PATTON HEALTHCARE CONSULTING, INC.

INSIDE THIS ISSUE

PERSPECTIVES

Last month we discussed several new standards changes scheduled for July 2022. The February edition of *Perspectives* is significantly thinner, and a slower pace in the constant change process is always welcome. However, the big news this month is not in *Perspectives*, it's from the Supreme Court and the Covid vaccine mandate for healthcare is back on. CMS and TJC have both issued guidance on this high priority mandate and we discuss it below under the heading of *Covid Vaccine Requirements*.

Standard Language Changes:

Perspectives this month does discuss what is called by TJC "editorial changes in some standards to better align with CMS language." They provide a link to the prepublication site where you can download these editorial changes.

We agree that these changes should not be significant in most organizations, and in fact the first change to EC.02.03.01, EP 9 seems to remove a "gotcha" we sometimes see. This EP currently requires the hospital's fire response plan to "describe the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin…"

In this revised EP, and several others we will discuss, the term "licensed independent practitioner" has been removed. It is replaced in this EP by just the term staff, but conceptually the LIP term was not a term CMS was as fond of using as TJC has been. CMS seems to prefer the term "physician or other licensed practitioner."

The change to this EP may be minimally advantageous as sometimes we did see hospitals cited for a failure to specifically reference the role of LIPs in their fire response plan.

EC.02.06.05, EP 1 has been somewhat modified. This EP currently guides hospitals undergoing construction or renovation that they should follow state rules and regulations, The FGI Guidelines 2018, and other reputable standards or guidelines. The revision specifically adds in that hospitals should comply with NFPA requirements, including emergency generator location requirements identified in NFPA 99-2012, NFPA 101 2012, and NFPA 110-2010, and Tentative Interim Amendments.

LD.04.01.03, EP 3 currently requires that the hospital's operating budget reflect the hospital's goals and objectives. The revision now points to 42 CFR 482.12(d) to add detail on what the operating budget should include. You can find those details in Appendix A using your E-Edition accreditation manual.

Essentially the budget should be developed according to generally accepted accounting principles, include all anticipated income and expenses, provide for capital expenditures for a 3-year period, identify anticipated sources of income for each capital expenditure in excess of $600,000 and the plan should be submitted for review by a regional health planning group or the state, if required by state law.

Now, you might be wondering if or how Joint Commission might ever examine this. If you look at your Survey Activity Guide, document #41 is governing body minutes for the last 12 months. We recalled that at one time there was greater clarity on this issue and in looking back at the 2012 Survey Activity Guide, the governing body minutes were not mandatory documents at that time, but it was identified that the surveyor may request these minutes to "verify compliance with budget requirements."

We can't personally say we have ever seen an RFI for this budget issue, but knowing that it is much more detailed in the revision, it could come up.

LD.04.01.11, EP 3 has a new note 1 added. The EP requires interior and exterior spaces to meet the needs of patients. The new note for deemed status surveys now adds that: "The extent and complexity of facilities must be determined by the services offered." This slight modification is unlikely to lead to any change in scoring frequency.

MM.05.01.07, EP 5 has been modified to also remove that term, licensed independent practitioner, replacing it with the phrase physician or other licensed practitioner.

MS.03.01.03, EP 3 has been modified to expand the mandate that a Medicare patient's care be managed by a physician to also include Medicaid patients.

PC.02.01.03, EP1 has the same deletion of the term licensed independent practitioner and replacement by physician or other licensed practitioner.

ESC and Clarifications:

The February *Perspectives* has a refresher article on how to complete an ESC or write a clarification. As this is something most organizations only do once every 3 years, it is worth reading.

We see two major teaching points, the first of which is that clarifications are not prohibited, although many organizations believe they are prohibited. While not prohibited, they are just more difficult to do than in past years. The second major teaching point we see is that an ESC should document clarity and completeness of actions while still being succinct.

We sometimes review a client's draft ESC and it drifts into side discussions not referenced in the finding or by the element of performance, and misses the corrective actions required by the observation(s) of noncompliance. In this article TJC provides detailed guidance in what they are looking for in each of the required content headers that must be addressed in the ESC.

