OCTOBER 2019
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

ORYX 20-Year Anniversary:
There is really nothing new and burdensome announced in Perspectives this month. The lead article is recognizing 20 years of using ORYX performance measures in the survey process, but we doubt any readers are celebrating this anniversary. The article includes some comparative data for 2017 and 2018 on ED measures, inpatient psychiatric measures, perinatal measures, VTE care, immunizations, tobacco and substance abuse care and the good news is that in general you see improvements in the data in that year to year comparison. It would be more interesting to see the change over a longer period to actually recognize and celebrate that the mandatory collection of standardized measures has led to national improvements.

Eliminating Redundancy:
There is also an article about eliminating some redundancy between the laboratory and hospital surveys. TJC is proposing to evaluate selected standards only during the hospital survey and not repeat that evaluation during the lab survey. This certainly makes sense and will affect some EC, IC and TS standards. It is important to note that this redundancy reduction is optional, meaning you have to request it during the application process. We assume everyone will want to avoid the duplication of effort, so remember that the next time you update your application to be on the lookout for the screen to request this change.

Heads Up – Nursing and Home Care:
TJC also announced a new "Heads Up" report for accredited nursing care centers and home care agencies. This report is reported to contain important topics that surveyors are citing, along with information on why these issues are being scored. This sounds valuable for learning, so we went to a home care agencies extranet to view the report, but

unfortunately the promised September edition is not yet posted. So, home care and nursing care center clients should keep their eyes open for this report when it is posted. It may be something worthwhile for all accredited programs.

ASC Dashboard:
Similar to what was reported above for home care and nursing care centers, TJC has announced the creation of a dashboard for accredited ambulatory surgery centers that will pull in selected CMS Quality measures for ASC's so that the organization can compare their performance with nationally reported data. This dashboard is supposed to be available at the end of September.

EC NEWS

Relocatable Power Taps:
The lead article in the October issue of EC News is about relocatable power taps. TJC points out that this issue has already been scored 319 times so far this year. We see these power strips continuing to "pop up" in hospitals meaning one of two things: Either they have never been identified, inspected and removed as necessary, or someone is sneaking new ones into the hospital after the offending items have been appropriately removed. In most organizations this is likely to be the former issue, meaning not all the relocatable power taps have ever been identified and inspected to determine if they are the correct type, placement and use. The Joint Commission has two elements of performance addressing this issue under EC.02.05.01, EP 23 and EP 24.

EP 23: Power strips in the patient care vicinity are only used for components of moveable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non-patient care rooms, power strips meet other UL standards.

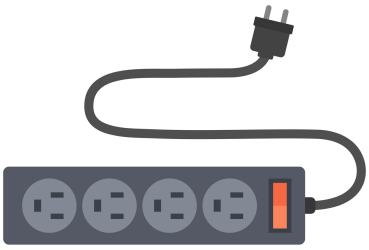
EP 24: Extension cords are not used as a substitute for fixed wiring in a building. Extension cords used temporarily are removed immediately upon completion of the intended purpose.

So, EP 23 establishes three requirements based on location, either the vicinity of the patient, elsewhere within the patient room, and elsewhere within the building. In each instance the power strip must meet some specific standard from Underwriters Laboratory. We suggest that the first step toward getting a handle on this issue is a building wide search, an inspection of what has been located, creation of an inventory, and some clear, legible marking that can be made known to all staff that this power strip has been inspected and it is appropriate for its current use.

While your facilities team makes periodic inspections of patient care areas, those staff don't spend as much time in the area as clinical staff so perhaps we need to find a way to incentivize clinical staff to help find the power strips in use. Hospitals use competitive, fun activities all the time to accomplish otherwise mundane tasks. How about an award, recognition, or hospital funded lunch for the unit or team that identifies the greatest number of power strips?? Then you can pass the locations to the facilities team for inspection and some large bold hospital marking of those that meet acceptable use and removal/replacement of those that don't.

After you find and inspect all the power strips in use, the remaining hurdle is preventing new and inappropriate strips from entering the hospital, and relocation of existing power strips to a new use that no longer meets criteria. Now we are going to need some policy guidance and coordination with the purchasing department to prohibit the purchase of any power strips by anyone other than facilities. In addition, you will want a policy prohibiting clinical staff from relocating or repurposing any power strips in patient care areas.

EC.02.05.01 has been in the top ten most frequently scored standards for several years now, so it is clear that current methods are not working effectively to identify and remove those power strips that are not appropriate. Having clinical staff team up with facilities to get a better handle on all the power strips may help eliminate this common pitfall.



USP 797 Delay:
The October EC News also has a nice article on USP Chapter 797, but since the publication in EC News, USP has announced a delay in the implementation date for Chapters 797 sterile compounding, 795 non-sterile compounding, and 825 radiopharmaceuticals. USP is going through an appeal analysis and at present it is thought that official implementation will not take place before the end of the first quarter 2020.

USP Chapter 800 on hazardous drugs is not subject to appeal right now, but essentially enforcement is delayed until 797 is official. Regardless of delays, the article provides a nice overview of the environmental

requirements that is excellent for staff from facilities, hospital quality, and administrators to gain additional insight into these requirements.

Medication Compounding Certification Program:
There is also a boxed "plug" for the Joint Commission's Medication Compounding Certification program. Obtaining such certification would of course be a great preparation for your hospital survey, but there is also an offer in the advertisement to access and review the MCC standards free of charge right now. This is a great opportunity for hospitals to understand what TJC is looking for and what TJC has focused on from USP Chapter 797. Hospitals have very little guidance at this time to understand what TJC is looking for relative to sterile compounding other than absolute compliance with USP Chapter 797. The USP book as a narrative document is much more difficult to identify the "must do's" than is the TJC element of performance format. In our September newsletter we had also pointed out the value of reviewing the most frequently scored standards in the MCC manual. Unfortunately, most hospitals do not have access to those standards, and this link can provide that access for free for a limited time.

