



Patton Healthcare Consulting Newsletter May 2016

NEWS FROM TJC - PERSPECTIVES:

New Scoring Logic for 2017

This month's edition of Perspectives is full of important information about changes coming in 2017. The lead article is about an entirely new scoring methodology that will eliminate the A and C elements of performance as well as the direct and indirect categorization of elements of performance. Consultants and some quality staff may shed a tear at the loss of the C elements of performance. If you really understood how to conduct audits, these made for good clarification opportunities and elimination of findings. But farewell to the C elements, it was a good decade. In addition to eliminating the C elements, this also means the Opportunities for Improvement section, or OFI's will also be gone. Next year any one observation against what used to be a C element of performance will now result in a finding that must be addressed in the ESC.

Replacing the existing scoring methodology will be a totally new logic developed by TJC called their SAFER Matrix. It basically is a risk assessment method, looking at the significance of a finding and how widespread the finding is. For example, a failure to time a paper medical record entry in one location, one chart would probably end up as low significance and limited scope within the hospital, thus using the SAFER methodology it would be deemed a low harm finding. This would contrast with a failure to pre-clean surgical instruments being returned to central sterile supply noted in all OR's and all

outpatient locations. This would likely be a high-risk issue with widespread application, thus in the red zone on the SAFER scoring method.

So what will it mean to be scored in the red zone? TJC indicates that a yet to be defined requirement will be created to add detail in the ESC on how the corrective action is going to be implemented and sustained. More practically, as senior leaders examine the report, those findings in the red zone should earn their attention, while those in the yellow area of the matrix might be considered minutiae, subject to more routine attention. TJC also hints that findings in the red zone might be subjected to an on-site validation. The article does not mention how the red zone scoring logic will play into the current method for identification of non-compliant COP's. Given that CMS and TJC have historically used a "manner and degree" logic, it would seem likely that high risk issues/widespread issues will also be COP issues.

ESC Deadlines Change in '17

There is also a change planned for 2017 on the ESC deadlines. Today there are two deadlines, one at 45 days for the direct impact findings and a second at 60 days for the indirect impact findings. Since both direct and indirect EP's disappear in 2017, one deadline for the ESC will be imposed at 60 days for all findings. However, if they do something like an onsite follow up for the red zone findings, it is unknown when such an event might be scheduled, so making corrections sooner than later is advisable. In

addition to only one submission deadline for corrective actions, the measurement phase that occurred for C elements with an MOS due will also disappear. Accredited organizations will appreciate that change, but sometimes the MOS served organizations well by really forcing the corrective action to happen in a quantifiable fashion.

The start date for all these changes will be January 2017 for hospitals and all other accreditation programs. However, the subset of psychiatric hospitals that use Joint Commission for their deemed status as a psychiatric hospital will experience this change effective June 6, 2016. TJC will undoubtedly be publishing additional details on this new scoring methodology, and discussing it in detail in upcoming training programs. It is likely that the seven months of experience with psychiatric hospitals and the SAFER matrix will provide fodder for clarifying and fine tuning of the new scoring mythology. Accredited organizations should be alert to modifications of the proposed model which could go into effect for the January 2017 roll out.

Our consulting clients should know that we are in the process of modifying our scoring tool also to reflect this new process. Since most of the preparatory work we will do in the second half of this year is in anticipation of a 2017 or later survey, we will begin to use this new format by the middle of this year.

Changes to the PDA Process

Perspectives also describes an important change in how they are handling preliminary denial of accreditation decisions, or PDA02. This is a particularly good news story, because TJC has found a way to not drive organizations all the way to a review hearing panel, providing they can quickly correct the issues found on survey. In the past a hospital that had a PDA02 decision had to submit their ESC, had to go through an ESC

implementation verification survey, and had to then convince the Accreditation Committee not to uphold the PDA decision, and if not successful next go to a review hearing panel in Chicago to plead their case. This has become much simpler and less threatening. Now if a hospital has a PDA02 decision they will have to submit their ESC in 30 days, must go through an ESC implementation verification survey, and if applicable must go through their COP level survey in 45 days. However, the really good news is if the hospital gets their act together quickly and they pass these surveys and make the corrective actions, the Joint Commission will change their accreditation status to Accreditation with Follow up, or AFS. That means one more survey at the 4-6-month point to verify that corrective actions are sustained, but you avoid the appeal to the accreditation committee and the in-person review hearing panel. In addition, these new rules will require senior leadership to participate in the intra-cycle monitoring process or ICM. Furthermore, TJC will schedule a telephone conference call with leadership to “review areas of risk and available Joint Commission resources.” We noted the small “R” in resources, so we assume this really means Joint Commission resources, not the Joint Commission Resources consultation services. TJC has many online tools, like the leading practice database and the Targeted Solutions Tool that hospitals make insufficient use of today that may provide helpful guidance in implementing corrective actions. Having worked with many organizations that had this onsite PDA decision, they all made swift corrective actions, but had an anxiety provoking 6-month period working their way through this, and hoping for the right decision from the accreditation committee, which in the past factored in only status at the time of survey, not the improvements. So this is very good news. There is one important additional step in this process; the next full survey will moved up in the schedule (e.g., at the 19— 33 month mark instead of the normal 33-36-month mark from the previous survey

decision) and if that survey should turn out with a PDA decision, its potentially “lights out” as the Joint Commission would up-score a second PDA to DA, or denial of accreditation. Thus the importance of sustainable corrective actions.

