FEBRUARY 2020
PHC NEWSLETTER

PATTON HEALTHCARE CONSULTING, INC.

NEWS FROM CMS AND JOINT COMMISSION

INSIDE THIS ISSUE:

PERSPECTIVES

Changes to Survey Agendas:
This month's edition of Perspectives has some announcements that are of interest, but nothing onerous or significant requiring immediate actions. There are some changes in the survey agenda for organizations that are anticipating a survey early this year, but these changes should not pose problems for organizations.

The Joint Commission is going to officially combine the first morning opening conference and the orientation into one session. This should be almost invisible as this very often just blended together already. The total time allotted for this combined session is one hour or less. At the recent consultant forum, we heard that TJC wanted the orientation session to be brief, so you may want to take a look at your orientation plan and either make sure it is brief, or prepare two discussion plans, a full one and an abridged one.

The surveyors will likely let you know their preference, or you will be able to read how rushed they feel. One reason they may feel rushed is the surveyor planning session that takes place immediately after the orientation has been eliminated. Surveyors have been advised to begin tracers at the conclusion of the orientation. This first planning session is when the surveyors usually review your day one documents. Perspectives advises that the day one documents should be delivered to the surveyors as soon as they arrive in the building. In addition, at the end of each day there will now be a combination special issue resolution/surveyor planning session where they can review documents. We suggest the following action items for accredited organizations:

1. Make sure your day one documents are complete and ready to be delivered at 7:30-7:45 am, depending on when the surveyors first arrive. Many organizations still try to "gather" the required documents when they hear surveyors have arrived. This has never been a good idea, and because surveyors are now going to likely feel additional time pressure it is even less of a good idea going forward.
2. Take a look at your discussion outline or PowerPoint slides you have planned for the orientation. Having both a short 5-minute orientation and a more fulsome 15-minute version prepared might work to your advantage. The key is to describe the salient points about your organization, even in a 5-minute discussion, rather than just cutting off the 15-minute version prematurely. We recommend having printed copies of your slides available for the surveyors so they can see how many total slides there are and anticipate the duration. If you darken the room and power up the LCD, they may get anxious that the orientation is going to take a lot of time.
3. Forewarn senior leadership that the combined opening conference and orientation will start promptly at 8:00 am and forewarn the escorts and scribes that tracers will begin at 9:00 am, if not sooner.

This article also mentions that the 2020 Organization Survey Activity Guide has been posted to your extranet, but these agenda changes just mentioned are not yet codified in that SAG.

Home Infusion Deeming:
Perspectives also announced that TJC is the first accrediting organization to obtain deemed status for the nursing component of home infusion therapy. All providers of this service seeking Medicare reimbursement are going to need accreditation this year or by January 1, 2021.

In addition, the article mentions that there is no State Survey option or direct CMS option to obtain this reimbursement authority. Organizations must use an approved accrediting body and at this time TJC is the only one. The good news is that the Joint Commission's home care manual was essentially already complete, with only two new elements of performance being added to accomplish this deemed status. These new EPs are as follows:

PC.02.01.03, EP 2: The patient plan of care is established and periodically reviewed by a physician and includes the medication(s), route, dose, frequency, and duration for home infusion.

PC.02.05.05, EP 7: The organization provides the patient with access to professional services, including nursing services, patient education and training, and remote monitoring services 24 hours a day, 7 days a week.

Closed Loop Communication of Test Results:
Perspectives contains a brief summary of a Quick Safety publication TJC published in December on closed loop communication. The Quick Safety points out a problem that many of us have seen in our healthcare organizations where an important clinical test result is not communicated to the patient so that they can take action in a timely fashion. They provide examples of suspicious radiologic findings requiring follow up that don't get communicated, delaying additional workup and treatment.

