



# **The Joint Commission Center for Transforming Healthcare Hand-off Communications Targeted Solutions Tool**

**April 2013**

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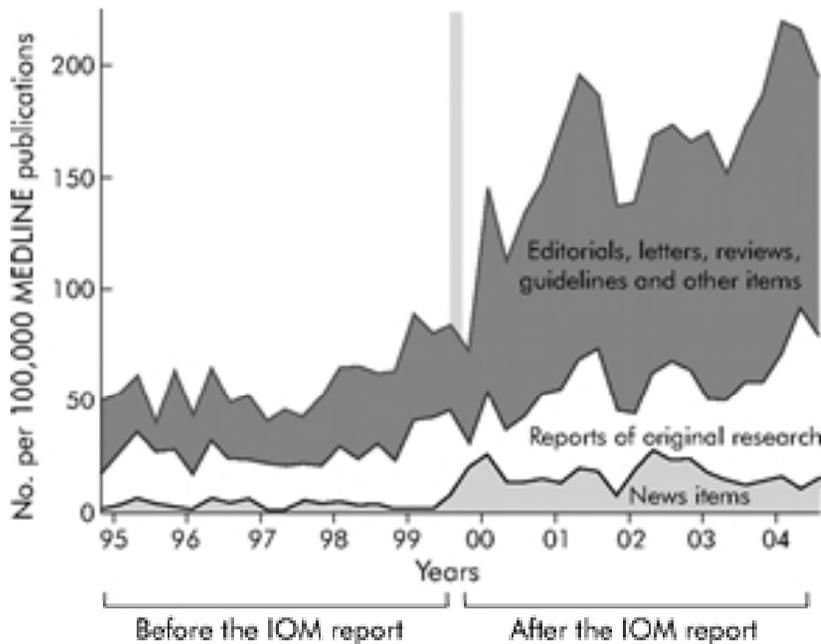
# Overview



- ▶ Introduction to the Joint Commission Center for Transforming Healthcare (CTH)
- ▶ Overview of the problem solving framework: Robust Process Improvement™ (RPI)
- ▶ Hand-off Communications Project
  - History
  - Outcomes
- ▶ Hand-off Communications Targeted Solutions Tool Demo

# Current State of Quality

## Patient safety publications before and after publication of the IOM report "To Err is Human."



Source: Stelfox HT, Palmisani S, Scurlock C, Orav EJ, Bates DW. The "To Err is Human" report and the patient safety literature. Qual Saf Health Care. 2006;15:174-178.

- ▶ We have focused intensely for more than a decade on improving quality and safety
- ▶ Yet, quality problems still surround us
  - Health care associated infections
  - Medication errors that cause harm
  - Failed communication in transitions of care
- ▶ Uncommon, preventable adverse events that are inexplicable to patients and families
  - Wrong site surgery, OR fires

# Introduction to CTH-Vision



The Joint Commission



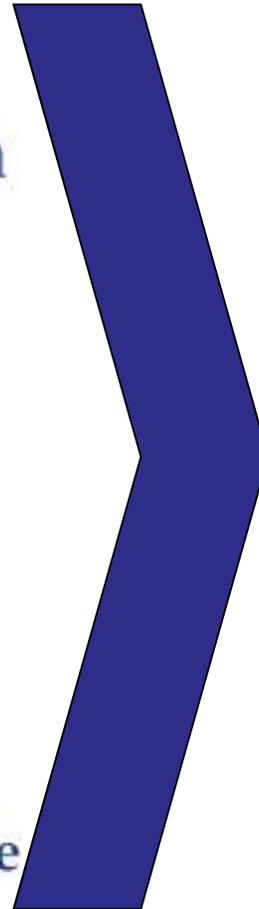
Joint Commission  
Resources



Joint Commission  
International



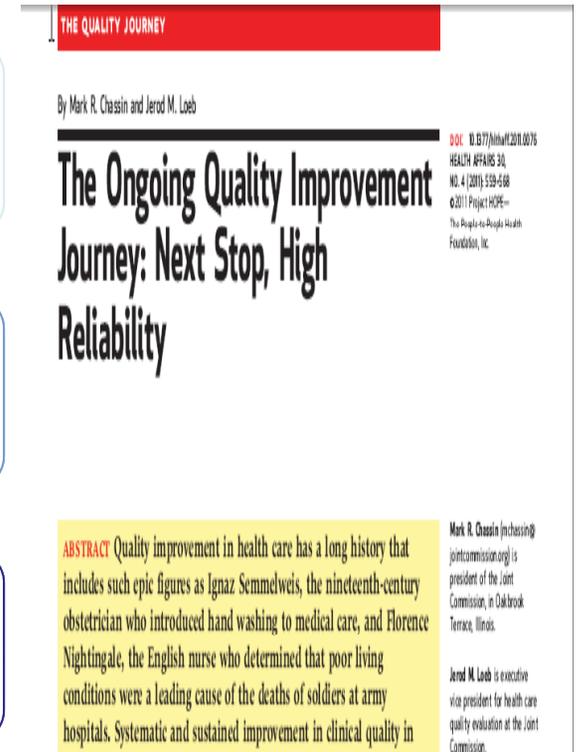
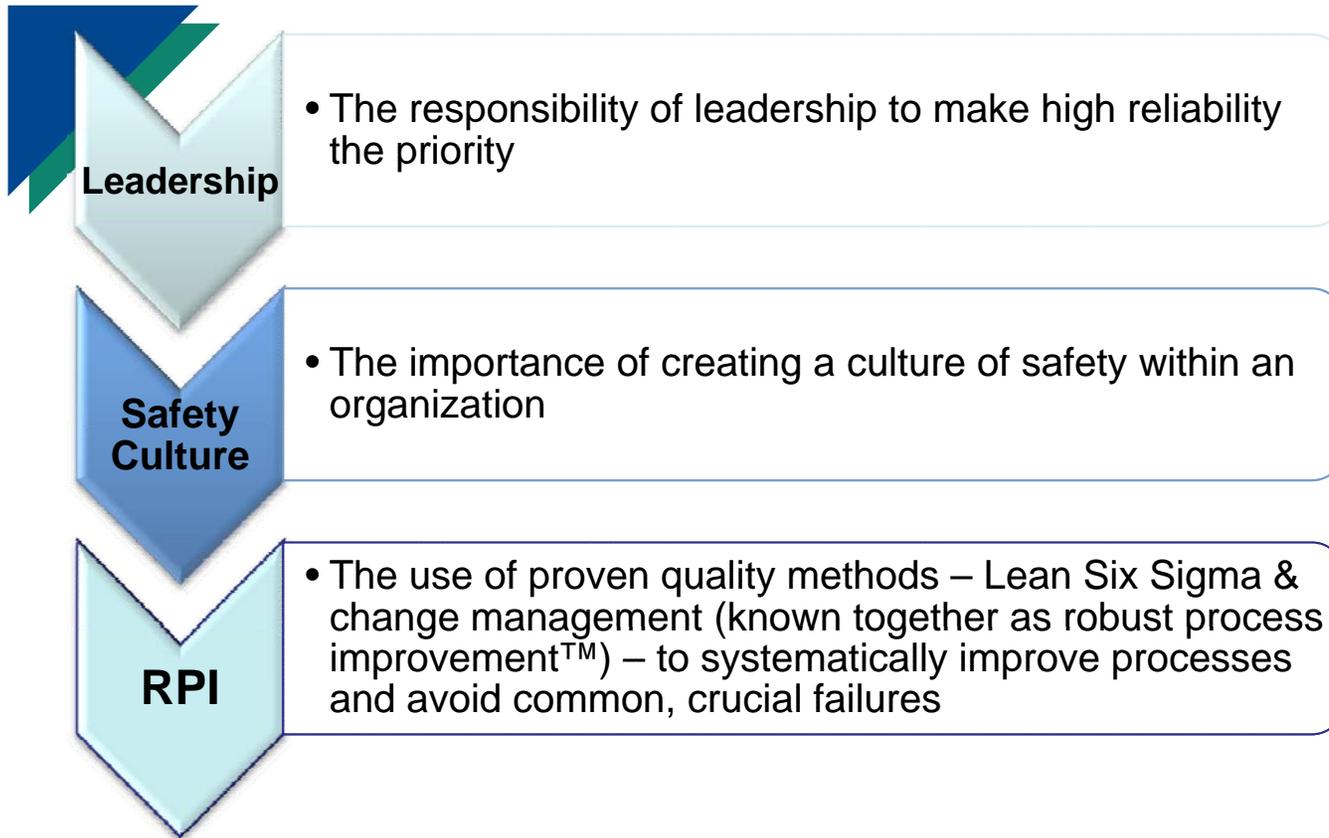
Joint Commission Center  
for Transforming Healthcare



