JANUARY 2020
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

New Dissemination Policy:
We hope that everyone had a pleasant holiday break and have now returned, ready to implement whatever changes The Joint Commission and CMS can send our way. We usually start off discussing the lead article in Perspectives, but this month we want to first discuss what we believe may be the most important article, which begins on page 19 of Perspectives. The Joint Commission is substantially loosening its dissemination and copying policy relative to Perspectives. The old policy is actually still printed on the last page (p. 30) of Perspectives, and it sounds very legalistic and somewhat threatening regarding duplication. The new policy will permit accredited organizations to copy and internally distribute articles or even full copies. You can even post copies to an organization-based intranet.

We believe this will be helpful for those readers who were hesitant to do so previously. We often provide advice about making sure different department heads review and react to specific content in Perspectives. The Joint Commission is now removing any limitations on an accredited organization from doing exactly that. Remember that when you send to a specific department head, or content expert a specific new article, it should not just be as an FYI. You will want specific feedback about implementation, current or future compliance, planning meetings, or changes needed.

TJC is also making it easier for staff within the organization to obtain their own full copies of Perspectives using a new website for Guest Access. This will no longer require specific authorization as long as staff are using their email address within the organization.

Safety Goal Changes:

The Joint Commission is making changes to the National Patient Safety Goals effective July 1, 2020. But the good news is there are no new additions, there are only some planned transfers of requirements from NPSG to standards. These planned changes only affect the hospital accreditation program. They plan to move the following safety goals to standards, under IC.02.05.01:

- NPSG.07.03.01 MDRO
- NPSG.07.04.01 CLABSI
- NPSG.07.05.01 SSI
- NPSG.07.06.01 CAUTI

TJC feels comfortable in moving these high priority issues from safety goals to standards due to their examination of survey results, which indicates that hospitals have effectively implemented these important requirements, all of which (with the exception of CAUTI) have been around for a more than a decade. Remember these safety goals are moving to standards, but they are not being eliminated. They will still be assessed during infection control and patient tracers and scored in the IC chapter if appropriate.

Public Reporting:

Perspectives announced that later this year, TJC will begin to publicly report PC-02 and PC-06 to Quality Check. The data for PC-02 will be a rolling two-year analysis providing there are more than 30 cases to analyze. In addition, the reporting will not be raw data, but rather whether you are meeting a benchmark figure or not meeting a benchmark. For example, PC-02, the cesarean birth measure will be reported publicly if the rate in either a one year or two-year period exceeds 30%. The display will be a (+) sign for those organizations with an acceptable rate less than 30% and a (–) sign for those organizations with a rate exceeding 30%, considered unacceptable. PC-06 will be a percentage of infants with unexpected newborn complications for full term infants with no pre-existing conditions.

New BHC Standards:

TJC announced new standards for substance use disorder treatment effective July 1, 2020 for organizations accredited using the behavioral health accreditation manual. If you are accredited using the BHC manual and you provide this service, you will want to go to the Joint Commission's Standards Prepublication page to download a copy. If you have not navigated the Joint Commission's new website it may take you some time to find the appropriate posting. Here is the link to the prepublication page:

[redacted]

Once you land on this page, scroll down to the Substance Use Disorder announcement. The changes are all in the CTS chapter. Organizations accredited using the BHC manual and providing this service will want to rapidly analyze the new standards, perform a gap analysis vs current practices, and begin planning implementation prior to July 1.

There are some new assessment documentation requirements such as CTS.02.03.07, EP 1 requiring gathering information about the method of acquiring substances the patient was using and the specific frequency, amounts, and route that these substances were taken. There are also some training requirements that may take time to implement such as in CTS.04.03.35, EP 5 which will require opioid treatment programs and Medication Assisted Treatment programs (MAT) to have staff trained in CPR, management of overdose, management of medical emergencies, and other relevant techniques. By the time readers are seeing this announcement there are really only five months left to implement, so starting as soon as possible is essential to get these changes implemented.

Medication Orders Changes:

TJC has proposed revisions to MM.04.01.01 posted to its website under Field Reviews. The proposed changes can be found at:

[redacted]

This standard establishes requirements for medication orders. The proposed additions help formalize the expectation for titrations that Joint Commission has been scoring for the past five years. This will be very helpful as organizations initially struggled to understand the details surveyors were looking for and to find guidance on what the expectation really was.

This was explained in a detailed article in Perspectives after heavy scoring started, and these proposed changes look like they will further clarify in one place what the requirement really is. In the proposed changes TJC also makes it clear that organizations should have policies regarding enhanced safety strategies for ordering of medication that have been identified as a potential look alike, sound alike danger.