The Quick Safety also discusses the potential value of patient portals but mentions how few patients are currently using them. They provide seven safety actions to consider, but hardwiring documentation of patient notification of the millions and millions of diagnostic tests performed each year is a massive undertaking. One key suggestion is to do more through the portals and of course to educate patients to make greater use of their portal. Every app on our smart phones already sends us important notifications of far less significance, but the overwhelming number of these sometimes has a numbing effect. Nevertheless, this is a very important issue that all of us have seen at some time, either professionally or personally. Developing a better process in our organizations is certainly a worthy goal.

Consistent Interpretation:
This month's discussion is on MM.01.01.03, EP 1, which requires identification of high alert and hazardous medication, and EP 2 which requires a process to manage high alert and hazardous medication. TJC indicates that in the first half of 2019, only 4 organizations (0.58%) were cited for noncompliance with EP 1 and only 25 (3.63%) were cited for EP 2. This is far lower than we have been seeing in our consultation visits. Identifying high alert

medications and having a process to manage them is a well-established process in most organizations. Leadership and guidance from ISMP have helped to provide organizations with structure on how to do this. However, we seldom see a hospital specific hazardous medication list and a process to manage them. We would encourage readers to verify that they have both portions of this requirement fulfilled.

NIOSH has identified a listing of all types of medications which are potentially hazardous to healthcare workers. Hospitals should review that list and identify which of those medications they stock or have on formulary to create the hospital list. The second EP requires a process to safely manage these hazardous medications and the first part of that process is developing a system to inform staff that they are working with a hazardous medication and what PPE they should wear to protect themselves. The most recent NIOSH document at this time is the 2016 listing, however they did post a new proposed list in the Federal Register last year and it is rumored that the new list should be finalized shortly.

Sterile Compounding:
At the recent consultant forum, TJC indicated that they would be developing a new surveyor tool for evaluation of sterile compounding and that they planned to share it with accredited organizations. Sharing tools that are developed to help organizations more critically self-evaluate services is a great concept, one that we hope TJC continues to use. That promised sterile compounding tool is now available on your extranet under the Resources tab. It is particularly helpful at this time in that it displays in a side-by-side fashion the requirements under the 2008 version of USP Chapter 797 and the 2019 version as well.

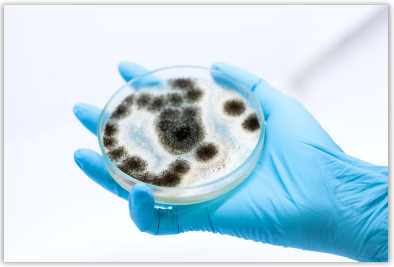
Since the implementation of the new USP Chapter 797 has been delayed, TJC is allowing organizations to select either the 2008 or 2019 versions and adhere to one of those two requirements. The 2008 version of USP Chapter 797 had some basic requirements for managing hazardous medications. In 2019, USP separated out and expanded upon the hazardous medication requirements in a new chapter titled USP 800. If you choose to be an early adopter of the new Chapter 797, TJC will also expect you to implement the requirements of USP Chapter 800, since the new 797 refers all hazardous medication issues to Chapter 800. TJC has also stated that if you choose to adopt the new USP Chapter 797, you will need to do so in its entirety. You cannot pick parts of the 2008 chapter and parts of the 2019 versions.

The surveyor tool also has columns identifying specific TJC and CMS standards for surveyors on where to score deficiencies relative to compliance with Chapter 797. Unfortunately, if you look up these standards you will not gain greater insight into the requirement as all the standards referenced are generic in nature dealing with the environment of care, infection control practices, or safe medication compounding. As we have stated previously, if you want a great reference or resource, obtain a copy of the home care medication compounding standards or the medication compounding certification standards for more details.

Be sure to locate this surveyor tool on your extranet and have your pharmacy team self-evaluate for compliance. This is the same resource your surveyor will use.