## One Vision

*All people always  
experience the  
safest, highest  
quality, best-value  
health care across  
all settings.*

# Introduction to CTH-Mission



**Our Mission:** Transform health care into a **high reliability industry** and to ensure patients receive the safest, highest quality care they expect and deserve

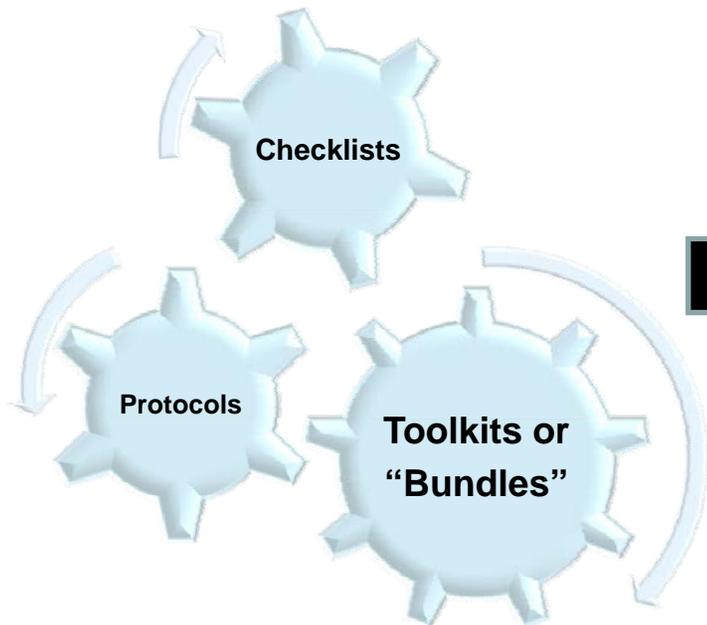
# Robust Process Improvement™(RPI)

## A New Way in Delivering Results

### Usual Approaches:

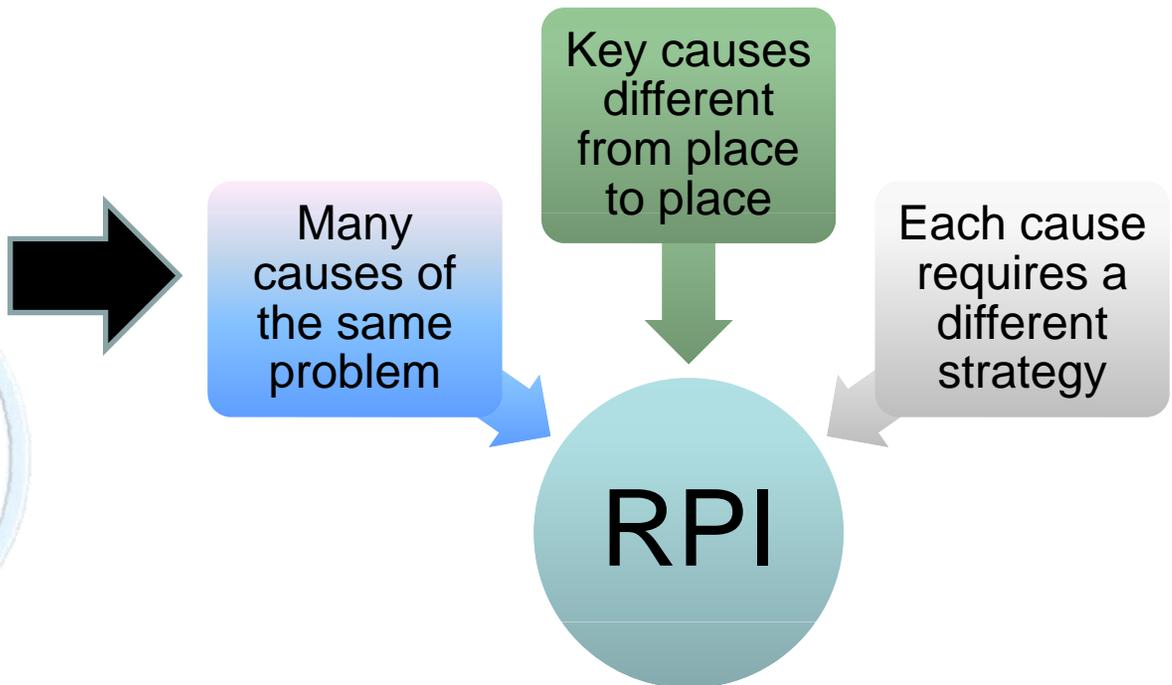
“One-size-fits-all” works well only in very limited circumstances:

- Process varies little from place to place
- Causes of failure are few and common

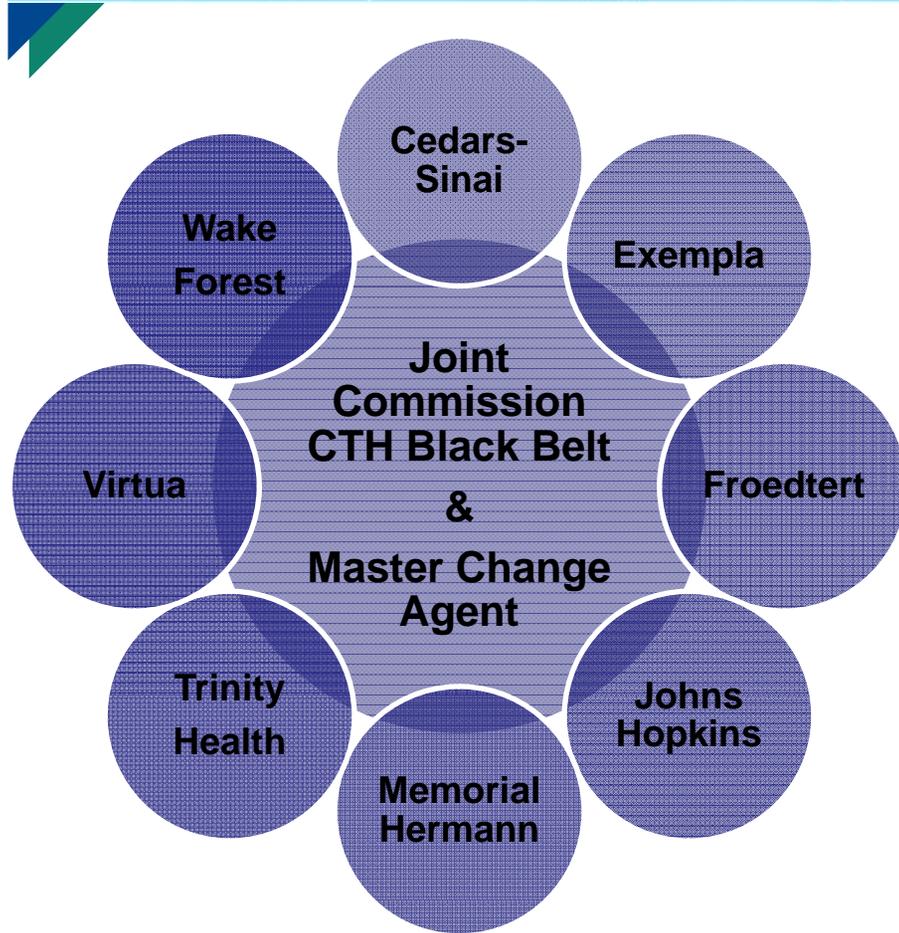
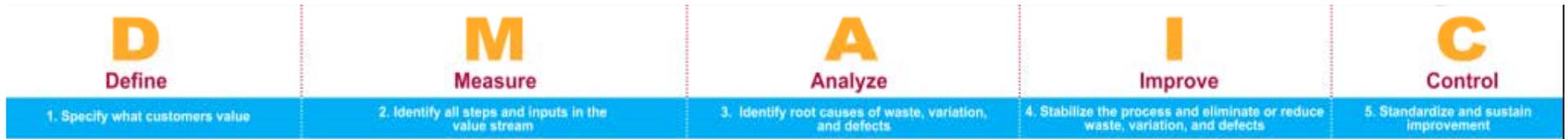