USP 797 Track Record:
The USP appeals process provides a delay and some breathing room for organizations that were slow to implement the published changes. Although no one should do it, we still find many organizations that plan out their improvements and implementation of new requirements in light of their anticipated survey date. Those who are not due for survey until late in 2020, or even 2021 may not have been pressing to implement all the new aspects of USP Chapter 797 on 12/1/19. Now you have more time to get ready so we would advise making use of the time now to complete needed changes.

Environmental Surface Sampling:
One important pending change is the required frequency for environmental surface sampling, which moves from every six months to every month. Many organizations today have the vendor who certifies their hood conduct air sampling and surface sampling during the 6-month recertification. That can still work for air sampling because that will stay on a 6-month schedule, but it may no longer work for surface sampling due to cost or vendor workload. Hospitals are faced with a decision to either have their vendor come every month to conduct surface sampling or to develop their own internal program for sampling, incubation, and analysis. You will want to go through the analysis of cost and quality now to determine if you want to purchase this service or establish the infrastructure to being it in house. If you plan to use a vendor, do discuss their ability to staff up to meet this new demand as they may get inundated with the additional new work.

Also, remember that whenever USP resets the date for official implementation, you will want to make sure you are up and running with your monthly surface sampling on or before the official implementation date. This is one area that will be noticeable and potentially scored deficient due to insufficient track record if you do not start on time. Surveyors routinely look back 12 months for standards evaluation. If USP 797 goes into effect April 1, 2020 and you are surveyed a year later in April 2021, you will want to have 12 months of data to show them.

EXECUTIVE BRIEFINGS

This past month, Joint Commission presented its annual Executive Briefing sessions in different cities around the country. As always, this was a good refresher, an update on the most frequently problematic standards, and insight into some future potential directions. There were no immediate policy direction changes announced that we need to warn you about. There was some information shared about medication titrations that sounded "customer friendly" but did not seem consistent with issues we see TJC scoring on survey, thus we will not comment until we see them published in Perspectives or a FAQ.

FDA

Disposable Duodenoscope Components:
At the end of August, the FDA published an electronic advisory suggesting that organizations transition to duodenoscopes with disposable components. The FDA advises that these newer scopes with disposable components are more easily cleanable. FDA again recommends monitoring through sampling and culturing surveillance. They indicated that they continue to find higher than expected levels of contamination with the fixed endcap scopes. FDA also introduced a new acronym for everyone to learn called RIFU. This is a new flavor of IFU meant to represent reprocessing instructions for use.

This FDA advisory can be found at: https://www.fda.gov/medical-devices/safety-communications/fda-recommending-transition-duodenoscopes-innovative-designs-enhance-safety-fda-safety-communication

We encourage readers to download this FDA notice and to share it with GI lab staff and infection prevention for analysis and discussion.

CMS

Rural Health Clinics & Emergency Medications:
CMS published QSO-19-18 on September 3, 2019 addressing rural health clinics and emergency medications. In the text of the memo, CMS also mentions that these requirements will apply to Federally Qualified Health Centers, or FQHC's. CMS identifies five categories of drugs that rural health clinics should have for "common lifesaving procedures." These include:

1. analgesics
2. local anesthetics
3. antibiotics
4. anticonvulsants
5. antidotes, emetics serums, and toxoids

CMS states that while each category of drugs must be considered, all are not required to be stored in the rural health clinics. For example, CMS states that it may be appropriate for a rural health clinic to not store a particular snake antivenin if you are located in a part of the country that does not experience this poisonous snake. CMS further advises clinics to analyze their community history, medical history of its patients, and accepted standards of practice. Furthermore, the clinic should have policies and procedures for determining which medications are going to be stored and address the process and individual(s) responsible for making this determination. Lastly, the RHC should be able to provide a complete list of drugs/biologicals that are stored and in what quantities.

While many hospitals own rural health clinics, CMS has its own standards for evaluating the clinic in isolation. Your hospital pharmacy might be responsible for providing medications to the clinic and your emergency management team might be including them in the EM plan. But to satisfy these requirements, you will want to:

- Analyze process to determine which medications in these five categories will be stored and what quantities must be available.
- Identify an organizational leader as the responsible individual for leading the analysis effort.
- Develop a policy and procedure for creating your emergency drug list and a process to tickler it for re-review each year.
- Make sure you actually maintain the par levels of the emergency drugs that you identify in your list at the rural health clinic.
- Identify your par levels of these emergency medications in the RHC in a stand-alone document.

CONSULTANT CORNER

Dear Readers,

We are delighted to introduce and welcome Christi Chavez, our new Director of Operations! Christi brings nearly fifteen years of healthcare accreditation and regulatory readiness experience. Recently, Mrs. Chavez served as the Accreditation Manager for Rush University Medical Center in Chicago where she was both a client and colleague. Prior to that, she held a project manager role at Access Community Health Network. Christi received her Bachelor of Healthcare Administration degree from Texas State University, and her MBA from Dallas Baptist University.

Christi joins Jen Cowel, Kurt Patton, John Rosing, and Mary Cesare-Murphy as a client coordinator and will be a point of contact for many of you. She has been in the same role as many of you are now and is uniquely qualified to partner with you in all phases of accreditation and regulatory compliance.

She will be an excellent addition to both our team and your organization. Please join us in welcoming her! Christi can be reached at CChavez@PattonHC.com.

Thank you,

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