So, take a look at the field review questions and respond to their survey if you have feedback for TJC. This is your opportunity to help shape or clarify any remaining ambiguities before the standards are finalized. The deadline for feedback is February 3, 2020.

Consistent Interpretation:
This month's column identifies six different standards where some performance gap in water management can be scored. Several of these standards are scored at a relatively low frequency, however EC.02.05.05, EP6 requiring inspection, testing, and maintenance of non-high-risk utility systems has been scored in over 60% of hospital surveys in the first half of 2019. The detailed guidance may cause this one EP scoring rate to diminish, while causing several others to go up. The specific EP where surveyors score a deficiency means far less to accredited organizations than it does to surveyors and SIG staff.

Do take a look at the Surveyor Observations column to see the wide array of things that can be scored relative to water management. These should be distributed to your Environment of Care Committee or other group handling this issue and a gap or vulnerability analysis conducted to determine your risk points. The risk points are two-fold, one for potential scoring and a more important second risk point in actually allowing a water borne infection to spread in your organization.

FAQs:
With the recent redesign of the Joint Commission website we noticed that there is now a date last modified next to each FAQ. We had been critical of this not being there, because they could tweak an FAQ and change the intent without anyone easily noticing. We also have mentioned our and our clients' dissatisfaction with disappearing FAQs, or important interpretations that are taken down, again without anyone noticing. Well that appears to have a solution in their redesign also.

There is now a link to print or print to file all the FAQs into one document that you can retain. Comparing what is currently posted with your stored document will enable you to see the missing or the changed. There will be a little bit of work involved to save these, perhaps quarterly, but it may be useful down the road. Here is the link to being able to print or print to file all the FAQs:

[redacted]

Thank you to The Joint Commission for this refinement. This only leaves us one remaining issue to suggest to the Joint Commission about on the FAQs and that is to review all FAQs over two years old. If the standard or EP is not clear and is still causing multiple organizations to ask for an explanation, we suggest they change the EP the following year to make it clearer.

EC NEWS

EM Exercise:
This month's EC News has a lengthy and very helpful article on Developing a Full-Scale Emergency Management Exercise. The author lays out a 7-step process for planning a full-scale exercise.

Step one is identified as conducting your hazard vulnerability analysis. When you perform the HVA you identify and rate the probability and impact of various types of disasters along with your readiness to manage these situations. The author reminds us of the need to include what CMS calls "emerging infectious diseases" such as Ebola or Zika, and to consider job actions such as an organized labor strike in the HVA.

The second step is to select a scenario and you use your HVA to do that, too. Your likely disasters along with your readiness to manage them were factors in the HVA, so pick a likely one that perhaps you are not fully prepared to deal with and test your capabilities. In fact, the author suggests outlining a multiyear plan from the HVA and test and improve each one selected over time.

The third step is formulating an EM planning team and you likely have one already. Here the author suggests selecting team members who have expertise in the six critical areas identified in the standards, which will help you to prepare for all six critical areas and to evaluate the six areas during your exercise. The six critical areas in the standards are (1) communications, (2) resources and assets, (3) safety and security, (4) staff responsibilities, (5) utilities and, (6) patient clinical and support activities. The section on resources and assets includes useful links to the Federal pharmaceutical and medical supply cache website and the

CHEMPACK Program website for chemical and nerve agent antidotes. The section on safety and security includes a link to the OSHA hazardous waste operations and emergency response requirements.

The fourth step suggested is identification of specific elements of performance that you will evaluate for the specific disaster scenario selected. For example, if you have focused on communication already, then focus on the EPs for resources and assets, or security and safety in the next exercise.

Step five is interesting as the author suggests developing emergency response guides or specific performance measures to help determine the degree of success for each EP being evaluated. The sixth step is the selection of an effective evaluation team and the seventh is the preparation of an after-action report and a plan for improvement.

You can see the performance improvement methodology at work in the authors recommendations, allowing each exercise to build off the previous one making your degree of readiness and reaction better each time. The author's suggestions for long range planning are excellent and should certainly be shared with your EM planning team. The advice provided is far better than the rush to get something done because the year is coming to a close and we still have to do one more drill.

