment.

Additional suggested actions for hospitals and providers to take for patients identified as high-risk (for example, those with pre-existing medical conditions such as hypertension, diabetes, morbid obesity):

4. Refer high-risk patients to the care of experienced prenatal care providers with access to a broad range of specialized services.

5. Make pneumatic compression devices available for patients undergoing Cesarean section who are at high risk for pulmonary embolism.

6. Evaluate patients who are at high risk for thromboembolism for low molecular weight heparin for postpartum care.

References


Additional resources


http://www.jointcommission.org

March 2010

The Joint Commission Perspectives
M.P.H., president of The Joint Commission. “Quality improvement is an important aspect of the ongoing reform effort to make health care accessible to more Americans and 'bend the curve' on increasing costs. By eliminating the preventable complications that today drive up the cost of care, we would easily save the many billions of dollars lawmakers are struggling so hard to locate.”

What the Data Show

The results are important because they show that hospitals have improved. They identify opportunities for further improvement and support continual measurement and reporting. There are eight measures of care relating to heart attack, four to heart failure, nine to pneumonia, eight to surgical care, and two to children's asthma care. The Joint Commission worked closely with clinicians, health care providers, hospital associations, performance measurement experts, and health care consumers across the nation to identify the quality measures. More than 3,000 Joint Commission–accredited hospitals contributed data.

The national performance summary table on page 11 shows the percentage of hospitals achieving rates of performance greater than 90% on a measure. (Note: The last column is reported as percentage points. This is the difference on a percentage scale between two rates, in this case, 2007 performance versus 2008 performance.) All improvements or decreases in performance are statistically significant. Many of the smaller percentage improvements shown in the table occurred within large patient populations, meaning that significantly more patients received a treatment. In some cases, performance was already quite high and there was less room for improvement.

Key findings from the report include the following:

1. Hospitals accredited by The Joint Commission have significantly improved the quality of care provided to heart attack, heart failure, and pneumonia patients over a seven-year period. The overall heart attack care result improved to 96.7% in 2008 from 86.9% in 2002. The overall heart failure care result improved to 91.6%, up from 59.7% in 2002. The overall 2008 pneumonia care result is 92.9%, up from 72.3% in 2002.

2. Hospitals have steadily improved on individual surgical care performance measures—as well as on additional individual heart attack and pneumonia care measures—over a two-, three-, and four-year period.

3. Hospital performance on two measures of quality relating to inpatient care for childhood asthma is excellent after only one year of measurement. Specifically, there was 99.8% performance on providing “relievers” to childhood asthma inpatients and 99.1% performance on providing systemic corticosteroids to childhood asthma inpatients.

4. Improvement is still needed. For example, only 52.4% of hospitals provided fibrinolytic therapy within 30 minutes of arrival to heart attack patients, and only 60.3% of hospitals provided antibiotics to intensive care unit pneumonia patients within 24 hours of arrival.

5. Where a patient receives care makes a difference. The quality of patient care varies depending on where it is delivered. Quality, safety, and patient satisfaction results for specific hospitals can be found at http://www.qualitycheck.org.

“The data in this report show steady improvement over time on vitally important measures of quality. Furthermore,” adds Dr. Chassin, “with more than 95% of hospitals now exceeding 90% performance on some measures, we are beginning to see the kind of consistent excellence to which we aspire for all of health care.”

The Joint Commission hopes that information in its national, comparative performance measurement database can inform internal health care organization quality improvement activities, external accountability, and pay-for-performance programs, as well as advance research. The complete report—Improving America’s Hospitals: The Joint Commission’s Report on Quality and Safety 2009—can be downloaded for free at http://www.jointcommission.org.
## Percentage of Hospitals Achieving Greater Than 90% on a Performance Measure