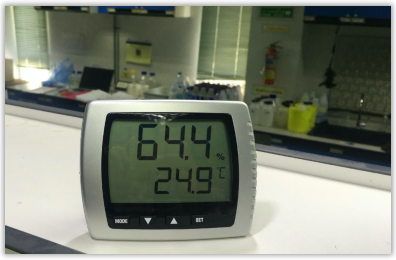
EC NEWS

Mold:
TJC has been advising us for at least two years now at their educational programs that mold is taking on an increasing importance in the survey process. If you have been reading the newspapers this past year you have likely seen the reports from a hospital in Seattle with environmental mold being linked to some patient infections. This month's EC News has a great article from an EC viewpoint about mold prevention and abatement.



The article initially discusses some changes made to EC.02.05.01, EP 15. This is the EP that discusses airborne contaminants, temperature, and air pressure relationships in critical areas. The EP has been changed to now also require compliance with ASHRAE 170 2008, or state requirements if more stringent. The ASHRAE standard establishes expectations for air filtration efficiency called MERV using a scale of 1-20, with higher numbers being greater filtration. Specifically, they advise surgical settings to have a MERV of at least 14 for the second filter bank, and areas serving immunocompromised patients having a MERV of at least 17 for the second filter bank. Ratings of 17 and above are considered HEPA filtration.

In addition to the adequacy of filtration, there will also be a survey focus on maintaining filtration system to the manufacturers specifications, or MIFU. This will include guidance on the type of filter and the frequency of changing these filters. In addition, they advise that these filters must be gasketed in place and that operating rooms not be used when filters are being changed unless there is redundant equally effective filtration. The key point here is that this EP 15 has been frequently scored for several years now due to problems with temperature, humidity, and air pressure and this will likely be scored even more going forward given the increasing complexity of the requirement.



There are also two new notes added to this EP, the first of which expresses that hospitals may implement a CMS categorical waiver to permit humidity as low as 20% in operating rooms. However, the note also states that if you do this you have to verify that your equipment and supplies are compatible with this lower humidity level. Getting such evidence from manufacturers is no easy task.

Note two with this EP requires hospitals who use accreditation for deemed status purposes to comply with NFPA 99-2012 ventilation requirements or the ventilation requirements adopted by CMS at the time of installation.

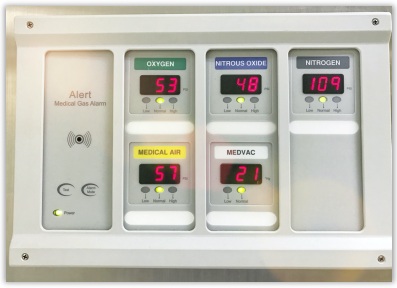
Proper air pressure relationships, air exchanges, dust prevention, and humidity levels can help reduce the possibility of mold formation. Unfortunately, dust formation during construction and renovation can contribute to problems as can the ever-problematic water leaks that occur. The authors tie back in the importance of well-designed and fully implemented ICRA and PCRA plans to help prevent dust particles from getting out of the construction area. The authors point to the 2018 FGI Guidelines which contain new infection control risk mitigation recommendations (or ICRMRs) and the CDC's Environmental Infection Control in Health Care Facilities Guideline, updated in July 2019. TJC then highlights some of these recommendations, one of which is maintaining the negative pressure value in the construction zone at least 0.03-inch water column to ensure adequate airflow out of the construction.

Given the risk to patients from mold, and the potential survey emphasis, this is an important article to share with your infection prevention and environment of care committees. As always, we suggest that this is not just sent as an FYI, but as a question—are we already adherent to these recommendations or do we need to do something additional?

Later on in the February EC News, there is an article/advertisement for a new book by JCR on Infection Prevention and Control Issues in the Environment of Care. Normally we would not discuss advertisements, but it is nicely linked to a companion case study describing a real-world nightmare at the New York Presbyterian Allen Hospital where they had a main sanitary line break causing a waste backup in the surgical areas and the need to repair the line under the semi-sterile corridor. The authors describe the very significant scope of their problem and the measures they took to safely manage this repair and the ICRA measures they undertook in doing so. It is a good piece to share in the context of our earlier discussion about mold abatement and ICRA in general.

