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PHC NEWSLETTER

Patton Healthcare Consulting, INC

News from Joint Commission and CMS

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PERSPECTIVES:

New Pain Management Standards:
The lead article in this month's edition of *Perspectives* is about their revised pain management standards. These take effect January 1, 2018 and to be ready it is best to start now on implementation. There are 7 leadership elements of performance relative to pain management including the following new requirements.

1. Establish or identify a leader or leadership team that is responsible for pain management and safe opioid prescribing and PI activities.
2. Provide nonpharmacologic pain treatment modalities
3. Provide staff and LIP's with resources and programs to improve pain assessment and management.
4. Provide staff and LIP's consultation or referral resources for patients with complex pain management needs.
5. Identify opioid treatment programs that can be used for referrals.
6. Facilitate practitioner and pharmacist access to the Prescription Drug Monitoring Program databases that are maintained in your state.
7. Leadership works with clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.

There is also a new medical staff EP, MS.05.01.01, EP 18 that requires the medical staff to be actively involved in pain assessment, pain management, and safe opioid prescribing by establishing protocols and quality metrics and reviewing PI data. There are then corollary requirements at PI.01.01.01 and PI.02.01.01 to collect data on pain assessment and pain management including the types of interventions and effectiveness. EP 18 at PI.02.01.01 then requires the hospital to analyze the data on pain assessment, pain management and to identify the need to increase safety and quality for patients. Then EP 19 requires the hospital to monitor the use of opioids to determine if they are being used safely including the tracking of adverse events such as respiratory depression, naloxone usage and the duration of opioid prescriptions.

The existing Provision of Care standards at PC.01.02.07 are modified, deleting the existing EP 1 comprehensive pain assessment expectation and replacing it with a requirement to have defined criteria to screen, assess and reassess pain that are consistent with the patients age, condition and ability to understand. This requirement does have a D for documentation. EP 4 of this standard then establishes a need for a pain treatment plan and pain management goals. This too must be documented. EP 5, another D, requires the patient to be involved in the treatment planning process by developing realistic expectations and measureable goals, discussing the objectives and providing education. EP 6 then requires that patients identified as being at high risk for adverse outcomes. EP 7 discusses required reassessment activities and there are 4 bullet points, each of which must be documented. These are:

1. Evaluation and documentation of response to pain interventions
2. Progress toward pain management goals including functional ability
3. Side effects
4. Risk factors for adverse events

Lastly EP 9 requires the education of the patient and family on discharge plans related to pain management including 4 bulleted items. These are:

1. Pain management plan of care
2. Side effects of pain management treatment
3. Activities of daily living including the home environment that might exacerbate or reduce effectiveness of the pain management plan of care
4. Safe use, storage, and disposal of opioids when prescribed

As you can tell from this summary, getting this up and operational by January 1, 2018 will require some work thus it is critical to being your efforts ASAP. The leadership team might be an existing multidisciplinary group like your pharmacy and therapeutics committee, or if you have pain management specialists or a department, you might want to form a new group using them as a resource. Providing educational resources and programs on pain management might be grand rounds, webinars, podcasts or some new resource on your hospital intranet. Consultation needs might be met if you have pain management specialists, or if small and rural you might need to consider a telemedicine resource. Urban areas should be able to identify opioid treatment and referral opportunities for referral, but again this may be more challenging in small and rural areas, or wait lists in urban areas. The facilitation of access to state operated prescription drug monitoring programs sounds like a good idea. We see that occasionally on consults, but not often enough. A place to start may be a review of the work done by the VA including their clinical practice guidelines for chronic pain and their support of complementary and integrative healthcare (CIH), including the biopsychosocial model of pain care.

The new medical staff and performance improvement expectations will require some thoughtful analysis to determine what you want to measure and how you will display or present the data so that it is meaningful. In this case if might be your pain management leadership person or team presenting to the medical executive committee periodically.

The provision of care standards will probably require some EMR refinements and these always take time to implement. If you don't already have one, you will want to template a treatment plan goal for pain management. Development of your educational content and formatting on the educational log may take some time along with space to document monitoring of progress on the plan of care. EP 6, the one that requires patients who are at high risk for adverse outcomes being monitored is an interesting one. Three years ago, CMS had sent an SC memo 14-15 that in some respects was similar to the Joint Commission's Sentinel Event Alert on safe opioid use, but CMS called for assessment of

patient types at greatest risk for adverse effects of opioids including the elderly, those with long surgeries and anesthesia, the opiate naïve and the opiate addicted. One element of CMS's advice at that time was to identify and use capnography monitoring on those at highest risk. This is one monitoring technique we seldom see used outside of the anesthesia setting and thus it may require purchase of additional equipment if use is expanded to other areas.