### New Generation of Best Practices:

Complex processes require RPI to produce solutions – customized to an organization’s most important causes



# Project 1: Improving Hand Hygiene Compliance



| Main Causes of Failure to Clean Hands<br>(across all participating hospitals)       | Each letter = one hospital |   |   |   |   |   |   |   |
|---|----------------------------|---|---|---|---|---|---|---|
|   | A                          | B | C | D | E | F | G | H |
| Ineffective placement of dispensers or sinks  | ○                          | x |   | x | x |   | x | x |
| Hand hygiene compliance data are not collected or reported accurately or frequently | x                          | x |   | x | x |   |   | x |
| Lack of accountability and just-in-time coaching                                    | ○                          | x | x | x | x |   | x | x |
| Safety culture does not stress hand hygiene at all levels                           | ○                          |   | x | x | x | x |   | x |
| Ineffective or insufficient education   | ○                          | x | x | x | x |   | x |   |
| Hands full  | x                          | x | x | x | x |   | x |   |
| Wearing gloves interferes with process  | x                          | x | x | x |   |   | x |   |
| Perception that hand hygiene is not needed if wearing gloves                        | x                          |   | x | x | x |   | x | x |
| Health care workers forget  | x                          | x |   | x |   |   | x |   |
| Distractions  | x                          | x |   |   |   | x | x |   |

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.

# Develop Solutions with Leading Hospitals

- 
- ▶ Atlantic Health
  - ▶ Barnes-Jewish
  - ▶ Baylor
  - ▶ Cedars-Sinai
  - ▶ Cleveland Clinic
  - ▶ Exempla
  - ▶ Fairview
  - ▶ Floyd Medical Center
  - ▶ Froedtert
  - ▶ Intermountain
  - ▶ Johns Hopkins
  - ▶ Kaiser-Permanente
  - ▶ Mayo Clinic
  - ▶ Memorial Hermann
  - ▶ NY-Presbyterian
  - ▶ North Shore-LIJ
  - ▶ Northwestern
  - ▶ OSF
  - ▶ Partners HealthCare
  - ▶ Sharp Healthcare
  - ▶ Stanford Hospital
  - ▶ Texas Health Resources
  - ▶ Trinity Health
  - ▶ VA Palo Alto HCS
  - ▶ Virtua
  - ▶ Wake Forest Baptist
  - ▶ Wentworth-Douglass

# Center for Transforming Healthcare



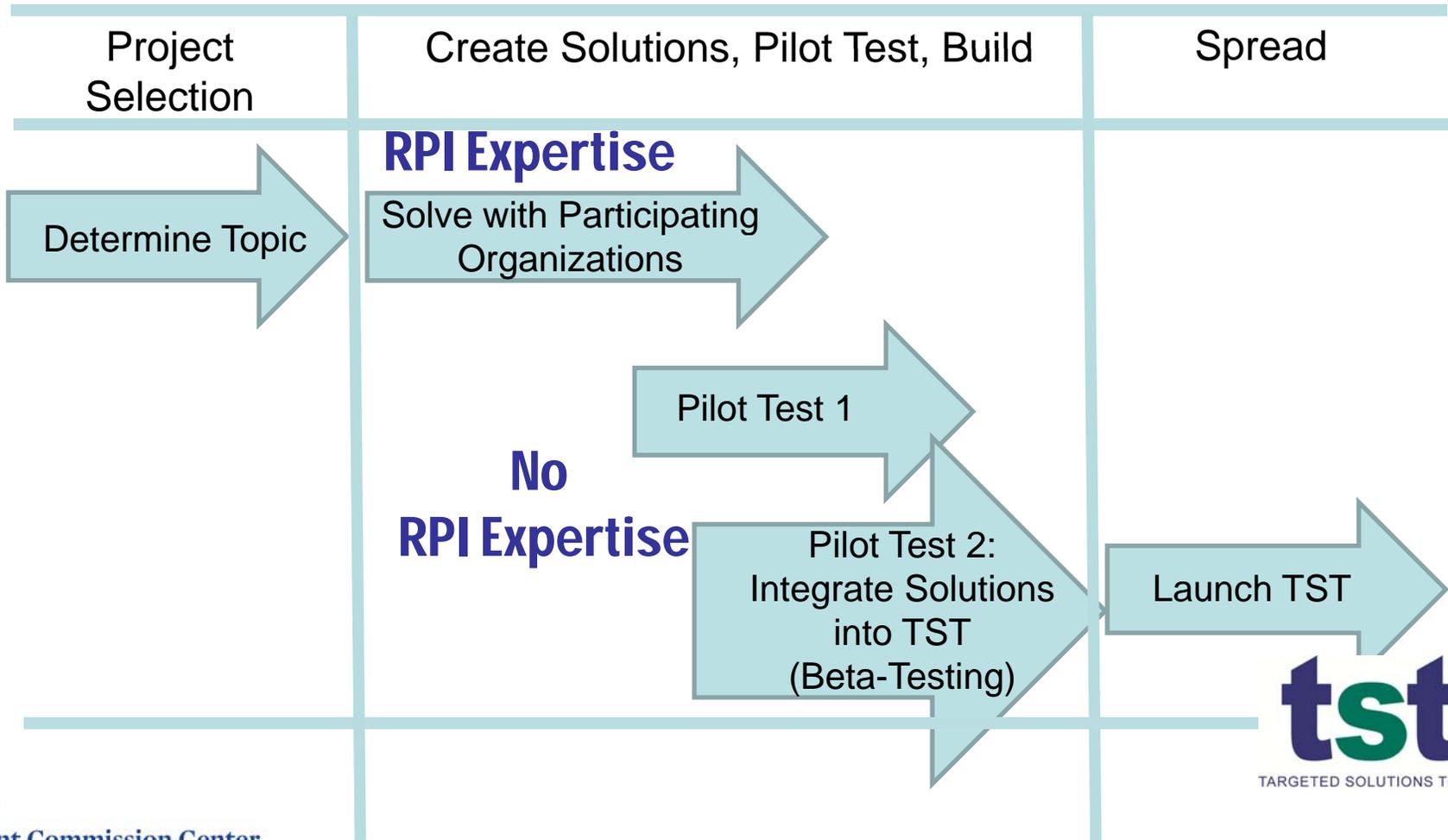
▶ 2009: hand hygiene, wrong site surgery and hand-off communications

▶ 2010: colorectal surgery SSIs

▶ 2011: safety culture, preventable HF hospitalizations, and falls with injury

▶ 2012: sepsis mortality, insulin safety

# Center Operating Model



# Confidential • Easy to Use • No Extra Cost Separate from Accreditation



**tst**

TARGETED SOLUTIONS TOOL™

- Educational, no jargon, no special training and no knowledge of RPI methodology needed
- Guides users to customized solutions. Data analysis conducted by the tool, not the user. Tool walks user through process of:
  - Measuring current state
  - Determining root causes
  - Selecting targeted solutions
  - Control of process after implementation

