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

April 2013
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Klaus Nether, Master Black Belt and Project Lead

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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

- 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

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

- Key causes different from place to place
- Many causes of the same problem
- Each cause requires a different strategy

Checklists
Protocols
Toolkits or “Bundles”

RPI

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Project 1: Improving Hand Hygiene Compliance

Main Causes of Failure to Clean Hands
(across all participating hospitals)

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineffective placement of dispensers or sinks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hand hygiene compliance data are not collected or reported accurately or frequently</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Lack of accountability and just-in-time coaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Safety culture does not stress hand hygiene at all levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ineffective or insufficient education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands full</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wearing gloves interferes with process</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception that hand hygiene is not needed if wearing gloves</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care workers forget</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distractions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
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

<table>
<thead>
<tr>
<th>Project Selection</th>
<th>Create Solutions, Pilot Test, Build</th>
<th>Spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine Topic</td>
<td><strong>RPI Expertise</strong> Solve with Participating Organizations</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>No RPI Expertise</strong> Pilot Test 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pilot Test 2: Integrate Solutions into TST (Beta-Testing)</td>
<td>Launch TST</td>
</tr>
</tbody>
</table>

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

- 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

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

- Project 6 – Safety Culture

- Project 7 – Preventing Falls with Injury

- Project 8 – Reducing Sepsis Mortality

- Project 9 – Medication Safety: Safe Use of Insulin

Web: 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

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

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.
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)

- Baseline: 26%
- Period: 12%
- Improve: 54% Reduction

Joint Commission Center for Transforming Healthcare

HAND-OFF COMMUNICATIONS
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.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate hand-offs</td>
<td>29%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>30-day readmissions</td>
<td>21%</td>
<td>10%</td>
</tr>
</tbody>
</table>
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
Improving Care with the TST

TARGETED SOLUTIONS TOOL™
TST – Step 1 Getting Started

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.
TST – Step 1 Getting Started

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
- Behavioral Health Care Facility
- Long Term Care Facility
- Home Care Facility
- Other

Enter your sender’s role:

Joint Commission Center for Transforming Healthcare
TST – Step 2 Training Observers

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:
TST – Step 2 Training Observers

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, reinforce training and provide additional time for data collection, and re-test at a later date.

Downloadable training materials/videos & competency exam
<table>
<thead>
<tr>
<th>Date of hand-off (month/day/year):</th>
<th>Time of hand-off (hh:mm):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your role:</td>
<td>☐ Primary physician ☐ Physician designee</td>
</tr>
<tr>
<td>Your unit:</td>
<td>IT TEST</td>
</tr>
<tr>
<td>Did the hand-off meet your needs to continue caring for the patient?</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

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

- ☐ A. The method of communication was ineffective
  - Check all that apply: ☐ Chart ☐ Electronic record
    - ☐ Face to face ☐ Fax
    - ☐ Handwritten ☐ Telephone
    - ☐ Text message ☐ 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: ☐ H&P ☐ Review of systems ☐ Fall risk ☐ Complications
    - ☐ MR# ☐ Code status

- ☐ H. The sender had little knowledge of the patient
TST- Step 3 Measuring Compliance

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 outcomes. 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:
- Sentinel events related to HOC
- Bounce backs
- Readmissions
- Length of stay
- Medication errors
- Patient satisfaction

Outcome Metric (Baseline):

<table>
<thead>
<tr>
<th>Outcome Metric</th>
<th>Percent (Days, %, Hours)</th>
<th>Date</th>
<th>Current Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of stay</td>
<td>12/12/2011</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>
TST- Step 4 Determining Factors

Mock Test-General Hospital
Hand Off Communication
Ambulatory Care Pre-op to Ambulatory Care Holding Area
P Chart of Defect Rate

- Baseline Mean = 0.416
- Improvement Mean = 0.161

Total Cases Audited = 229

NOTICE: It is recommended to collect a minimum of 70 receiver and 70 sender observations over at least a two-week period to best reflect the current state of hand-off communications process.
Mock Test-General Hospital
Hand Off Communication
Ambulatory Care Pre-op to Ambulatory Care Holding Area
Pareto Chart of Contributing Factors

Sender and Receiver

<table>
<thead>
<tr>
<th>Defect Description</th>
<th>Percent</th>
<th>Cum %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interruptions occurred</td>
<td>38</td>
<td>26.2%</td>
</tr>
<tr>
<td>Report information</td>
<td>32</td>
<td>48.3%</td>
</tr>
<tr>
<td>Incomplete/incomplete procedure</td>
<td>28</td>
<td>67.6%</td>
</tr>
<tr>
<td>Incomplete/incomplete procedure</td>
<td>14</td>
<td>77.2%</td>
</tr>
<tr>
<td>No standard procedure</td>
<td>7</td>
<td>82.1%</td>
</tr>
<tr>
<td>Sender knowledge</td>
<td>5</td>
<td>83.3%</td>
</tr>
<tr>
<td>Incomplete/incomplete procedure</td>
<td>5</td>
<td>83.8%</td>
</tr>
<tr>
<td>Receiver knowledge</td>
<td>4</td>
<td>91.7%</td>
</tr>
<tr>
<td>Time inadequate</td>
<td>3</td>
<td>93.8%</td>
</tr>
<tr>
<td>Method ineffective</td>
<td>3</td>
<td>95.9%</td>
</tr>
<tr>
<td>Not able to follow up with Sender</td>
<td>2</td>
<td>97.2%</td>
</tr>
<tr>
<td>Unwanted transfer/transport</td>
<td>1</td>
<td>98.8%</td>
</tr>
<tr>
<td>Lack teamwork/transport</td>
<td>1</td>
<td>99.3%</td>
</tr>
<tr>
<td>npy gap</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Unable to contact Receiver</td>
<td>1</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Total Cases Audited = 229

Contributing Factors Audited With No Observed Defects

- Not able to follow up with Receiver
- Inadequate staffing
- Receiver knowledge
TST Step 5: Implementing Solutions

Targeted Solutions to Root Cause
TST Step 6: Sustaining the Gains

Mock Test-General Hospital
Hand Off Communication
Time Series Plot of HOC Defect Rate, Readmission Rate

- HOC Defect Rate
- Readmission Rate

Month:
- Oct 2011
- Nov 2011
- Dec 2011
- Feb 2012

- Improvement Start Date: 2012

Leadership support is key. Project teams need leadership support at every level to succeed. Most successful improvement projects are start following a series of events. These projects are not just implemented once, but as a standard and practice. Improved metrics are measured, and numbers start to change as a result. Continued data collection and analysis are needed. The need to collect data is maintained. How improvements are sustained and measured is important. How process improvements are measured can be substantially. How changes are sustained can be made to ensure improvements are maintained.
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.
Center for Transforming Healthcare

Hand Hygiene Solutions

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

Learn More

www.centerfortransforminghealthcare.org
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 or
  - Lt. Cindy Renaker 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?