4 Tricky Life Safety Clarifications — Door Inspections, ED Occupancy Type, Door Ratings, & Fire Drill Timing Patterns:

Perspectives includes another in the series on Clarifications and Expectations, this month discussing LS.02.01.30 including existing requirements and potential new requirements effective January 1, 2018 which are still in negotiation between CMS and TJC. There is also a second article clarifying 4 LSC requirements. The first clarification is that emergency departments can be classified as either a healthcare occupancy or ambulatory occupancy (but not a business occupancy). This may be a concern for those organizations that have remote emergency departments. The second clarification is on the annual door inspection process required by EP 25 in EC.02.03.05. The new information is that this annual door inspection process must have been completed by July 5th, 2017 although that was not published in the manuals at the beginning of the year. The third clarification we have written about previously and that is on doors that are rated for more than the barrier being maintained. For example, if a fire door is placed in the hallway instead of a smoke door, when all that is required is a smoke door. This door must be maintained as a fire door and inspected as a fire door, unless you remove those features that make it a fire door. The 4th clarification is about fire drills and ensuring they are at different times and varying conditions. TJC advises at least one hour between drills but also to avoid creating an identifiable pattern. We are seeing this issue scored very frequently as surveyors are identifying patterns you may not be aware of. We would actually suggest you use a random number generator to create your times, and to retain your random schedule to verify it was indeed randomly chosen.

As we suggest, each month these EC/LS articles should be shared with facilities leadership, then discussed and analyzed for implications for your hospital.

New Behavioral Health Standards:

Some standards revisions, which take effect 1/1/18 in the behavioral health manual, were announced in this month's *Perspectives*. A fifth EP was added to CTS.02.01.03 which will require behavioral health organizations to reach out to other providers of behavioral or physical healthcare services when "clinically relevant." Furthermore, when it is not possible to obtain the information organizations will be required to document the reason why it could not be documented. The difficulty with the wording is "clinically relevant" is subjective and the clinical team "treating the patient" may have a different definition for each surveyor.

CTS.02.01.11, EP 1 has changed from just requiring a nutritional screening to now requiring a nutritional screening that, at a minimum, touches on 5 different screening issues including food allergies, weight loss or gain of more than 10 lbs. in the last 3 months, decrease in food intake or appetite, dental problems and eating habits or behaviors that may be indicators of an eating disorder. For those readers who use an EMR, this may require some modification to your existing screening questions or prompts.

CTS.05.05.09, EP 1 will now require anyone applying a physical hold on a child to be an authorized individual and policies and procedures should state this. CTS.05.06.35, EP 18 will now specifically require a debriefing after use of a physical hold on a child. RC.02.01.05 establishes the documentation expectations after each episode of a physical hold and that will include 14 specific data elements to be addressed. Organizations using either paper or and EMR will want to prepare a template document for staff to be able to make all of this very specific documentation.

Sterile Product Preparation:

The last item we wanted to mention from *Perspectives* you quite likely did not notice in your review and that is a small announcement on page 2 that new standards for medication compounding have been approved for the home care program. This is very significant and we are already seeing a huge impact on surveys as a result of these new standards and level of expertise on the part of surveyors. We had mentioned the availability of the new medication compounding standards for the voluntary certification program several months ago and these new home care requirements appear identical,

but with a different numbering scheme. The importance of the certification requirements for home care is that the Joint Commission now has detailed expectations for sterile product preparation and they have created a cadre of expert surveyors to conduct this analysis. If one of these experts is assigned to your survey team (a "compounding specialist") they can identify potential flaws in your sterile product preparation because of their detailed knowledge about USP 797 and other chapters from USP. In fact, the new standard MC.02.01.01, EP 2 references 16 different USP chapters dealing with sterile, non-sterile, hazardous drugs, and many different settings and conditions that look like this could become every bit as complex as understanding all the AAMI requirements, or NFPA manuals and their requirements.