# Introduction to CTH-Projects

- Project 1 – Hand Hygiene Compliance
- Project 2 – Wrong Site Surgery
- Project 3 – Hand Off Communication



- Project 4 – Surgical Site Infections

With American College of Surgeons

**Pilot Testing**

- Project 5 – Preventing Avoidable Heart Failure Hospitalizations  
With American College of Physicians

- Project 6 – Safety Culture

- Project 7 – Preventing Falls with Injury

**“Solve”**

- Project 8 – Reducing Sepsis Mortality

- Project 9 – Medication Safety: Safe Use of Insulin

**Web:** [www.centerfortransforminghealthcare.com](http://www.centerfortransforminghealthcare.com)



# HAND-OFF COMMUNICATIONS PROJECT:



# Why Tackle Hand-off Communications?

- Health care organizations have long struggled with the process of passing necessary and critical information about a patient from one caregiver to the next, or from one team of caregivers to another
- An estimated 80 percent of serious medical errors involve miscommunication during the hand-off between medical providers



# Why Tackle Hand-off Communications?

- ▶ A hand-off is the transfer and acceptance of patient care responsibilities achieved through effective communication
- ▶ The hand-off process involves “senders” – the caregivers transmitting patient information and releasing the care of the patient to the next clinician, and “receivers” – the caregivers who accept patient information and care of the patient

# What was Measured?

- ▶ Defective Hand-offs
  - ▶ A 'defective' hand-off occurs when the hand-off did not meet the needs of either the sender or the receiver

# Validated Root Causes for Transition of Care: Hand-off Communications Failures

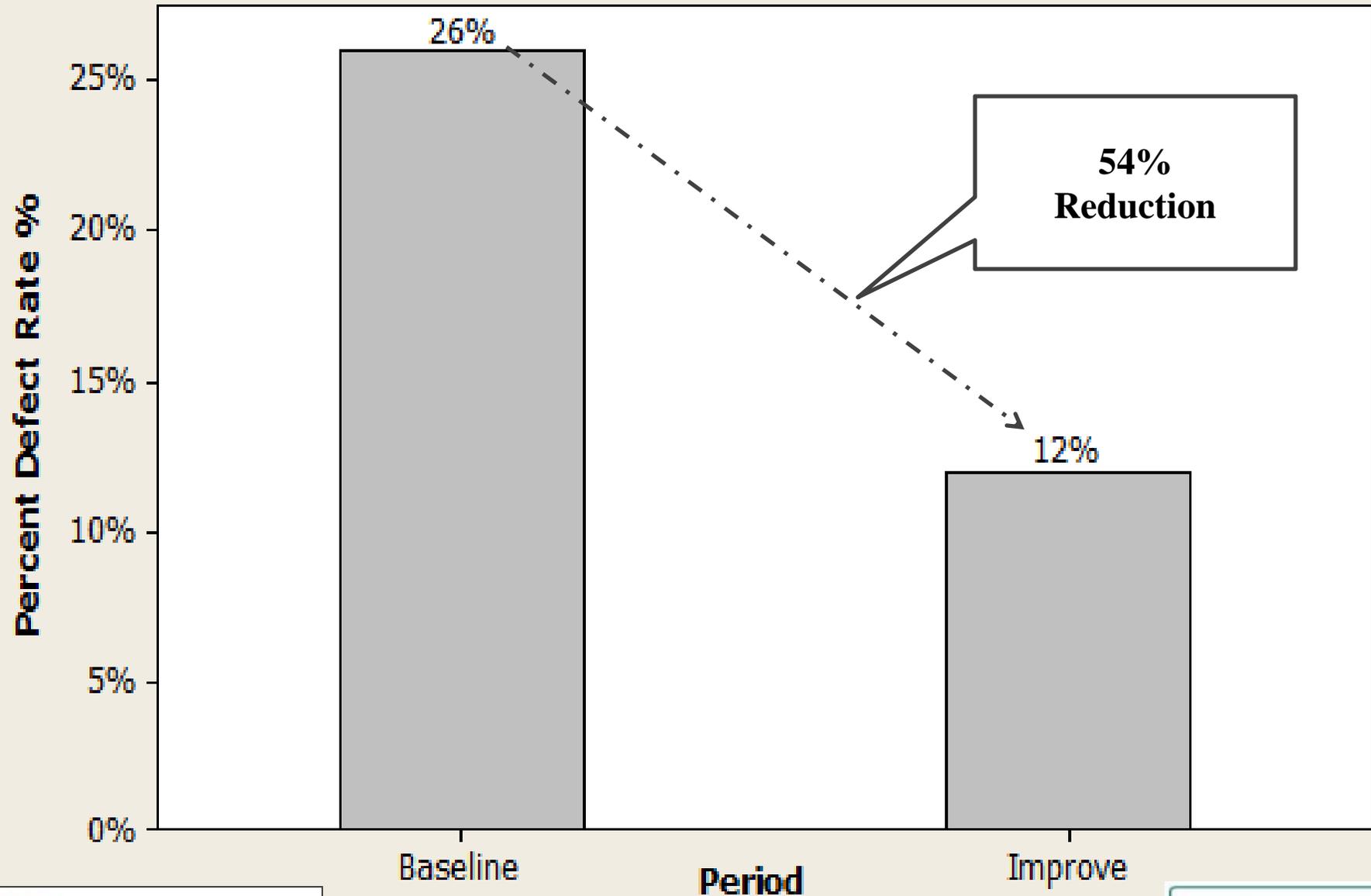
All participating hospitals

|   | A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|---|
| <b>General</b>  |   |   |   |   |   |   |   |   |   |   |
| Culture does not promote successful hand-off, e.g. lack of teamwork and respect   | X | X | X |   | X |   | X |   | X | X |
| Expectations between sender and receiver differ   | X | X | X |   | X |   | X |   | X | X |
| Ineffective communication method, e.g. verbal, recorded, bedside, written   | X |   |   |   | X |   | X | X | X | X |
| Timing of physical transfer of the patient and the hand-off are not in sync   |   | X |   |   | X | X | X |   | X | X |
| Inadequate amount of time provided for successful hand-off  | X | X | X |   | X | X |   |   |   |   |
| Interruptions occur during hand-off   |   |   | X |   | X | X |   |   |   |   |
| Lack of standardized procedures in conducting successful hand-off, e.g. SBAR  |   |   | X | X | X |   | X |   |   |   |
| Inadequate staffing at certain times of the day or week to accommodate successful hand-off  |   |   |   |   | X | X |   |   |   |   |
| Patient not included during hand-off  | X |   |   |   |   |   |   |   |   |   |
| Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/ issues, contact information            | X | X | X | X | X | X | X | X | X | X |
| Sender, who has little knowledge of patient, is handing off patient to receiver   | X |   | X | X | X |   |   | X | X | X |
| <b>Sending</b>  |   |   |   |   |   |   |   |   |   |   |
| Sender unable to provide up-to-date information, e.g. lab tests, radiology reports, because not available at the time of hand-off |   |   |   |   | X | X |   |   |   | X |
| Sender unable to contact receiver who will be taking care of patient in a timely manner   |   |   |   |   | X |   | X |   |   |   |
| Inability of sender to follow up with receiver if additional information needs to be shared                                       |   |   |   |   |   | X |   |   |   |   |
| Sender asked to repeat information that has already been shared   |   |   |   |   | X |   |   |   |   |   |
| <b>Receiving</b>  |   |   |   |   |   |   |   |   |   |   |
| Receiver has competing priorities and is unable to focus on transferred patient   |   |   |   |   | X |   |   |   | X | X |
| Receiver unaware of patient transfer  |   |   |   |   | X |   |   | X |   |   |
| Inability for receiver to follow up with sender if additional information is needed   |   |   |   |   |   | X |   |   |   |   |
| Lack of responsiveness by receiver  | X |   |   |   |   |   |   |   |   |   |
| Receiver has little knowledge of patient being transferred  |   |   |   |   | X |   |   |   |   |   |