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>2006 High (% &gt;90)</th>
<th>2007 High (% &gt;90)</th>
<th>2008 High (% &gt;90)</th>
<th>Difference (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring oxygen in blood (Pneumonia)</td>
<td>99.6</td>
<td>99.8</td>
<td>99.7</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Smoking cessation advice (Heart Attack)</td>
<td>91.5</td>
<td>96.7</td>
<td>98.0</td>
<td>1.4%</td>
</tr>
<tr>
<td>Aspirin at arrival (Heart Attack)</td>
<td>93.0</td>
<td>96.4</td>
<td>97.5</td>
<td>1.1%</td>
</tr>
<tr>
<td>Beta blocker at discharge (Heart Attack)</td>
<td>88.7</td>
<td>93.7</td>
<td>96.2</td>
<td>2.4%</td>
</tr>
<tr>
<td>Smoking cessation advice (Heart Failure)</td>
<td>75.2</td>
<td>89.7</td>
<td>94.8</td>
<td>5.1%</td>
</tr>
<tr>
<td>Aspirin at discharge (Heart Attack)</td>
<td>90.0</td>
<td>91.9</td>
<td>94.3</td>
<td>2.4%</td>
</tr>
<tr>
<td>Patients with appropriate hair removal (Surgical Care)</td>
<td>N/A</td>
<td>N/A</td>
<td>93.5</td>
<td>N/A</td>
</tr>
<tr>
<td>Appropriate prophylactic antibiotics (Surgical Care)</td>
<td>N/A</td>
<td>83.2</td>
<td>91.9</td>
<td>8.7%</td>
</tr>
<tr>
<td>Beta blocker at arrival (Heart Attack)</td>
<td>79.0</td>
<td>86.0</td>
<td>89.1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Left ventricular systolic (LVS) assessment (Heart Failure)</td>
<td>69.5</td>
<td>81.1</td>
<td>88.6</td>
<td>7.5%</td>
</tr>
<tr>
<td>Smoking cessation advice (Pneumonia)</td>
<td>62.8</td>
<td>78.1</td>
<td>88.3</td>
<td>10.2%</td>
</tr>
<tr>
<td>Blood culture in intensive care unit (ICU) (Pneumonia)</td>
<td>66.8</td>
<td>75.4</td>
<td>84.6</td>
<td>9.2%</td>
</tr>
<tr>
<td>Antibiotics within 6 hours of arrival (Pneumonia)*</td>
<td>N/A</td>
<td>N/A</td>
<td>83.4</td>
<td>N/A</td>
</tr>
<tr>
<td>Angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) at discharge (Heart Attack)</td>
<td>43.6</td>
<td>68.8</td>
<td>82.1</td>
<td>13.3%</td>
</tr>
<tr>
<td>Blood culture in emergency department (Pneumonia)</td>
<td>58.3</td>
<td>64.2</td>
<td>77.2</td>
<td>13.0%</td>
</tr>
<tr>
<td>Antibiotics to ICU patients within 24 hours (Pneumonia) non</td>
<td>49.3</td>
<td>69.4</td>
<td>77.2</td>
<td>7.8%</td>
</tr>
<tr>
<td>Antibiotics within one hour before the first surgical cut (Surgical Care)</td>
<td>39.9</td>
<td>53.7</td>
<td>76.1</td>
<td>22.4%</td>
</tr>
<tr>
<td>ACEI or ARB at discharge (Heart Failure)</td>
<td>36.1</td>
<td>57.7</td>
<td>72.3</td>
<td>14.7%</td>
</tr>
<tr>
<td>Beta blocker patients who received beta blocker perioperatively (Surgical Care)</td>
<td>69.7</td>
<td>20.3</td>
<td>N/A</td>
<td>49.4%</td>
</tr>
<tr>
<td>Receiving venous thromboembolism (VTE) medicine/treatment (Surgical Care)</td>
<td>N/A</td>
<td>29.3</td>
<td>66.5</td>
<td>37.2%</td>
</tr>
<tr>
<td>Cardiac patients with controlled 6 a.m. postoperative blood glucose (Surgical Care)</td>
<td>N/A</td>
<td>N/A</td>
<td>58.3</td>
<td>N/A</td>
</tr>
<tr>
<td>Stopping antibiotics within 24 hours (Surgical Care)</td>
<td>20.1</td>
<td>37.6</td>
<td>58.0</td>
<td>20.4%</td>
</tr>
<tr>
<td>Pneumococcal vaccination (Pneumonia)</td>
<td>2.7</td>
<td>38.6</td>
<td>57.9</td>
<td>19.3%</td>
</tr>
<tr>
<td>Prescribing VTE medicine/treatment (Surgical Care)</td>
<td>N/A</td>
<td>43.6</td>
<td>52.4</td>
<td>8.8%</td>
</tr>
<tr>
<td>Influenza vaccination (Pneumonia)</td>
<td>N/A</td>
<td>26.9</td>
<td>43.1</td>
<td>16.3%</td>
</tr>
<tr>
<td>Discharge instructions (Heart Failure)</td>
<td>17.7</td>
<td>27.5</td>
<td>40.1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Primary percutaneous coronary interventions (PCI) balloon therapy within 90 minutes (Heart Attack)</td>
<td>7.8</td>
<td>15.1</td>
<td>35.0</td>
<td>20.0%</td>
</tr>
<tr>
<td>Antibiotics to ICU patients within 24 hours (Pneumonia)</td>
<td>0.7</td>
<td>7.2</td>
<td>4.9</td>
<td>-2.3%</td>
</tr>
</tbody>
</table>

* This measure changed to “providing antibiotics within six hours of arrival,” according to practice standards, in 2007. However, 2008 is the first year sufficient data for reporting purposes were available.

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