

MARCH 2020 PHC NEWSLETTER



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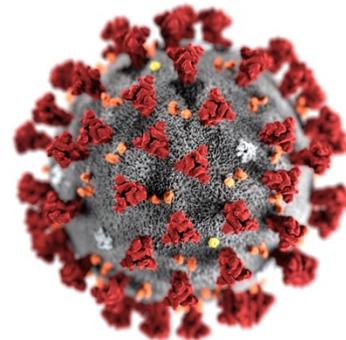
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CMS

Coronavirus Memos:

We normally start the Newsletter out discussing Perspectives, but just before going to print, CMS posted three memos on the Coronavirus. Due to the urgency of the matter, we wanted to bring this foremost.

These three memos are (1) QSO 20-12, describing the CMS survey focus on infection control and some limitations on routine surveys, (2) QSO 20-13 providing advice to the hospital industry on managing patients with confirmed or suspected virus, and (3) QSO 20-14, a similar advisory memo to the nursing home industry. Our advice is to read all three memos, and although many of us prefer to print and read, you will want to read these electronically so you can follow the many web links CMS has provided to other information sources.



The hospital memo, QSO 20-13, has guidance on screening visitors, staff, and patients and the supplies that should be available to prevent transmission of any infectious organism. There is also valuable information on how to compliantly restrict visitation rights for infectious patients and the implications for Medicare discharge planning

regulations when preparing to discharge a patient who was infected with COVID-19.

To view each memo, please visit:

- Suspension of Survey Activities
- Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

QSO 12-14 has information for the nursing home industry, but you might want to share and analyze this memo with your infection prevention and discharge planning teams as it provides information about what a nursing home may do, or not do, relative to accepting a discharged patient who had been infected with COVID-19.

- Tracking and assessment of employees who provide care to COVID-19 infected patients
- Movement of patients within the facility
- Environmental cleaning
- Management of visitors and visitor restrictions

PERSPECTIVES

CMS Rules:

On first review, the March edition of Perspectives looks simple, straightforward, and nothing to worry about. However, the two-paragraph article on page 5 referring you to look on their website for the prepublication standards designed to align with the CMS rules on burden reduction and discharge planning is a very significant piece of news.



These new CMS rules published in QSO 20-07 were discussed in our January and February newsletters. When we initially wrote about this QSO memo, the new content had regulations, but no interpretive guidance written. This remains the case today. TJC has developed standards and elements of performance in accordance with the regulations but without access to the official CMS interpretive guidance. We were informed at the consultant's forum in January that TJC was sharing these draft standards with CMS for their review, but the article does not mention if CMS has officially blessed them. It is possible that CMS will add a curve ball in the interpretive guidance that will require some modification to these new standards at a later time. Most importantly for our readers, the new standards and EPs, except for MM.09.01.01, go into effect March 15, 2020. The MM change goes into effect March 30.

CMS had expressed a federal goal of burden reduction and indeed some of the changes open up new flexibilities that were not previously available or reduce the frequency of a requirement. An example of new flexibilities includes the corporate or health system model for QAPI activities and the frequency changes include moving some emergency management requirements to every second year. Unfortunately, there are also some changes that appear to be new requirements. The corresponding TJC changes touch ten different chapters in the accreditation manual. These are EM, HR, IC, LD, MM, MS, NR, PC, RC and RI. The highlights we noted are as follows.

Emergency Management (EM):

- The update to EM policies and procedures can occur every two years instead of annually.

CDC

Coronavirus Update:

The CDC continues to publish updates to their information and our readers should be checking their website on a daily basis to see what new information has been provided. One essential new document to very carefully review is entitled Coronavirus 2019 (COVID-19) Hospital Preparedness Assessment Tool. This is essentially a tracer tool that you can use internally, CMS and TJC surveyors are likely to use and we will use on our consultation visits.