# Hand-Off Communications (HOC)

- ▶ In 2011, targeted solutions for hand-off communications were pilot tested in hospitals and ambulatory care settings to prove their effectiveness in demographically diverse hospitals and other care settings
- ▶ Both hospital and ambulatory pilot settings experienced a decrease in defects

## Percent of Overall (including Senders and Receivers) Defect Hand-offs (Pilots)



# Experience of HOC Projects



- ▶ The universal experience was the differing expectations of the senders and receivers.
- ▶ Organizations
  - aligned expectations of the hand-off
  - developed a process for a successful hand-off
  - fostered better relationships and communication among staff

# Improving Transitions: Hand-off Communications

- One hospital focused on the transition from its inpatient units to a nursing home

|                      | <u>Baseline</u> | <u>Improve</u> |
|----------------------|-----------------|----------------|
| Inadequate hand-offs | 29%             | <1%            |
| 30-day readmissions  | 21%             | 10%            |



# Did improved HOCs impact anything else?



## Other Outcome Metrics

- Reduction in bounce backs
- Reduction in LOS in ED
- Improved Patient Satisfaction
- Improved Family Satisfaction
- Improved Staff Satisfaction



**tst**

TARGETED SOLUTIONS TOOL™

# TST – Step 1 Getting Started

The screenshot shows the TST website interface. At the top left is the logo for the Joint Commission Center for Transforming Healthcare, with the tagline 'Creating Solutions for High Reliability Health Care'. To its right is the 'tst' logo, with 'TARGETED SOLUTIONS TOOL™' underneath. In the top right corner, there is a header for 'Mock Test-General Hosp' with address '123 T Villa Park, IL 601 HCO ID: 3378'. Below the logos is a navigation bar with five tabs: '1. Getting Started', '2. Training Data Collectors', '3. Measuring Compliance', '4. Determining Factors', and '5. Implement'. Below the navigation bar is a breadcrumb trail: 'Home > Getting started'. The main heading is 'Targeted Solutions Tool™ - Hand Off Communication for IT TEST / IT TEST'. The content area is titled '1. Getting Started' and includes the following text and list:

**The goal: Improving hand-off communications.**

This secure Targeted Solutions Tool™ outlines the specific steps you can take to improve hand-off communications. Hand-offs involve the transfer of clinical information, responsibilities and duties concerning a patient from one health care provider or team (the senders) to another (the receivers). This site includes:

- Forms, tools and tips for recording and interpreting defects in the hand-off communications process
- Instructions for pinpointing the solutions that will work best at your organization
- Guidelines for maintaining success

**To make your project successful**

- Measure accurately. The participating organizations with the Center for Transforming Healthcare found that, on average, 37 percent of hand-offs did not allow the receiver to safely care for the patient and, in 21 percent of the hand-offs, senders were dissatisfied with the quality of the hand-off. Identify your organization's root causes for hand-off communication failures to determine the targeted solutions that will work for you.

**How long will it take?**

Some solutions can be implemented today; others may take months to fully implement. However, this project can be completed within 16-21 weeks and that should be your organization's goal.

At the bottom of the page, there is a footer with 'for Transforming Healthcare' on the left and 'Week' in the center.

Tips from Experts

Peter Silver, M.D.  
North Shore LIJ Health System  
Cohen Children's Medical Center



Terrence O'Malley, M.D.  
Partners HealthCare



# TST – Step 1 Getting Started

1. Getting Started

2. Training Data Collectors

3. Measuring Compliance

4. Determining Factors

5. Implementing Solutions

6. Sustaining the Gain

Home > Getting started > Tailoring the project

## Targeted Solutions Tool™ - Hand Off Communication for IT TEST / IT TEST

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### 1c. Tailoring the project to your organization

Let's get started by answering a few questions identified by the ► icon. This will allow you to populate the forms and tools with information specific to your organization, and it will enable you to experience the full range of benefits of the tools provided here.

#### ► Check one of the boxes:

- We will not be changing the scope of our project.
- We have read the information above and have decided to change the scope of our project. We understand that our data and feedback will not be aggregated with other data.

#### ► Select your **sender's** setting:

- Hospital
- Ambulatory Care Facility
- Behavior Health Care Facility
- Long Term Care Facility
- Home Care Facility
- Other

#### ► Enter your **sender's** area:

#### ► Enter your **sender's** role

Jeffrey E. Thompson,  
Mayo Clinic



Sommer Alexander, M.S.  
Fairview Health Services



# TST – Step 2 Training Observers

Joint Commission Center for Transforming Healthcare  
Creating Solutions for High Reliability Health Care

tst  
TARGETED SOLUTIONS TOOL™

Mock Test-General Hospital  
123 Test  
Villa Park, IL 60181  
HCO ID: 337843

Help Projects Observations Charts Export Exit

1. Getting Started 2. Training Data Collectors 3. Measuring Compliance 4. Determining Factors 5. Implementing Solutions 6. Sustaining the Gains

Home > Training Senders/Receivers > Identify Your Critical Information

Targeted Solutions Tool™ - Hand Off Communication for IT TEST / IT TEST [Print this Page](#)

## 2d. Identify your critical information

**Critical elements selected (40 max): 2**

▶ **Patient's identity information:**

Name  DOB  H&P  Completed charting (paper)

Age  Gender  MR#  Admitting physician and consults requested

▶ **Diagnosis:**

Not applicable  Reason for admission  Interpreted EKG rhythm

Chief complaint  Review of systems  Past medical history

▶ **Limitations on life-sustaining treatment:**

Not applicable  Code status  Advance directives

▶ **Current status:**

Not applicable  Isolation precaution  Special needs - ADA requirements

Vital signs (current status)  Fall risk  Therapeutic needs - equipment

Labs (current status)  Family needs  Medications administered

Allergies

▶ **Recent Changes:**

**Customize your data collection form**

Please identify the critical information for your receivers. The selections to the left will create your **customized** receiver data collection form.

Joint Commission Center for Transforming Healthcare

# TST – Step 2 Training Observers



Joint Commission Center for Transforming Healthcare / **tst** TARGETED SOLUTIONS TOOL™

Mock Test-General Hospital  
123 Test  
Villa Park, IL 60181  
HCO ID: 337843

Help Projects Observations Charts Export Exit

1. Getting Started 2. Training Data Collectors 3. Measuring Compliance 4. Determining Factors 5. Implementing Solutions 6. Sustaining the Gains

Home > Training Senders/Receivers > Training data collectors

**Targeted Solutions Tool™ - Hand Off Communication for IT TEST / IT TEST** Print this Page

## 2e. Training data collectors

At this step of the project, some receivers will also be core team members. However, senders should not yet be members of the core team.

It is important that sender and receiver data collectors are trained separately to avoid confusion between the groups and to maintain anonymity of the senders and receivers while collecting data.

There are two main components to training both sender and receiver data collectors:

- Scenario review and practice with the hand-off communication collection tool
- Written scenario-based testing

The following training tools are provided to ensure reliable data collection.

### Ensuring that hand-off communication data collectors are ready

It is important to ensure that hand-off communication data collectors understand the material and will be able to measure the data consistently. This is done by completing the training modules, which include a test.

The links for the downloadable training modules are located at the bottom of this screen.

The expectation is that hand-off communication data collectors will pass the written exam with a score of 90 percent or higher. In the event that a hand-off communication data collector does not pass the exam, reinforcement and provide additional time for data collection, and re-test at a later date.