COVID VACCINE REQUIREMENTS

The big news this month is not in *Perspectives*, it is the actions of the US Supreme Court and the rapid initiation of the Covid vaccine implementation requirements by CMS and TJC. To refresh your memory, we have had the following announcements:

- Federal Register announcement 11/4/21 of an interim final rule for healthcare worker Covid vaccination.
- QSO-22-04 issued 12/2/21 suspending any enforcement of the vaccine rule for healthcare workers while court cases are proceeding.
- QSO 22-07 issued 12/28/21 implementing the vaccine mandate in roughly half the states, those not covered by a court decision.
- QSO-22-09 issued 1/14/22 implementing the vaccine mandate in those states not initially covered after the Supreme Court decision but not yet in the state of Texas.
- Joint Commission Online 1/19/22 indicating TJC's decision to survey to the Interim Final Rule as of 1/27/22 for those states identified in the 12/28/21 CMS memo and as of 2/14/22 in those states covered by the 1/14/22 CMS memo.
- Joint Commission posted 7 FAQs explaining the nuances of how they will be evaluating compliance.
- QSO 22-11 issued 1/20/22 implementing the vaccine mandate in Texas.

The approach to survey by both CMS and TJC appears to be in phases, with phase 1 tied to those states identified in the 12/28/21 CMS memo and phase 2 to those states identified in the 1/14/22 QSO memo. Now with the most recent QSO memo including Texas, we assume that will be phase 3 as it has its own deadlines just like the other QSO memos.

30 and 60 days after publication the hospitals must achieve 100% compliance with all staff receiving at least one dose of vaccine, then 100% compliance at 60 days with all staff having received two doses of a two-dose vaccine, or one dose of a one dose vaccine like Johnson and Johnson's.

If the healthcare organization has less than 100% compliance at the 30-day evaluation point, but more than 80% with a plan to obtain 100% by the 60th day, they will not be subject to enforcement action. Similarly, at the 60th day evaluation point if the hospital has less than 100% compliance, but more than 90% with a plan to reach 100% within an additional 30 days, there would be no enforcement action.

We should talk about what it means to be 100% compliant. This does not mean that 100% of staff must be vaccinated, it means that 100% of staff are either vaccinated, or have a qualifying medical or religious exemption approved.

From a perspective of managing this process it means that each hospital needs to know who has already received the vaccine and who has not. Then for the group that has not you will want to establish a process to review medical and religious exemption requests.

Guidance has not been developed to instruct hospitals when or how to approve such exemptions. CMS states it should be done in accordance with law and regulation, the content of which your HR department and attorneys are familiar.

You might also be wondering who is subject to this requirement. TJC has posted one of their many standards FAQs on this stating it is employees, licensed practitioners, students, trainees, volunteers, contracted staff, and other staff who perform duties on site. You might also want to look back at the November Federal Register posting as CMS provided lengthy narrative discussion on who is subject to the requirement and who is not. For example, CMS stated that staff who work only remotely and do not interact in person at the care site would not be subject to the vaccination mandate.

One of the other FAQs that TJC has posted includes a definition of what it means to be fully vaccinated. This is identified as two weeks or more since completing all "required" doses of a vaccine series. At

present this interpretation is consistent with the CDC definition of fully vaccinated. We have Moderna's and Pfizer's two dose vaccines and the Johnson and Johnson's single dose vaccine. Booster doses are not yet part of the required series but could be in the future if the FDA approved drug package insert or CDC guidance changes.

Another interesting FAQ from the Joint Commission describes documents that surveyors will want to review to evaluate vaccine compliance. These include overall vaccination rates, a list of staff hired in the last 60 days including their vaccination status, and all policies regarding vaccination.

They also describe a need to see the organization's process for tracking and securely documenting vaccination status, the process for tracking booster status, the process for requesting an exemption, the process for tracking and securely documenting information relative to exemptions granted, and lastly a process for ensuring that all documentation confirms recognized clinical contraindications to vaccine and supports staff requests for medical exemptions have been signed and dated by a licensed practitioner who is acting within their defined scope of practice under state and local laws.

Importantly, TJC does mention that they will not be re-evaluating the appropriateness of the request, only verifying the completeness of the documentation.

EC NEWS

Smoke Barriers vs. Fire Barriers vs. Smoke Partitions:
The lead article in this month's EC News is an interesting review of what smoke barriers, fire barriers, and smoke partitions are, and how they differ.

Smoke barriers are described as dividing a building into different smoke compartments, and functionally they extend from the floor, to the floor or roof deck above. They should have a one-hour fire resistance rating in new construction and a half hour in existing construction.

Fire barriers may be walls or floor/ceiling assemblies and their fire resistance rating can be anywhere between 30 minutes to 3 hours depending on the use in the protected area and what kind of area it is separating from.

