



## **JOINT COMMISSION REQUIREMENTS UPDATE** **January 2011**

### **HAPPY NEW YEAR**

There were relatively few new standards or safety goals to be concerned about as we begin 2011, but that has just changed. As you read last month, medication reconciliation will be scored again beginning in July 2011. The new MS.01.01.01 will be evaluated and scored as of March 31, 2011. The new standards to improve patient-provider communication were announced in *Perspectives* January 2010 and are being evaluated in 2011, but these new elements of performance were not planned to be factored into your accreditation decision until 2012. As part of the Joint Commission's alignment with CMS they are in essence advancing the implementation date for RI.01.01.01, EP 28 although technically they will not score this EP until July. Until July they would score issues relative to patient visitation rights under LD.04.01.01, EP 2 which requires hospitals to be compliant with law and regulations. Our advice is to consider RI.01.01.01, EP 28 in place and effective as of February 18, 2011.

For the most part the entire set of patient provider communication standards are very do-able and to a large extent are already in place in hospitals today. Most clients we visit are already determining the competency of translators and most hospitals are already gathering information about a patients preferred language. Some hospitals may require some policy development to operationalize RI.01.01.01 allowing family members, friends or other individuals to be present for emotional support during the course of stay. You will want to advance your timeline for adopting these policy changes given the announcement from Joint Commission and CMS that will advance when they begin to evaluate this requirement. We would also like to point out one new requirement however that may not be routinely collected in your paper or electronic medical records and that is race and ethnicity. This falls under RC.02.01.01, EP 28 and it is an A element of performance. If you use an electronic medical record it may take some time to develop the data entry screens to collect this information. While the Joint Commission has not defined race and ethnicity in its glossary, the Federal Office of Management and Budget has. Collection of this data is also a requirement under the July 2010 final rule requirements for meaningful use. These Federal requirements for collecting data on race and ethnicity may be found at:

[http://www.whitehouse.gov/sites/default/files/omb/assets/information\\_and\\_regu](http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regu)

[latory affairs/re app-a-update.pdf](#)

Do also take a look at the Joint Commission's publication entitled: Advancing Patient Provider Communication: A Roadmap. It is available on their website at: <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf> This roadmap provides more extensive background about ethnicity, however the meaningful use process appears to create its own standard for how to do this.

In addition to the changes on patient provider communication, the Joint Commission has also just published 11 pages of new elements of performance they are required to implement to stay consistent with CMS on other issues. These may be downloaded from the Joint Commission website under prepublication standards. We will discuss the important changes in this document in our February newsletter.

## ANNUAL REPORTS, PLANS AND EVALUATIONS

Last year at this time we prepared a grid identifying the annual reports, plans and evaluations that should be prepared at this time. We will not repeat that listing; it is available on our website; however you should be scheduling delivery dates for these 2010 evaluations and the revised 2011 plans now. Each plan should follow the classic PDCA cycle, meaning you have the plan, you write an evaluation about how the plan worked and you revise the plan based on your findings in the evaluation. While it is easier for staff to say "no revisions necessary, the plan worked well" we encourage our readers to be sure that really is the case before stating that. Surveyors may look at minutes, drills or other critiques and conclude that the plan really did not work that well. If you take this route, be sure it is the correct route first.

Remember also if you did an "intensive review" or FMEA in 2009 or 2010, then you should also be looking for feedback and analysis about how it worked. Did you genuinely make things better as a result of your effort or are conditions still the same, in which case do you want to reanalyze? Given the new 18 month cycle for a new FMEA in hospitals, don't lose sight of your dates for doing the next one either. This requirement has now been deleted for organizations accredited under the ambulatory care or behavioral care manuals. However, AHC or BHC organizations are still advised to do their year 2 follow up analysis about making things better.

One final recommendation, 2010 marked the first year of the three new NPSGs for Surgical Site Infection, Central Line Blood Stream Infections and MDRO. Embedded within each of these safety goals is the expectation that you evaluate the effectiveness of the program and/or the education you are providing on these subjects as well as report outcome data up to leaders, physicians and others. Based

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on past experience we should expect TJC surveyors to begin scoring this aspect of these three safety goals this year.

We suggest you review the specific goals and have your evaluations and outcome data at the ready. Don't forget to also update your risk assessments for these three NPSGs as the expectation is that risk assessments are conducted "periodically". In Joint Commission language, this means at least annually.