**Douglas A. Evans, Kaiser Permanente**

Douglas A. Evans

**Data Collection Forms**

- [Receiver data collection form](#)
- [Sender data collection form](#)

**Additional audit tools**

[Download all audit tools \(.zip\)](#)

- [Operational Definitions](#)
- [Written test for senders](#)
- [Written test for receivers](#)
- [Test answers for senders](#)

|         | Web-based                         | Downloadable                      | PDFs (no test)                    |
|---------|-----------------------------------|-----------------------------------|-----------------------------------|
| Initial | <a href="#">Sender / Receiver</a> | <a href="#">Sender / Receiver</a> | <a href="#">Sender / Receiver</a> |
| Re-test | <a href="#">Sender / Receiver</a> | <a href="#">Sender / Receiver</a> | <a href="#">Sender / Receiver</a> |

Downloadable training materials/ videos & competency exam

Date of hand-off (month/day/year): \_\_\_\_\_ Time of hand-off (hh:mm): \_\_\_\_\_

Your role:  Primary physician  Physician designee

Your unit: IT TEST

Did the hand-off meet your needs to continue caring for the patient?  Yes  No

\*If "No," please check all that apply:

A. The method of communication was ineffective

Check all that apply:

|                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Chart        | <input type="checkbox"/> Electronic record             |
| <input type="checkbox"/> Face to face | <input type="checkbox"/> Fax                           |
| <input type="checkbox"/> Handwritten  | <input type="checkbox"/> Telephone                     |
| <input type="checkbox"/> Text message | <input type="checkbox"/> Other (please specify): _____ |

B. The timing of physical transfer/transport of the patient and the hand-off communication were not in sync

C. The amount of time provided was inadequate

D. Interruption(s) occurred

E. Standardized procedures were not followed

F. Staffing was inadequate

G. The sender provided inaccurate or incomplete information to me Check all that apply:

|                              |  |                                    |  |
|------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> H&P | <input type="checkbox"/> Review of systems | <input type="checkbox"/> Fall risk | <input type="checkbox"/> Complications |
| <input type="checkbox"/> MR# | <input type="checkbox"/> Code status       |                                    |  |

H. The sender had little knowledge of the patient

# TST- Step 3 Measuring Compliance



Creating Solutions for High Reliability Health Care



TARGETED SOLUTIONS TOOL™

Villa Park, IL 60181  
HCO ID: 337843

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1. Getting Started
2. Training Data Collectors
3. Measuring Compliance
4. Determining Factors
5. Implementing Solutions
6. Sustaining the Gains

Home > Measuring defect rate > Entering data into database

**Targeted Solutions Tool™ - Hand Off Communication for IT TEST / IT TEST**
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### 3c. Entering outcome (baseline) data

Now that you have started on your journey to improve hand-off communication, your organization's leaders and staff may want to know how outcomes have improved. The following tool can help you track outcome. It is recommended that you pick at least one outcome metric (for example, readmissions) that is appropriate for your pilot settings and enter the metric data for the six month period just prior to implementing solutions. You can then compare pre and post implementation outcome metric data. This will allow you to see the impact the hand-off communications project is having on the outcome metrics. This also speaks to the importance of sustaining a successful hand-off communication process.

Based on the setting for your pilot project, you will need to select a measurable outcome to track for improvement, such as readmissions, bounce-backs or medication errors

**▶ Select your outcome metric**

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Sentinel events related to HOC | <input checked="" type="checkbox"/> Length of stay | <input type="checkbox"/> Other <input style="width: 80px;" type="text"/> |
| <input type="checkbox"/> Bounce backs                   | <input type="checkbox"/> Medication errors         | <input type="checkbox"/> Other <input style="width: 80px;" type="text"/> |
| <input type="checkbox"/> Readmissions                   | <input type="checkbox"/> Patient satisfaction      | <input type="checkbox"/> Other <input style="width: 80px;" type="text"/> |

Save

**▶ Outcome Metric (Baseline):**

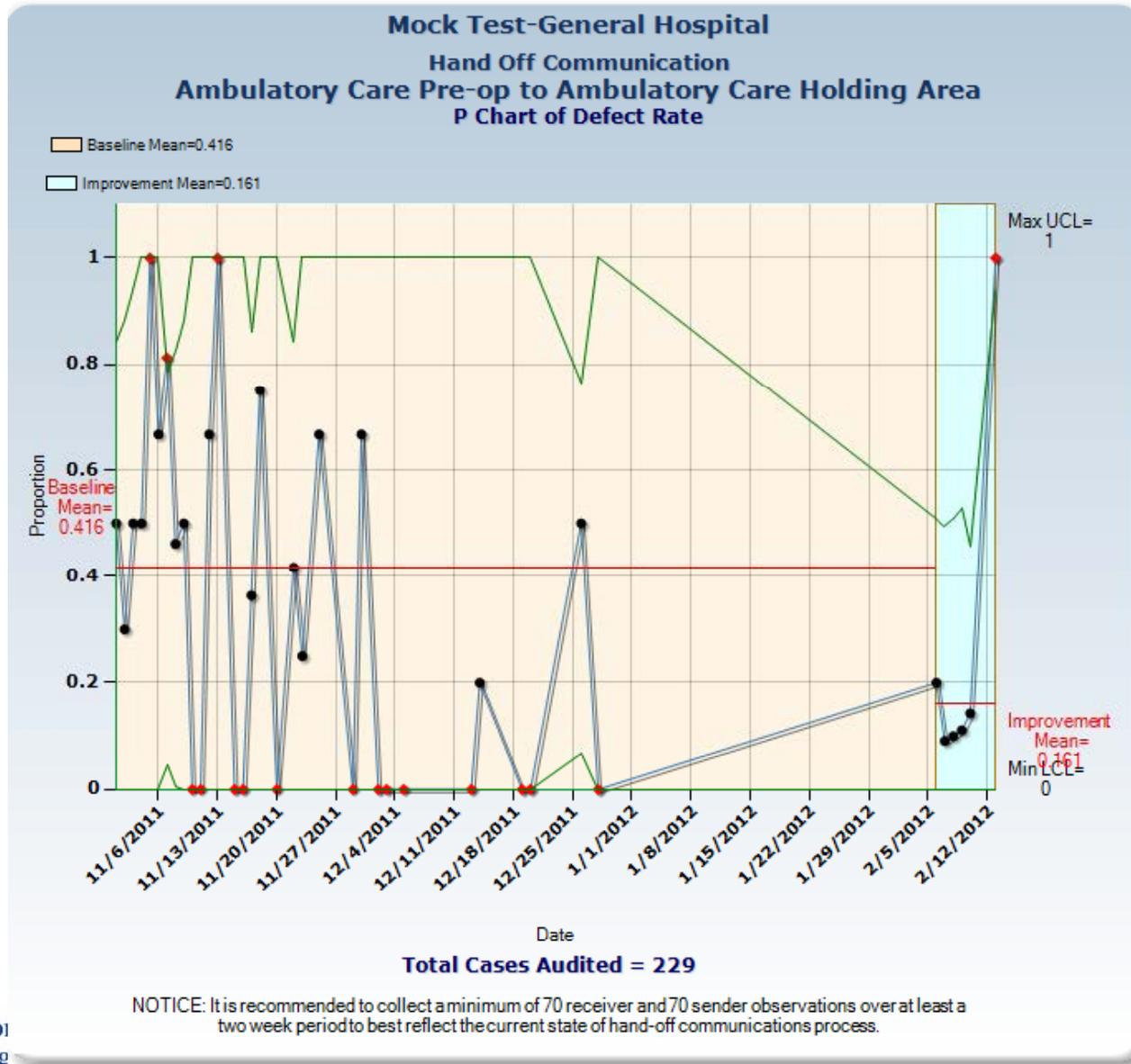
| Outcome Metric                            | Format (Days, %, Hours)                   | Date                                      | Current Performance                       |   |
|---|---|---|---|---|
| Length of stay                            | Percent                                   | 12/13/2011                                | 5   |   |
| <input style="width: 80px;" type="text"/> | <span style="color: #0070C0; font-weight: bold;">+ Add</span> |