Smoke partitions do not have a fire resistance rating as they are meant to prevent the spread of smoke.

The content in this article is likely known to your facilities leadership, however it may be an excellent summary for organization administrators or clinicians who are not as familiar with life safety codes and building design.

"New" Emergency Management Chapter:
The article to focus on this month in EC News is entitled, "Getting ready for the new emergency management chapter." These standards revisions are due to be implemented July 2022 and they appear to better align the TJC standards with the CMS appendix Z for emergency preparedness.

This article tries to describe and summarize what is new in the chapter and pertinent issues you may need to focus time and energy

on to get ready for July 1. Specifically, they focus on the "new" standards EM.09.01.01 – EM.17.01.01. However, there is also a significant amount of promotion about how different, how much better, and how much more effective the new chapter will be in getting organizations ready for disaster.

For example, in the description of the EM program requirement in EM.09.01.01 they emphasize that it's not just about the Emergency Operations Plan, there also must be a functional program. We have always assumed that there was an actual functional program underpinning or surrounding the EOP which merely describes what and how the leaders of the program implement required actions.

Similarly, the continuity of operations plan in EM.13.01.01 is promoted as new, however this requirement has been around for several years in EM.02.01.01, EP 12, although it now is its own standard, not just an EP.

The good news is that the amount of change is not as significant and the work load burden to get ready for these new standards will not be as extensive as you might have thought. Do share this article with the hospital leaders responsible for your emergency management activities for them to review.

The concept that this revised chapter is substantially different, better, etc. appears to be an exaggeration, however given what our planet has just gone through with Covid, it is possible that there will be a much more intensive focus on EM standards than there has been in the past, leading to more RFIs.

Thus, a careful re-examination of how you meet each of these standards is warranted. We will discuss below only the content we observe to be new and unique in the standards that are due to be implemented July 1, 2022.

EM.09.01.01, EP 2: CMS and TJC in recent years have developed options for healthcare organizations that are part of a larger health system to form system wide approaches to infection prevention, quality, medical staff and this EP provides similar flexibility for emergency management. The same was with other flexibility options, the EM option does require the unique needs of each organization to be considered and each organization needs to be part of the plan development process.

EM.10.01.01, EPs 1–4: This section describes the role of senior leadership in EM planning. While senior leadership responsibility was previously mentioned in the standards, there is more detail here about those responsibilities. We should also mention that we have perceived that TJC officials believed there should be greater involvement and leadership oversight of this chapter. Our experience through consulting is similar in many organizations as it appears the assignment of this chapter to a manager is just one more thing someone with multiple other key responsibilities has been assigned. As a result, their ability to lead the program is limited. Our prediction on this revised standard is that the role of leadership could be much more closely examined going forward. Our two recommendations would be to ensure senior leadership is really directing and monitoring activities in the EM chapter, and to ensure that the manager assigned genuinely has the ability to conduct that lead role.

LD.04.01.10: There is a corresponding change in the leadership chapter that will require hospital leaders, including leaders of the organized medical staff, to provide oversight for emergency management activities. This has been a consistent theme we have heard over many years that hospital leadership needs to be more involved in the EM program. Here you might anticipate greater examination of minutes, participant lists and documentation of involvement.

EM.12.01.01, EP 8: The standard describes content requirements for the EOP and implementation issues, but we noticed EP 8 describing an issue we had not seen previously and that is an alternate site plan for incident command. These past two years many organizations have become all too familiar with alternate care sites, but your documentation in your plan of an alternate site for incident command may be new.

EM.12.02.11, EP 4: The standard describes managing utilities and that concept has been in the chapter, however we noticed a few bullet points in EP 4 that were not as detailed previously. Specifically, the new chapter is looking for a plan description of how the organization will maintain fire detection, extinguishing and alarm systems, and sewage. We identified these as new by doing a PDF word search, and while utilities in general were described, these bullet point terms were not present in the current chapter.

EM.13.01.01: This standard describes the continuity of operations plan, and while that concept is not new, this issue is one of the more frequently scored deficiencies on survey today. Thus, it would be worthwhile to verify you have a COOP that meets these requirements.

EM.14.01.01: This standard describes disaster recovery, and while this too has been a feature of the existing standards, the standard now reads more prescriptively when it states: The hospital has a disaster recovery plan. Previously recovery was a recognized phase in emergency management planning. This subtle shift will likely mean there will be a need for a document identified as a disaster recovery plan, or at least a clearer identification of the recovery planning in the EOP. Also do take a look at EP 1 where it describes the need to "conduct organization wide damage assessments." EC News has had several articles describing this process the last couple of years where they described start up procedures and damage assessments after a disaster. This may require additional content in your EOP.