Waste Anesthesia Gas:

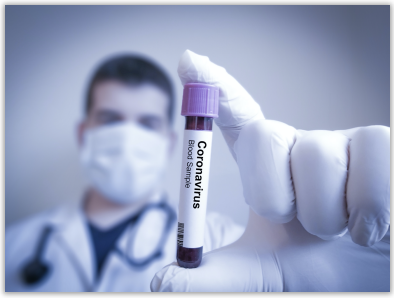
Hospitals have been expected under OSHA standards to manage waste anesthesia gases (WAG) for many years. TJC has added additional clarity to its standards to help detail these expectations and the February edition of EC News has a very thorough article how this should be managed. Details start with two elements of performance under EC.02.02.01: EP 9 requires minimizing risks associated with hazardous gases and vapors and EP 10 requires monitoring of levels of hazardous gases and vapors.



One of the ways in which hospitals minimize risks is through the use of waste anesthesia gas scavenging systems. Then the maintenance of these systems would fall under EC.02.05.09, EP 7 requiring the organization to inspect, test, and maintain critical components of all medical gas systems including WAG. This same EP also requires the individuals maintaining the system to be deemed qualified by training and certification to the American Society of Sanitary Engineering ASSE 6030 or 6040. The article also includes some tips for anesthesia providers on their provision of care and airway management. Again, this is a very detailed article that we suggest it be shared with operating room leaders, facilities leadership, and anesthesia leadership for discussion and verification of current compliance.

CMS

Coronavirus Memos:
On February 6, CMS issued two new QSO memos on the Coronavirus. The first memo, QSO-20-09 is a general information memo for health care providers and it contains multiple links to CDC resources that you will find worthwhile. You will want to follow the links in the QSO memo. The more interesting CDC link is to a document entitled Interim Infection Prevention and Control Recommendations for Patients with Confirmed 2019 Novel Coronavirus 2019, or Persons Under Investigation for 2019 Novel Coronavirus in Healthcare Settings.



The CDC provides guidance for patients if they have symptoms of any respiratory infection prior to scheduling appointments at a provider and for EMS bringing patients to providers. There is also advice for separating out patients with respiratory illness and providing rapid triage and isolation, as well as providing patient waiting areas with hand sanitizer, tissues, and face masks. There is also extensive advice for healthcare providers about adherence to standard, contact, and airborne precautions and placement of patients in airborne isolation rooms.

For respiratory protection of healthcare workers, the CDC recommends a minimum of a fit tested N 95 mask, or a powered air purifying respirator, or PAPR. CDC also recommends eye protection, either goggles or a disposable face shield. If goggles are reusable, they must be cleaned and disinfected between uses using the appropriate MIFU.

The CDC also has detailed recommendations for management of visitors to patients with Coronavirus including visitor education about protection, instructing visitors to limit their movement within the hospital and teaching visitors to report any signs and symptoms of acute illness for at least the next 14 days. Lastly, there is a link to a brief guidance document for health department and home care providers who may be visiting the home of patients who did not need hospitalization or are recovering after hospitalization.

Correction – Medical Records:
Last month we discussed QSO memo 20-07 on burden reduction and the revisions to Appendix A. In our discussion of providing copies of medical records to patients upon request we overstated the conclusion on what an organization may charge for providing copies of medical records. Based on Federal Guidance in HIPAA, the following options are all available depending on the type of medical records and the format requested by the patient:

- If state law says copies must be provided free of charge, then you must provide copies for free; you cannot charge what is permissible under HIPAA.
- If state law says you can charge more than HIPAA, you cannot.
- If you have a certified EHR with transmit and download functions, and the patient wants an electronic copy, it must be free.
- If the patient wants paper you can charge an actual paper cost and actual labor charge, unless you are in a state that has a more restrictive law.

Details on this issue are posted by HHS at 45 CFR 164.524. In addition, there is a court case from January 2020 that modifies the HHS posting which you can read at: https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0040-51.

CONSULTANT CORNER

Dear Readers,

Just a reminder that 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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