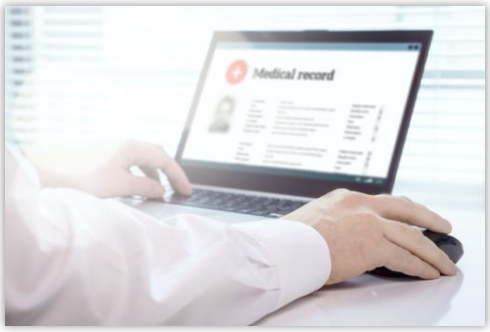
Fire Drill Requirements:
This month's EC News has a useful refresher article on planning for fire safety and drills. There are also a couple of pearls in the article that we see scored in many TJC survey reports.

The first is on timing of fire drills. Although this is not published in the TJC standards, the article reminds us that fire drills must be conducted at least one or more hours apart from the prior drill. The article also reminds us that during the night the fire alarm does not have to ring, however all other functions must be activated such as strobes, electrical door releases, and signals being sent to a central station.

CMS

Burden Reduction – A Tags:
Last month we discussed the Federal "Burden Reduction Plan" published in the Federal Register. On December 20th CMS published the 680-page QSO 20-07, providing changes to the regulations and interpretive guidance that will help to implement the burden reduction. Don't be too intimidated by the length of this document however as it includes guidance for all provider types, not just hospitals so there are many sets of regulations to promulgate.

The first A tag for hospitals with changes is A-0148, which states that patients have a right to access their medical records and providers have a responsibility to provide them (for free, by the way) if requested. We had not seen this in the burden reduction notice, so it must just be an additional change CMS wanted to make. There is no interpretive guidance yet published on this requirement.



The first of the burden reduction items in A-0168 where CMS has created a new acronym for us, LP instead of the usual LIP. This basically becomes a "find and replace" type of feature, where previous references to licensed independent practitioners, are now licensed practitioners. Given the vastly expanded roles of nurse practitioners, physician assistants, and others in healthcare today, CMS is making it clear that the regulations in this tag on restraints and other tags to follow, allow them to fulfill all the duties they are authorized to perform under state law. This may help reduce some confusion about roles and responsibilities.

Tags A-0320-0322 describe the newly allowed unified QAPI program in system hospitals. Those health systems that were considering this will want to analyze these three tags carefully, but this looks like it might actually help simplify some things for health systems.

Tags A-0358-0362 establish the acceptability of the "less than a full H&P or comprehensive H&P" for selected patients receiving outpatient surgery. Hospitals will want to study this one and determine if it has value and if it represents something unique for your organization. As we mentioned last month, many clients already have a full

H&P template and a so-called short form or focused H&P, and this may just be authorizing a practice that is already in place in many hospitals. Bear in mind that the regulations do call for any changes you desire to make to be authorized in the medical staff bylaws, and revising bylaws is often a time-consuming task.

Tag A-0399 describes the burden reduction regulation established to allow some outpatient departments to a hospital to not have an RN on duty. The hospital will have to develop policies authorizing specific departments, if any, who want to implement this. However, this is another burden reduction change that was already in place for many hospitals that acquired physician practices with medical assistants working with the physicians rather than RNs. The interpretive guidance on this one is yet to be published.

The very lengthy section of the State Operations Manual on medication preparation and administration is reproduced here, but the change is negligible. CMS deleted specific references to requirements in USP Chapter 797 because the references were not needed. CMS already requires hospitals to comply with national standards of practice and USP is one of many such national standards.

Tag A-0747 establishes new CMS requirements for antibiotic stewardship programs, however this should be easy for hospitals already accredited by The Joint Commission as they had required these programs for several years now.

Tag A-0785 describes the newly approved concept of a unified infection prevention program for health systems. Similar to the unified QAPI authorization, this one may be well received by health systems seeking to create greater standardization across their hospitals.

Tags 0799-0817 describe CMS' new regulations for the discharge planning process. These were not part of the burden reduction notice, but actually a separate set of regulations posted in the Federal Register first back in November 2015, that later had their own burden reduction edits and were revised in a final Federal Register notice in September 2019. You will want to give this section to your discharge planning leaders and ask them to help analyze these requirements. The new requirements appear conceptually very similar to the existing requirements.

One new tag we would like to draw your attention to is A-0804. This will still require hospitals to provide lists of after care providers, but in addition the hospital will now have to share objective quality measures with the patient for home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care acute hospitals. CMS will be assisting in development of this data on their website.

CONSULTANT CORNER

Dear Readers,

Happy 2020! We hope everyone starts the year (and *decade*!) off strong and healthy and wish success and prosperity to each of you!

It's wild to think that 2020 is just starting and we have to think about the next year already! Many of you will be surveyed in 2021, so don't forget to contact us for your readiness survey this year.

Thank you,

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