EM.15.01.01: This standard describes training requirements for emergency management however the change here is actually a form of burden reduction rather than new requirements. Currently training is an annual expectation, but CMS and TJC are going to permit training to become an every-two-year activity if you want. We also noticed the new Note 2 in EP 1 that would permit an organization to retrain on specific or new content in their EOP, rather than retraining on everything. The only aspect of this standard that may require additional work is Note 1 in EP 1. Here TJC provides specifics on testing of trainees using post training tests, trainer/trainee discussion and Q+A, or other methods. Many organizations use computer-based training modules for this content and you would want to verify there is a testing component to that process.

EM.16.01.01, EPs 1–3: This standard describes how you should be selecting your scenarios for a drill, but what is different again is the use of the term "plan" when they state in EP 1 that the hospital "describes in writing a 'plan' for when and how it will conduct annual testing of its EOP." The issues hospitals should consider seem consistent; however, the term "written plan" is different from just planning at a meeting of the EM team. This may also be an attempt to better align the standards with the FEMA/DHS exercise evaluation program. They have multiple resources on their website that may help in planning and evaluating exercises.

EP 2 describes the two exercises per year that should be conducted and the expectation mirrors what CMS wrote last year in its regulations. One exercise should be a full-scale community based, or a functional facility-based exercise if a community exercise is not available. The second drill can be full scale community based, or a functional facility based, or mock disaster drill or even a tabletop seminar or workshop led by a facilitator.

EP 3 also seems to be a burden reduction in that it describes the need for only one operations-based or discussion-based drill per year in freestanding outpatient buildings that provide care.

EC.02.05.07, EP 11 and EC.02.06.05, EP 1: Yes, there are also two changes to EC standards in the revisions on emergency management. The change at EC.02.06.05, EP 1 is also posted in the prepublication changes we discussed earlier to align for CMS deeming purposes. The change at EC.02.05.07, EP 11 may be more problematic, although it reads really simple. It states that the

"hospital meets all emergency power system requirements found in NFPA 99-2012 Health Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.

At first glance you might look at this one and say: Yea sure, those are the NFPA references we comply with. This could turn into a future "gotcha" however because it references huge texts with many, many minutia requirements that could be scored noncompliant if any one of them is missing from your documentation.

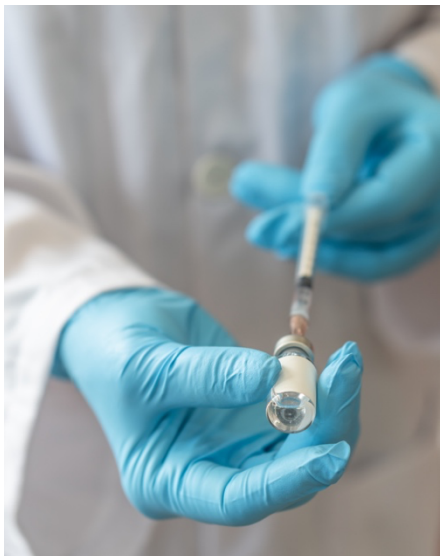
In conclusion, the revised chapter may not be as large a burden as the published 40-page prepublication version first looked, however it is an excellent time to reconsider your approach to managing this process and verify that all of the content expectations are in your documents.

As we have mentioned in this newsletter previously, given what we have all experienced with the pandemic the past three years, it seems likely that emergency management could take on a much larger role in the survey process than it has in the past.

CMS

Vaccination Requirements:

We have already discussed the many memoranda CMS has issued relative to vaccination requirements for your workforce. On January 25th, CMS issued QSO 22-10 which describes vaccination requirements for their workforce and the accrediting body's workforce.



Basically, the vaccination requirements for state surveyors and accreditors are the same as you are doing. Everyone needs to be vaccinated or have an authorized medical or religious exemption. Those surveyors with approved exemptions may continue to survey but may be subject to additional test requirements or work modifications as directed by the state agency or accreditor.

What is different about this process is on page 3 of the memo where CMS states: "Therefore, certified providers and suppliers are not permitted to ask surveyors for proof of their vaccination status as a precondition for entry." CMS recognizes that healthcare organizations may have questions about their state's process, and they encourage states to proactively communicate with providers and suppliers about their vaccine implementation approach.

CONSULTANT CORNER

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