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29

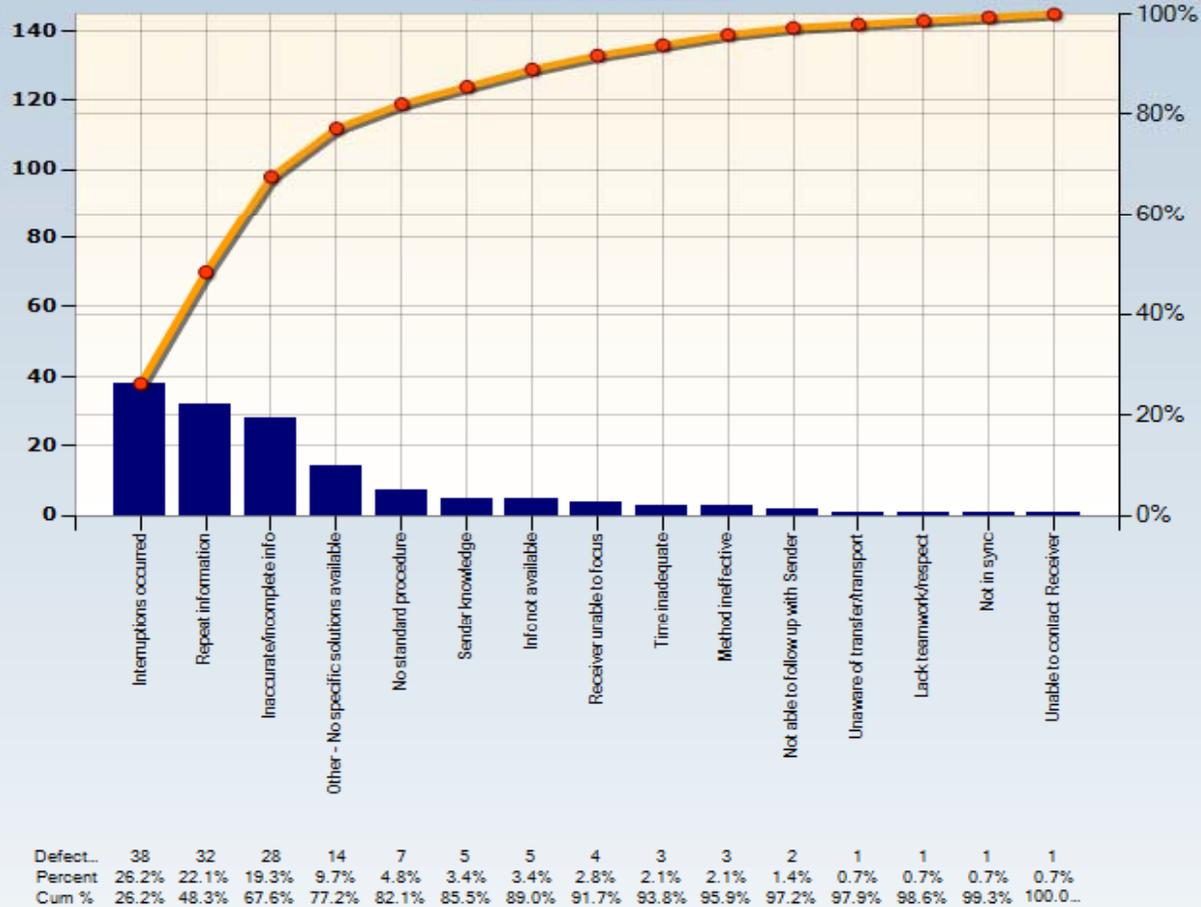
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# TST- Step 4 Determining Factors



**Mock Test-General Hospital  
Hand Off Communication  
Ambulatory Care Pre-op to Ambulatory Care Holding Area  
Pareto Chart of Contributing Factors**

**Sender and Receiver**



**Total Cases Audited = 229**

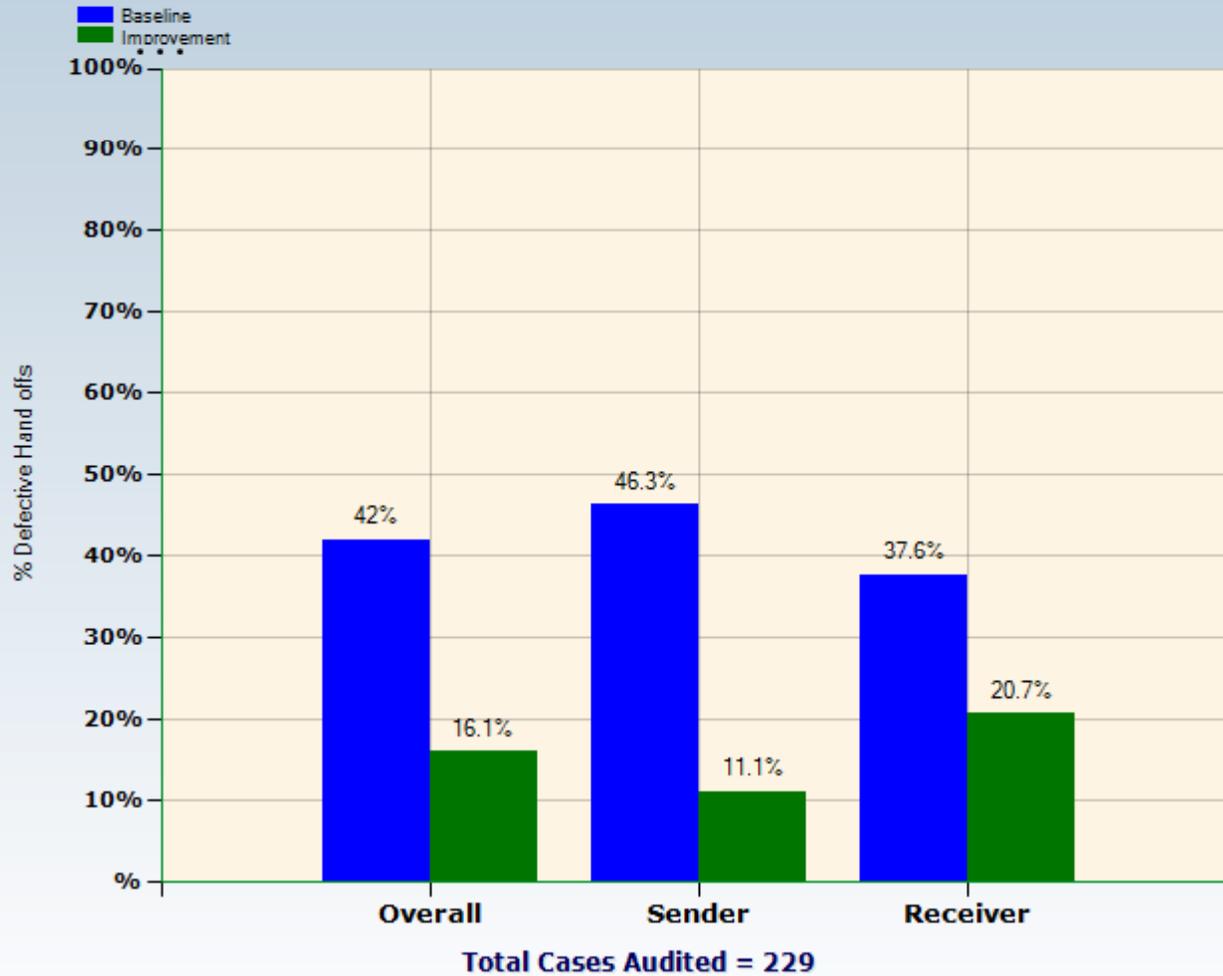
■ Column Series    ● Pareto

**Contributing Factors Audited With No Observed Defects**

Not able to follow up with Receiver    Inadequate staffing    Receiver knowledge



### Mock Test-General Hospital Hand Off Communication Ambulatory Care Pre-op to Ambulatory Care Holding Area Bar Chart of Defects