The CDC advises that their tool is not mandatory, but our consistent advice is if the CDC experts advise we should be doing something, we need a good reason to not do it, documented in a risk assessment format. You can download a copy of this tool from: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/hospital-preparedness-checklist.pdf>

The tool provides guidance on:

- Employee education
- Signage and supplies for patients with respiratory infections
- Patient placement including testing the effectiveness of airborne isolation rooms

- The staff training on EM can occur every two years, instead of annually.
- The training program content can be updated every two years instead of annually.
- The HVA update can be every two years, instead of annually.
- The review of the scope and objectives of the EOP can be every two years.
- If you implement your EM plan in response to an actual emergency, the hospital is exempt from its next full scale, community based functional exercise.
- One of your two annual exercises can be a table-top exercise “if it is led by a facilitator, includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages or prepared questions designed to challenge the plan.”

Infection Control (IC):

- The list of responsibilities and authorities for the infection prevention program now includes additional elements, one of which is communicating with and collaborating with the antimicrobial stewardship program.
- The individual who leads your infection prevention program should be appointed by the governing body based on recommendations from medical staff leadership and nursing leadership. How this will be surveyed becomes an interesting question. Will surveyors look for governing body minutes, as well memos from the medical staff and nursing leadership making recommendations?



Leadership (LD):

- Individual Medicare certified hospitals with a system governing body can now have an integrated QAPI, IC, and antibiotic stewardship program (ASP) providing it is acceptable under state law and the governing body ensures that the process for individual hospitals:
 - “Meets the QAPI requirements at 42 CFR 482.21.”
 - “Is structured in such a manner that accounts for unique circumstances and differences in patient populations and services at each hospital.”
 - “Establishes and implements policies and procedures to make certain that the needs and concerns of each hospital are given due consideration.”

- There is also a requirement that the QAPI data reviewed must include quality indicator data, including patient care data submitted and received by the Medicare quality reporting and performance program.

Medication Management (MM):

- Here appears the first of several changes in multiple chapters changing the terminology for LIP or physician to “practitioner responsible for the patients care.” Basically, medication orders have to be from such a practitioner.
- The antimicrobial stewardship program (ASP) should include a review of antimicrobial resistance patterns and the program should cover all departments and services.
- The person responsible for ASP should be appointed by the governing body.

Medical Staff (MS):

- Currently MS.01.01.01, EP 16 states that the medical staff bylaws include a requirement that states a physician, oral maxillofacial surgeon, or other qualified licensed individual conduct a history and physical. The requirement now is modified to include a statement that “a physician is defined in section 1861(r) of the social security act.” Opening up and changing the medical staff bylaws is never an easy thing to do, and it remains to be seen if TJC is actually going to survey for this addition.
- The medical staff chapter also has the burden reduction change that allows for certain outpatient surgeries and procedures to waive an H+P requirement and substitute an “assessment.” The assessment would still have to be done and documented prior to the procedure, but the content may now be streamlined. If you already have a short/focused form H+P as an option in your EMR this may not have value for you, but if your outpatient procedures all still require a full H+P then your medical staff may want to define the requirements for this simplified assessment.
- If the medical staff chooses to allow an assessment in lieu of a full H+P, the medical staff would have to develop a policy to identify the patients to whom this would apply including factors such as age, diagnoses, type of surgery or procedure, level of anesthesia, nationally recognized CPGs and standards of practice as well as state or local laws.



Nursing (NR):

- The hospital needs to establish policies and procedures to identify which outpatient departments, if any, are not required to have a registered nurse present.

Provision of Care (PC):

- The H+P standard, PC.01.02.03 was modified to exempt an H+P from any procedures where the medical staff has authorized the new assessment.
- The standard on patient orders, PC.02.01.03 now authorizing patient orders from individuals using that new term, “other practitioner in accordance with professional standards, law and regulation, hospital policies, medical staff bylaws, rules and regulations.”
- PC.02.02.01, discussing access to dental services for swing bed patients now specifically states that hospitals must assist patients in applying for reimbursement of dental services as an incurred expense under the state plan and that hospitals may charge a Medicare resident an additional amount for routine and emergency dental services.
- PC.03.05.05 when discussing who may order restraint now uses that new phrase authorized licensed practitioner. This new terminology will help because the existing language, LIP, is sometimes confusing when it comes to whether midlevel practitioners and residents may order a restraint.
- These authorized practitioners must now be included in the hospitals training requirements and must be familiar with the hospitals policy on restraint and seclusion.
- The standard on discharge planning, PC.04.01.01 now substitutes the term “patient’s representative,” for the previous term; patient’s family.