Detail on the Deleted 225 EPs

Then there is the detailed article on the deletion of 225 elements of performance from the hospital manual that was announced electronically just before we went to print with our April newsletter. You will want to sit down with this article and cross out the deleted EP’s in your paper version of the standards, and share these deletions with your chapter leaders. Bear in mind some requirements really go away, some are redundant and remain behind stated another way in a second EP, and some remain score-able because they belong to CMS, or NFPA, CDC, or some other reference standard, and thus don’t need to be duplicated in the CAMH. In addition to these selective deletions, TJC is also doing an en-masse deletion of the restraint standards for non-deemed status hospitals. This is very welcomed as searching for the specific EP you want is very difficult given the current redundant state of restraint standards. Now all hospitals, including VA and DOD will use the deemed restraint standards.

Texting Orders Now Acceptable, if:

Perspectives also has an update on texting of orders to the hospital. Essentially TJC will eliminate their prohibition on this practice. However, before you announce this change be sure to share the article with IT leadership and note the new requirements for the security of the text message process. It is not as simple as just using any phone with text capability. The security requirements for the text message process must include:

- A secure sign on process
- Encrypted messaging
- Delivery and read receipts
- Date and time stamp

- Customized message retention timeframes
- Specified contact list for individuals authorized to receive and record orders

The article also points out the need to develop policies and procedures for texting of orders, and to develop methods to ensure that these texted orders are documented in the medical record.

TJC provides additional guidance to do the following prior to authorizing any text messaging of orders:

- Develop and attestation documenting capabilities of their secure text messaging platform.
- Define when text messaging is not appropriate.
- Monitor how frequently text messaging is used for orders.
- Assess compliance with texting policies and procedures
- Develop a risk management strategy and perform a risk assessment.
- Conduct training for staff, LIPs, and other practitioners on applicable policies and procedures.

Lastly the article provides external weblinks to the Federal office of health information technology on security of mobile devices. Clearly you will want to go slowly on this, and proceed only after thorough analysis at your organization. As word gets out from email communication and web summaries, it is likely that this will be a hard issue to control if staff incorrectly concludes previous restrictions are now completely off.

More Consistent Interpretations

This month’s issue of Perspectives is 19 pages long and the “consistent interpretations” article focuses on standard PC.02.01.03 which we mentioned last month is new to the TJC top 10

most frequently scored. There are multiple examples of actual surveyor findings and advice from SIG staff on how or how not to score this observation. Since this standard is now being scored with a high frequency it is worth reading these examples of score-able issues.

CMS UPDATE:

New Rules on Prison Units:

On May 3rd CMS issued Survey and Certification memo 16-21 entitled Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Patients. The implications of this memo may be significant, but the focus is really going to be on billing rules, not clinical practices and thus is outside of our area of expertise. However, if you serve individuals in police custody, patients from department of corrections, or patients under community supervision you will want to share this memo with your CFO for their perspective. Your local DOC or jail may also have interest in this memo because they are in most cases the current payer for these services. It appears that the Federal Government is going to expand access to Medicaid coverage, which DOC and county jails might like, though now being subjected to Medicaid rules concerning patient rights for hospitalized patients in custody might prove unwelcome. One such rule will be that the placement of the patient must be for clinical reasons, not custody reasons, and thus no prison units would be permissible.

For most of our readers this CMS memo will have

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little impact, but for some it may. In particular county run hospitals who share the cost of running the hospital and the county jail may be interested in cost shifting some expense to Medicaid, but you will have to understand the limitations on restrictions of patient rights.

CMS Adopts 2012 LSC, Finally

The other important change announced by CMS is the planned adoption of the 2012 Life Safety code effective July 5th 2016. This was not announced in an SC memo, but rather in the Federal Register. This has been anticipated for some time now and there are features in the 2012 LSC that hospitals looked forward to and have selected to adopt early that are covered by CMS waivers. These waivers should become moot once the 2012 is officially approved in July. We have not yet seen any analysis that points out any significant downside, but we would suggest being on the lookout for analysis that will likely come from ASHE, from health law attorneys, and engineering consultants. We noted a brief analysis from a former TJC colleague Sue McLaughlin and her team from MSL that provides a summary of the changes that are most pertinent. This can be viewed at: <http://www.mslhealthcare.com/msl-blog/2016/5/4/2012-life-safety-code-adopted-by-cms>

There will likely be a Perspectives or EC News article on this in the coming months also. At this time, just make sure your facilities staff has a copy of the 2012 LSC.