# TST Step 5: Implementing Solutions

Mock Test-General Hospital  
123 Test  
Villa Park, IL 60181  
HCO ID: 337843

Help Projects Observations Charts Export Exit

1. Getting Started 2. Training Data Collectors 3. Measuring Compliance 4. Determining Factors 5. Implementing Solutions 6. Sustaining the Gains

Home > Implementing solutions > Selecting your solutions

**Targeted Solutions Tool™ - Hand Off Communication for IT TEST / IT TEST** Print this Page

### 5d. Selecting your solutions

43% - Method ineffective

▶ Pick your solutions by checking the boxes in the left column. Click on the links provided under the "Implementation Guide" column to download the corresponding implementation guide.

|                          | Solution      | Description | Implementation Guide          | Rating              |
|--------------------------|---------------|-------------|-------------------------------|---------------------|
| <input type="checkbox"/> | HOC Procedure |             | <a href="#">HOC Procedure</a> | ☆☆☆☆☆ Not Yet Rated |
| <input type="checkbox"/> | HOC Process   |             | <a href="#">HOC Process</a>   | ☆☆☆☆☆ Not Yet Rated |
| <input type="checkbox"/> | HOC Tool/Form |             | <a href="#">HOC Tool/Form</a> | ☆☆☆☆☆ Not Yet Rated |

7% - Not in sync

▶ Pick your solutions by checking the boxes in the left column. Click on the links provided under the "Implementation Guide" column to download the corresponding implementation guide.

|                          | Solution    | Description | Implementation Guide        | Rating              |
|--------------------------|-------------|-------------|-----------------------------|---------------------|
| <input type="checkbox"/> | HOC Process |             | <a href="#">HOC Process</a> | ☆☆☆☆☆ Not Yet Rated |

7% - No standard procedure

▶ Pick your solutions by checking the boxes in the left column. Click on the links provided under the "Implementation Guide" column to download the

Targeted Solutions to Root Cause

# TST Step 6: Sustaining the Gains

Targeted Strategy  
for Ambulatory Care

## 6a. Develop

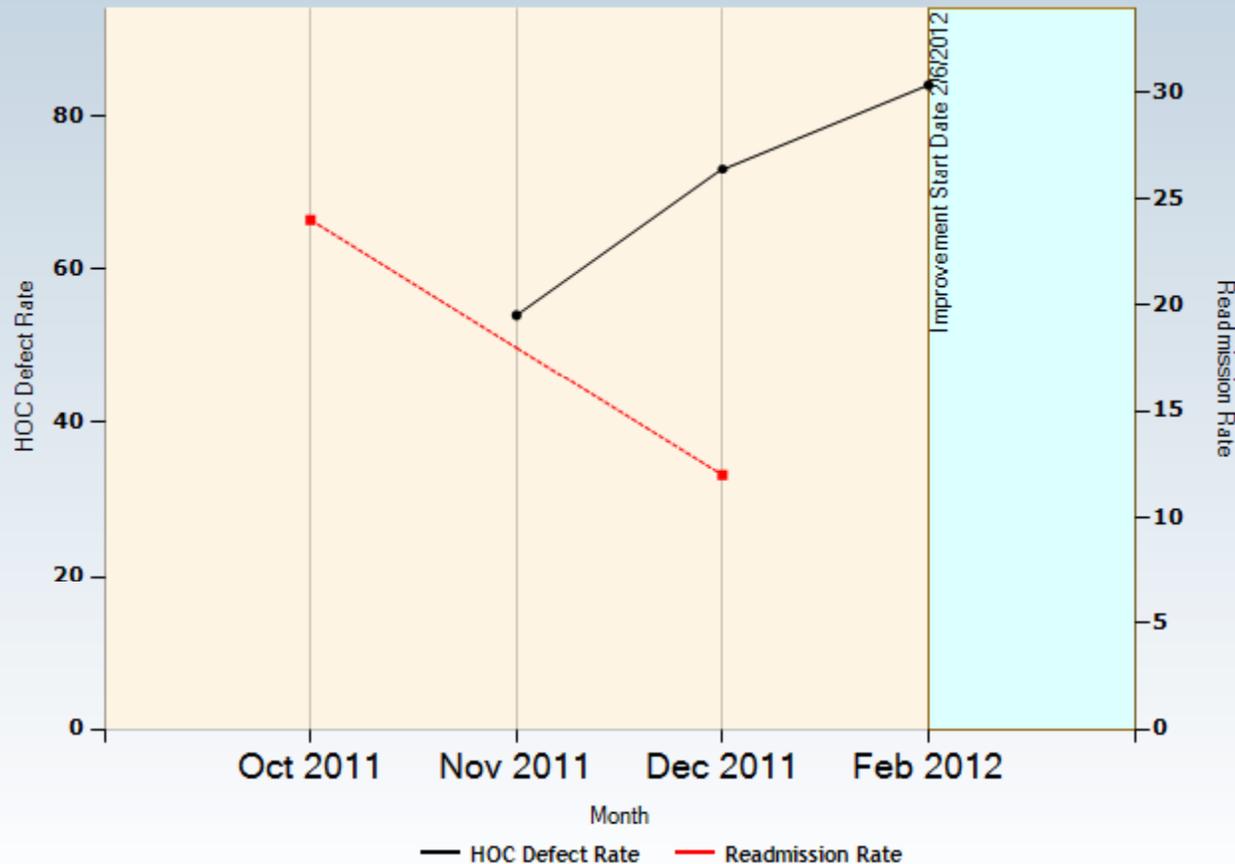
Without a well-thought-out plan, the implementation of the program may not be sustained. The program may revert to past behaviors and the gains may be lost.

Leadership support is a key factor in the success of most successful areas. This leadership support is staff following the project is not just a standard and procedure numbers start to change and how the implementation is sustained.

Continued data collection is needed. The need to collect data is being sustained substantially. How often the week in the

## Mock Test-General Hospital Hand Off Communication

Time Series Plot of HOC Defect Rate, Readmission Rate



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are

# Conclusions



- ▶ Persistent safety issues are complex and multi-factorial.
- ▶ Unless you understand the true reasons why something isn't working, you will constantly struggle to improve it.
- ▶ CTH's approach: data-driven methodology that seeks to uncover the true root causes of failure leading to customized solutions.

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## Hand Hygiene Solutions



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- Hand Hygiene Measures: Expectations vs. Reality
- Main Causes of Failure to Clean Hands
- Identifying Causes, Targeting Solutions

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# **How an Organization's Extranet Security Administrator can Grant Access to Users of the TST**

# Getting Access to the TST

- 
- ▶ The Targeted Solutions Tool (TST) is a secure, password protected, web based application.
  - ▶ To access the TST, you must have a valid login ID and password.
  - ▶ Access to the TST is administered by the designated Extranet Security Administrator at each Joint Commission accredited healthcare organization. Usually, this individual is responsible for the organization's accreditation related activities.
  - ▶ If you do not know who your organization's Extranet Security Administrator is send an email message, with your name, your organization's name and location to:
    - Mr. Tony Cabell [joseph.t.cabell.civ@mail.mil](mailto:joseph.t.cabell.civ@mail.mil) or
    - Lt. Cindy Renaker [cindy.s.renaker.mil@mail.mil](mailto:cindy.s.renaker.mil@mail.mil)
  - ▶ If you are a designated Extranet Security Administrator and you are looking to learn how to grant access to a TST user, please follow the instructions in this video tutorial <http://tjc.s3.amazonaws.com/tst/tsthelp.html> .



# QUESTIONS OR COMMENTS?