- We also noted that the specific language that requires the medical record to document that a list of nursing homes or home care agencies be provided to patients being discharged has been deleted.
- There is still a responsibility to share information about home health and aftercare providers and the responsibility now requires sharing quality measures and resource use measures with the patient being prepared for discharge.
- The requirement to evaluate the discharge planning process has become more detailed now requiring an analysis of a representative sample of patients readmitted within 30 days.

Record of Care (RC):

The one change in the RC chapter applies only to psychiatric hospitals and while it discusses how often progress notes be documented; it does not change that requirement. It only changes the term Doctor of Medicine

or osteopathy to physician, psychologist, or other licensed practitioner.

Patient Rights (RI):

There are three modifications that apply only to psychiatric hospitals providing longer term care, greater than 30 days, regarding work assignments for patients.

As you read the long list of changes it will seem rather daunting, but some changes, such as in the EM chapter, genuinely seem like burden reduction and you likely will want to take advantage of them quickly. The system level approach to QAPI, IC, and ASP recognizes that many health systems are already headed in that direction and this provides clear authorization guidance. The assessment in lieu of a history and physical may be promising for some organizations. There are required discussions, policy development and approvals you will have to go through, but there is no deadline to get it done other than how quickly you want to take advantage of the briefer assessment if you have not already.

Do take a careful look at these changes and distribute to your subject matter experts for analysis. We also suggest being on the lookout for the interpretive guidance from CMS which should be out shortly, as well as any revisions or FAQs from TJC.

Sentinel Event Data:

Perspectives has a brief overview of the types of sentinel event reports received this past year and a graphical presentation comparing reports of different types over the past three years. This usually links with a more detailed PowerPoint they post to their website that is always very informative and include root causes for each type of sentinel event. The one displayed as we are writing this is still from early 2019, summarizing calendar year 2018. We will discuss this more when the new one is posted.

Psychiatric Advance Directives:

Perspectives mentions a recent Quick Safety, #53 published February 2020 that TJC has published on psychiatric advance directives. The Quick Safety discusses the benefits and barriers to psychiatric advance directives as well as the regulatory and standards framework. If you have psychiatric services, this would certainly be worth reading and trying to improve the utilization of these advance directives.

EC NEWS**FGI Guidelines 2018:**

The lead article in this month’s EC News highlights the fact that TJC is now referencing the 2018 edition of the FGI Guidelines in standard EC.02.06.05. These guidelines apply

to new construction you may be planning, but they also apply to renovation projects that are being developed. Step one is, of course, making sure you have access to the latest guidelines. The article also points out that 2018 FGI references the 2017 ASHRAE 170 for ventilation requirements. However, CMS and TJC for deemed status point to the 2008 edition of ASHRAE 170 as it is referenced by the 2012 edition of NFPA Health Facilities Code. This would seem potentially problematic, but EC News provides the guidance that newer isn't always more stringent. They advise examining and analyzing potentially conflicting requirements and suggest meeting the most stringent of the minimum requirements to stay ahead of the game.

Slips, Trips, and Falls by Staff:

When most of us think about falls, we usually think about patient falls, but EC News has an interesting article pointing out that falls can and do occur among healthcare workers with alarming frequency. In fact, they report that approximately 20% of all employee falls reported in private industry are occurring in healthcare and social assistance settings. The Bureau of Labor statistics reports just under 10,000 employee falls each in hospitals and nursing

home/residential care facilities. They point out the risks from parking lots in the winter, wet floors, and construction debris as contributing to falls.



EC News reports ten specific suggestions from OSHA to help prevent and reduce falls among healthcare workers in the article. Most of the falls are at the same level, but some come from falls at a different level such as falling off of a ladder. OSHA also has standards for ladder safety published at 29 CFR 1910.23. There are also seven references mentioned in the article. Our suggestion is to be sure to have your environment of care or safety committee review and analyze this article and determine if there are best practices that should be implemented in your own organization.

CONSULTANT CORNER

Dear Readers,

We wish everyone a healthy month ahead. Don't forget to wash your hands and cover your cough!



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