

Spotlight

Q&A with The Joint Commission's Jean Range

Jane Martinsons, Staff Writer

Jean Range, MS RN CPHQ, executive director, Disease-Specific Care Certification Program, The Joint Commission, recently spoke with Synapse E-News about the benefits and future direction of the certification program.

Q: What is the Disease-Specific Care Certification Program? Please explain the benefits.

In 2002, The Joint Commission launched the Disease-Specific Care Certification Program to address the needs of organizations with programs focused on chronic illnesses. This launch followed the release of the Institute of Medicine's landmark reports, *Crossing the Quality Chasm* and *To Err is Human*, which predicted increasing difficulties in healthcare delivery and our ability to care for patients with chronic conditions. The Joint Commission saw the benefits in developing an evaluation framework for clinical treatment programs that focused on specific diseases and conditions and chronic illnesses.

Unlike accreditation, which is an overall evaluation of an entire organization, certification is a focused evaluation of a clinical treatment program. Certification is a 2-year award; accreditation is a 3-year award. And while accreditation is driven in many ways by the location of the care provider, certification is blind to where care is rendered.

Many of our certification standards are core standards used to evaluate treatment programs of any kind, including primary stroke certification. There are 28 core standards that are used to evaluate disease-specific care, including primary stroke, in topical areas such as

- program management (leadership, program structure)
- the delivery of care (ensuring evidence-based clinical practice guidelines are used and fully implemented)
- patient self-management
- clinical information management (ensuring both the confidentiality of patients' medical information and the sharing of relevant clinical information among providers across the continuum of care)
- performance measurement and performance improvement. (All certified organizations are required to actively collect data in these areas to demonstrate they have improved the quality of patient care.)

The program requires certified primary stroke centers (PSC) to use evidence-based clinical practice guidelines and to collect performance data on 10 standardized performance measures.

Organizations that apply for certification are required to engage in a 1-day onsite evaluation of their program. Midway through the first certification cycle, they must consult with our review staff to talk about their experience collecting performance measure data, among other things. At the end of the second year, we visit them onsite again to perform a recertification review.

Among its many benefits, the program improves the quality of care provided to stroke patients. The certification requirements provide organizations with a very comprehensive road map to establishing themselves as certified PSCs. It also creates a good deal of camaraderie and enthusiasm within organizations. Certification is galvanizing, and often organizations that are PSC-certified go on to seek certification for other diseases, such as heart failure.

Nationwide, there are 501 PSC certified programs—about 380 more programs than those that existed in 2005. In Florida, there are currently 68 such centers certified by The Joint Commission.

Q: Are there new or upcoming trends in stroke certification? Is there anything newsworthy in this area?

There are several things. First, as of January 1, 2008, we have electronic submission available for standardized measures. Organizations can now report the 10 required measures to us using a secure Web site. Likewise, this allows us to conduct some analysis on measure data in the future. Currently, organizations can apply for certification or recertification through our electronic application process.

Second, more organizations are recognizing the value of these standardized measures. Recently, the National Quality Forum (NQF) endorsed 8 of the 10 measures, and the Centers for Medicare and Medicaid Services is considering doing the same for its prospective payment programs.

As of January 1, 2009, there will be changes to PCS certification requirements. (See page 6 of The Joint Commission's July 2008 *The Joint Commission Perspectives* magazine for details.) These changes are designed to ensure that an adequate infrastructure and support system are in place to provide optimal care of stroke patients in every hospital. These requirements target, for example, the appropriate documentation for administering thrombolytic therapy.

Q: Any particular message you'd like to share with AANN members?

We are extremely excited about progress underway to improve the care of stroke patients through Joint Commission certification and the involvement of the American Stroke Association (ASA), our collaborative partner. We certainly recognize the hard work of dedicated neuroscience nurses in this important area and look forward to a bright future with this program to help ensure that patients with stroke are treated with the highest quality of care.

Feel free to visit www.jointcommission.org to get assistance with preparing or applying for certification. We have a team of people ready to answer your questions. You also will find information on the site about The Joint Commission Resources' 1-day disease-specific care workshop. Moreover, both The Joint Commission and ASA provide speaking engagements, so don't hesitate to contact us.

A Nurse's View of Care After Her Husband's Stroke

Lincoln Brunner

When veteran nurse Jan Flewelling, BSN RN CNRN, watched her husband, Mike, suffer a stroke at the age of 53, the professional side of the stroke outreach program coordinator jumped into gear.

Now, a year later, Flewelling reflects on life after his stroke—this time through the eyes of a family member faced with coping with a new reality.

"I think if there's anything I came away with, it is a much deeper understanding of just what our families go through," says Flewelling, who provides community stroke education for healthcare professionals and laypeople in the Greater Houston, TX, area. She is stroke outreach

program coordinator at The Methodist Hospital in Houston, TX. “I do patient and family teaching all the time, and I tell them the truth all the time. That is a good thing, but it’s not the main thing. All they want to know is ‘Is it going to be OK?’”

Flewelling’s husband suffered a stroke while recovering from a heart attack in the hospital. As she watched the left side of her husband’s face droop, “the nursing side of me kind of kicked in, and I did a quick neural assessment,” she says. “I knew exactly what we were dealing with, and I put on the call light.

“Then, once it was out of my hands, it’s like a switch flipped, and I was nothing but a family member sitting there praying that this was all going to turn out. It’s a very helpless and terrible feeling.”

Being Human First

Flewelling says that nurses must address these types of emotions if patients and their families are to pull through the anguish of a stroke.

“When I went to nursing school a thousand years ago, they really stressed keeping that professional distance,” she says. “I think sometimes our busyness—our schedules, routines, medication passing, and hanging IVs—allows us to keep a distance.

“I’m not encouraging people to be unprofessional, but I think we have to be able to let down some of that barrier so that we can give patients and their families what they really need, and that’s an assurance that we’re not going to let them down.”

Flewelling should know. Of all the hospital personnel she dealt with in the aftermath of Mike’s stroke, the person who made the most difference wasn’t a neurologist or even a fellow nurse; it was an MRI department receptionist who noticed her crying, made a fresh pot of coffee, and reassured her that they were going to take care of her.

“That meant the world to me at that moment,” Flewelling says. “That’s exactly what people need. It’s not the coffee; it’s the acknowledgment that you’re human and I’m human, and we’re in this together.”

Insist on Information

As an educator, Flewelling also advises family members to insist on getting the information they need to deal with the situation—and for her colleagues not to shun patients who do.

“There have been times when patients and families who insist on information are treated as difficult people,” she says. “That is dead wrong. People need to be brave and insist on their rights of information. We nurses need to understand they aren’t going to get it the first time we explain it to them. We need to help people be brave enough to say, ‘I’m sorry—I didn’t get it yesterday. Can you go through it again?’”

Today, Flewelling’s husband is back working as a computer systems analyst and even playing tournament chess, though he tires more easily than he did and takes longer to think through things. Life is almost like it was before, even if Flewelling’s approach to her work is not.

“It wasn’t that I wasn’t doing it right. It’s just that I suddenly realized how inadequate it could be,” she says. “These people are going through a situation in which, in many cases, life will never, ever be the same again.”