You might think, I don't have to worry, I don't have home care. However, one of the pharmacists trained to conduct these surveys may be assigned for a different reason which might include TJC awareness that you perform high risk compounding, complaints, sentinel events or just the fact that you are a large teaching hospital. If you have home care pharmacy services and one of the skilled surveyors is assigned to review this program, remember that surveyors work as a team and they may assist the hospital team with evaluating sterile product preparation organization wide. We have recently seen some examples of how thorough these surveyors are in evaluating sterile compounding and it is way-more detailed than we have seen before in evaluating sterile product preparation.

At this time, the prepublication version of the home care standards is available to download from the Joint Commission website under the Standards Tab, prepublication standards section for home care. Regardless of whether you have home care or not; we would encourage you to download the standards and self-assess your own organization against these new standards. There is clearly a developing expertise and rigor at Joint Commission on sterile compounding and it is very different that we have seen previously.

Ligature Risks, Again:
Hospitals appear to be getting hammered on this issue regardless of mitigation strategies or screening for patient risk levels. The only mitigation strategy we are seeing them accept is one-to-one supervision for every patient at any level of suicide risk. There clearly is a lot of confusion as we have seen hospitals use what they call "suicide precautions" as their lowest risk category with patient checks in place every 15 minutes, followed by line of sight observation for the next level, then one-to-one as their highest risk category. Unfortunately seeing the term "suicide precautions" can be perceived by the surveyors as high risk. At this time, the only advice we can provide is make the patient bedrooms and bathrooms safer and use more liberal application of one-to-one until there is greater clarity. TJC has designed a very thorough set of instructions for surveyors that describe stratification of risk similar to the methods used in the FGI Design Guide for the Built Environment. However, at present TJC appears to be hitting potential hazards in group rooms and hallways with equal vigor. We hope that this changes overtime since these potential hazards are more easily mitigated through routine staff supervision and observation. We have learned that TJC has established a task force to help provide clarity on priorities, but if you are surveyed prior to their completion of recommendations and CMS/TJC acceptance of any such recommendations this can be a nightmare on survey.

EC NEWS:

Active Shooter Recommendations and Resources:
EC News duplicates much of the content we already spoke about from *Perspectives*, however their lead article is thought provoking on active shooter situations in hospitals. This article provides 8 solid recommendations and a table of resources and references from Joint Commission, Homeland Security, FBI, AHA, CA Hospital Association and UCSF. Given that just last week we had an active shooter in a New York Hospital, it is a good subject to conduct an emergency management drill and to be better prepared for.

CMS UPDATE:

New S&C Memo on Filling Your Own Saline Syringes:
CMS had a productive month in terms of publishing new Survey and Certification memos but the content of these memos should not pose a significant challenge to our readers. The first memo was 17-31 addressed to ESRD facilities about not filling saline syringes for patients from a large volume saline bag. Apparently, CMS surveyors have noted staff filling syringes of saline from a hanging IV bag and that should never be done. Saline syringes should be purchased from a manufacturer, not

filled from a saline bag, which is a single dose package according to the FDA and a potential source of contamination if drawing from a bag already hanging on a patient.

New S&C Memo on Cleaning Dialysis Equipment After a Patient Leaves the Space:
The second memo 17-32 is similarly simple and also addressed to ESRD facilities stating that cleaning of dialysis equipment, surfaces, tables, chairs, etc., should not begin until the patient has vacated the location. Again, CMS has reportedly seen staff starting their cleaning activities while the patient is still present and could potentially re-contaminate something.

New S&C Memo on Screening for Hepatitis C:
The third memo, also addressed to ESRD facilities discusses that CMS will not cite ESRD facilities for a failure to screen for hepatitis C. They indicate that hepatitis C should be considered based on elevated liver enzymes, in particular ALT, but that routine screening is not required.

New S&C Memo on Revisions to the 2567 Completions Process:
The fourth memo talks about the 2567 that hospitals receive as their statement of deficiencies and the elimination of the requirement to type the corrective action on their form, right hand column near the citation itself. CMS is going to eliminate that placement requirement and you can address the deficiencies in a separate document. This 2567 form has been a burden for many years, but a type-able PDF would have been a preferable solution. There is some risk that a redundant or repetitive finding cited under different COP's might be missed if you are not documenting corrective actions next to each finding.

CONSULTANT CORNER

Please note that we do not publish an August PHC Newsletter, as this is a month many are focused on summer vacations. We will publish again in September with a longer issue. Enjoy the rest of your summer!

Thank you,

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