For MDROs, NPSG.07.03.01 EP5 requires you to evaluate the education program provided to staff and LIPs and monitor compliance with your evidence-based guidelines. This is an "A" EP. Providing process and outcome data to key stakeholders and leaders is also an expectation and is also an "A" EP. Similar expectations exist for Central Line Bloodstream Infections and Surgical Site Infections. Hospitals are expected to monitor compliance, evaluate effectiveness of your program and provide data to leaders and others (NSPG.07.04.01 EP4, EP5 and NPSG.07.05.01 EP 4 and EP6)

## **JOINT COMMISSION REVISION TO THE PUBLIC INFORMATION POLICY**

The January edition of Perspectives had a somewhat confusing article on revisions approved by the Joint Commission's Board to their disclosure of accreditation information policy. The boxed insert on page 8, 5<sup>th</sup> bullet point stated: "Joint Commission Quality Reports for each accredited and certified organization include the following information: Standards with requirements for improvement that generated an accreditation or certification decision". This would represent an important new policy change and be similar to the policy in effect prior to 2004. You might remember that the Joint Commission used to disclose standard level findings on their website for each accredited organization. Email discussion with Joint Commission staff since the publication of this article in Perspectives has indicated that the policy change is not as broad as stated. They will be publishing a clarification of the intent. We have been informed that the intent was to disclose standard level findings only when the accreditation or certification decision is adverse. However, the adverse category is now reported to include the new contingent accreditation, preliminary denial of accreditation, denial of accreditation and accreditation with follow up survey. It appears that the content crossed out in this bullet point should not actually have been crossed out. The important point here for our readers is that if you receive a CMS condition level finding, resulting in a Medicare deficiency follow up survey, or other accreditation with follow up survey, that will open up all of your RFI's to public disclosure. Organizations are advised to remember their clarification rights and to appeal Condition level findings

if appropriate. There remains some degree of subjectivity in Condition level findings and if you have any evidence to help mitigate the significance of an issue, it is certainly worth clarifying that issue. We have seen the Joint Commission accept clarifying evidence that was not intended to eliminate an RFI, but was intended to reduce the severity of the finding from Condition level to standard level.

## WASTE ANESTHESIA GAS MONITORING

We saw an RFI at the end of 2010 at standard EC.02.02.01, EP 10, which calls for a hospital to monitor the levels of hazardous gas and vapors to determine if they are in the safe range. There is a note with this EP that states that “law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges.” Most states do not have regulations covering this issue. OSHA however has published a document available online titled: Anesthetic Gases: Guidelines for Workplace Exposure. Section H of this guideline does describe air monitoring for both nitrous oxide and halogenated anesthetic agents. This document may be found on the web at:

<http://www.osha.gov/dts/osta/anestheticgases/index.html>

The CDC and NIOSH have also published guidelines on waste anesthetic gases and they have identified a recommendation for parts per million of these gases permissible for both nitrous oxide and halogenated anesthetic agents. The NIOSH reference can be found on the web at: <http://www.cdc.gov/niosh/docs/2007-151/>

The 2006 AIA Guidelines provide recommendations for OR air exchanges at 15 per hour with 3 outdoor air changes per hour.

We encourage our readers to know where they are with regard to monitoring this element of performance. Although it is not at present a frequently scored issue, it could be a difficult issue if totally neglected.

## CMS SURVEY AND CERTIFICATION LETTER

On December 17, 2010 CMS issued Survey and Certification Letter 11-05-LSC. This letter explained and clarified CMS’s stance on occupancy type. We encourage our

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readers to print and distribute this letter to your engineering staff responsible for updating your basic building information and Statement of Conditions. The full text of this letter may be found on the web at:

[http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11\\_05.pdf](http://www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_05.pdf)

CMS also included a revised version of the State Operations Manual for tag A-0710. We found it interesting that CMS states in the revised State Operations Manual that they do not consider the number of patients receiving treatment or services in determining the occupancy type. They also state that they do not require the health care organization to “render” the patient incapable of self preservation, they just have to be incapable of self preservation. CMS summarized their conclusions in 5 bullet points:

- \* If patients receiving medical treatment or services could potentially be incapable of self-preservation during an emergency, and are provided with sleeping accommodations or treatment and services on a 24-hour basis, the facility must be classified as a Health Care Occupancy.*
- \* If patients receiving medical treatment or services could potentially be incapable of self-preservation during an emergency or receive anesthesia services, but are not provided with sleeping accommodations or treatment and services on a 24hour basis, the component facility must be classified as a Ambulatory Health Care Occupancy.*
- \* If patients receiving medical treatment or services are capable of self-preservation during an emergency, are not provided with sleeping accommodations or treatment and services on a 24-hour basis, and do not receive anesthesia, the facility must be classified as a Business Occupancy.*
- \* Hospital facilities to which patients are not expected to have access (i.e., “customary access”) and are non-contiguous or adequately separated from other occupancies, as required by the LSC, may be surveyed as other occupancy classifications, as determined by the LSC.*
- \* If more than one occupancy classification exists within a hospital building and there is not adequate separation between them, as determined by the LSC, the most stringent occupancy classification must apply to the entire building*

### CLINICAL CONTRACTING STANDARD: LD.04.03.09

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Many organizations we work with still struggle to both understand and implement the expectations under this standard. The first task is to identify which contracted services fall under this expectation. Hospitals often will have one list of all clinical services, including professional services contracts with licensed independent practitioners who are not covered by this standard. Your LIP's receive privileges through the medical staff process, thus they are exempt from this leadership requirement. What remains is non-LIP-provided services such as high tech pharmacy compounding, radiology services technical component, physical therapy, cardiac perfusionist, pace maker interrogation and analysis services, speech pathology and others. If you choose to provide clinical privileges for any of these providers of services they would also be exempt from the LD standard evaluation.

After you have identified and refined your listing of services you want to verify that each contract details performance expectations, each contractor has someone analyzing their performance and each contractor's performance and renewal allows for input from the medical staff.

One persistent question is what should we include as performance expectations? We suggest simple performance expectations in these contracts such as:

1. Contractor will perform and document primary source verification of state licensure in any applicable profession.
2. Contractor will train their staff and validate competencies on at least an annual basis in the tasks assigned by this contract.
3. Contractor will seek and maintain Joint Commission accreditation if it is applicable to their services.
4. Contractor's employees will wear clearly identifiable name badges, displaying the contractors name, employees name, title and applicable profession.
5. Contractor's employees will sign in upon arrival to the hospital using the hospitals vendor registry.
6. Contractor's employees will participate in an brief orientation to the hospital where issues relative to patient confidentiality, medical record documentation expectations, fire safety and infection control will be discussed. This will not last more than 1 hour.
7. Contractor's employees will announce their presence and purpose on any patient care unit or department to the nursing supervisor.
8. Contractor's employees will be subject to visual observation by hospital staff and adhere to hospital policies and procedures as applicable.
9. Contractor will respond in writing within 5 days to the hospital if any patient complaints are received relative to contractor's performance.

Each contract should have a contract manager assigned, essentially the person that says to administration "I want to purchase this service". The contract manager

should fill out a form evaluating adherence to these requirements and any other more specific requirements on an annual basis. The contract manager should validate that the contractor can produce evidence for at least one employee of primary source verification of licensure and annual competency validation. If a schedule can be organized to have these contracts expire in the same month, then once a year a summary should go the MEC and be documented in minutes for their input into contract renewal. If a consistent schedule cannot be organized, then throughout the year these performance reports should be presented to the MEC or other committee of the medical staff for their input.

We recommend avoiding any contractual obligations that require the hospital to spend a large amount of time analyzing data or performing redundant oversight that the contractor should themselves be performing such as primary source verification of licensure. For example some hospitals consider analysis of patient satisfaction data, but in addition to the work involved, volumes may be so low as to not provide meaningful information. Some hospitals choose to redo primary source verification, however since this involves work, you may prefer to make this a deliverable from the contractor that you only spot check.

Lastly you should be prepared to provide your survey team with a listing of clinical contracts. This should be do-able in a short period of time and be ready with other “day one” materials. Surveyors are likely to select one or more contracts to review, to validate that performance expectations do exist in the contract. They may ask to see the evaluation of the contractor’s performance and evidence that the medical staff was afforded the opportunity to provide input. Putting this all together is often a challenge we see on mock surveys, so we encourage our readers to test their process for providing all this information.