PATTON HEALTHCARE CONSULTING, INC.
AN AFFILIATE OF HEALTHCARE BUILDING SOLUTIONS, INC.

INSIDE THIS ISSUE

PERSPECTIVES

As we review this month's edition of *Perspectives*, the good news is that there are not multiple new requirements however there is one very important new standard on Covid vaccination; IC.02.04.02. This month's Consistent Interpretation column discusses EPs 5 and 6 for NPSG.15.01.01. EP 5 is scored fairly often, on 21% of surveys, but EP 6 is just under 3%. The explanatory information about these EPs does not shed any new light on the nuances of scoring, but clearly many organizations have gaps in their training and competency processes for safe care of patients at risk for suicide.

IC.02.04.02 – New Covid Vaccine Standard:
The important new Covid vaccine standard is not actually reprinted in *Perspectives*, but you can find it posted on the Joint Commission's prepublication standards section of their website. The new standard indicates that it becomes effective July 1, 2022, but don't let that date confuse you. The requirements are all effective now, because CMS has posted regulations and these requirements could be scored against the existing TJC leadership standard for compliance with law and regulation.

As you would anticipate, the new standard mirrors the CMS directives and is consistent with what we have been discussing in this newsletter for several months. Seeing this new standard and its seven (7) elements of performance is very valuable to understand the multiple, detailed requirements that CMS discusses in its 14-page narrative for hospitals (*see CMS section on this same issue*).

The EP format is clear and succinct as it points out the many different factors, all of which will be evaluated to determine if you are compliant with the new standard.

Remember when looking at any element of performance, if that EP has bullet points, each bullet point must be compliant in order to be compliant with the EP and each EP under any one standard must each be compliant in order to be compliant with the standard.

There are also multiple Notes attached to these elements of performance, which help to explain questions a reader might have about the requirement. We also noted that six (6) of the seven (7) new elements of performance include the Ⓓ (for documentation) icon, so when TJC says there is a "process," they really are looking for a written process, not just a verbal description of how you manage the process.

EP 1 Ⓓ establishes the foundation for who this new requirement applies to; namely it applies to organizations using TJC accreditation for deemed status. It also states that the organization must develop and implement policies and procedures to have all "staff" fully vaccinated for Covid-19. We put quotations around the term staff because it is much more than just employed staff as you will see in the discussion on EP 2. There is a note associated with this EP defining the term fully vaccinated to mean completion of a primary vaccination series of either a multidose vaccine or single dose vaccine. The requirement is silent on the subject of any boosters at this time.

EP 2 is the only new EP missing a Ⓓ for documentation but here they do explain that the requirement is applicable to employees, licensed practitioners, students, trainees, and volunteers, anyone who provides care, treatment or other services for the hospital or its patients under contract or other arrangement. There is also a note that describes that the EP is not applicable to those who work exclusively outside of the hospital, (remotely) not having any direct contact with either patients or "staff " of the hospital.

EP 3 Ⓓ establishes the requirement to have written policies, procedures and a process to ensure all the staff in EP 2 have in fact received their single dose vaccine or the first dose of a vaccine series prior to providing any care, treatment or services. There is a note with the EP that describes the EP to be nonapplicable to those who have been granted exemptions, have pending exemptions or those who must have their vaccination delayed per CDC guidance. We would add that while the mandate to vaccinate such individuals at this time is not applicable, you would of course still need to track or categorize these staff and keep track of the dates when they might be required to be vaccinated if it was temporarily delayed per CDC guidance.

EP 4 Ⓓ reads a lot like EP 3 in that it describes the need for a process for ensuring all staff are vaccinated, however this EP goes beyond the first dose of a series vaccine to full vaccination at the appropriate schedule. Much like EP 3, the note exempts those whose vaccine must be delayed or are authorized an appropriate religious or medical exemption. You would of course require a system and written process to track and tickler staff in any of these categories.

EP 5 Ⓓ requires policies and procedures to track and securely document Covid vaccination status for all staff. We would advise verifying that your policies, procedures and process for doing this does consider and address security of this confidential information. This EP also requires you to track any booster doses received by staff, although there is no mandate to accept or administer booster doses at this time.

EP 6 Ⓓ is perhaps the most complex requirement because it involves the evaluation of exemption requests. It mandates a process for staff to request an exemption based on Federal law, a process to securely track authorized exemptions and to maintain this information securely. The third mandatory process under this EP is to compile the documentation that confirms recognized clinical contraindications to Covid 19 vaccination, signed and dated by an authorized, licensed practitioner who is not the individual requesting the exemption, and is practicing within their defined scope of practice.

EP 7 Ⓓ requires policies, procedures and a process to mitigate Covid 19 transmission by those individuals who are not fully vaccinated due to an authorized exemption or clinical contraindication.

CMS

Workforce Vaccination:

At the beginning of April, CMS revised its earlier memos on workforce vaccination, issuing simultaneous updates to QSO-22-07, 22-09 and 22-11, issuing comprehensive updates for different provider types. The hospital update was attachment D and provides 14 pages of narrative details that help to explain exactly what CMS will be looking for, and may help to answer questions you may have after reading the new TJC standard.

CMS has also placed its requirement under the COP for Infection Prevention, Tag A-0792. A detail that becomes clearer on which staff this applies to is in 482.42(g)(2)(i) and (ii). CMS states that staff who perform their duties exclusively through telemedicine/telehealth outside of the hospital and do not have any contact with the hospital's patients are exempt from the requirement.

In addition, CMS states that staff who perform support services outside of the hospital setting and who do not have any direct contact with patients or other staff are also exempt. So, if for example they work exclusively from home they would be exempt, but if they worked in an offsite hospital office complex with coworkers, they would still be subject to the vaccine mandate.

CMS, later in its guidance for surveyors, states that staff who have been placed on family medical leave or workers compensation leave would not count as unvaccinated staff. CMS also guides us that infrequent "one off" vendors, volunteers and professionals would not be subject to these requirements and they provide an example of the annual elevator inspector, or staff who perform some infrequent service off site, not at or adjacent to patient care such as accounting. CMS further guides, that hospitals should consider the frequency of presence, the services provided and proximity to staff and patients in making their decisions. You will want to develop policy guidance for managers who might interact with such vendors.

They also provide insight that survey findings need not lead to hospital termination proceedings; however, they make it clear they are looking for 100% compliance, nothing less. As was done with the initial memos from CMS, they applied to different states and with different deadlines, 30-60 and 90 days, but by the time you are reading this newsletter, just about every state will be 90 days out meaning the data on vaccine status should be complete.

CMS states that the level of a deficiency would be immediate jeopardy if 40% of the staff are unvaccinated, or anything less than 100% vaccination, plus observations of deficient infection control practices, plus one or more of the required policies and procedures has not been developed. A condition level finding would be anything less than 100% and one or more required policies and procedures has not been developed, or 21% - 39% of the staff remain unvaccinated.

CMS provides some examples of actions that could be taken for those staff who cannot be vaccinated due to some exemption, in order to protect patients and coworkers. These actions include reassigning staff to remote work, not assigning the unvaccinated staff to immunocompromised patients, using physical distancing, requiring weekly testing of exempt staff, or requiring N95 mask usage by these staff.

However, CMS does not mandate which additional safety precautions must be taken, this is left up to the organization. The good news is CMS is not overly prescriptive, the bad news is subjectively a surveyor might perceive your design for "enhanced precautions" to be inordinately minimal from their perspective.

The new TJC standard and the April update by CMS say little about religious exemptions. CMS included a link to an EEOC Compliance Manual on Religious Discrimination, but it appears to be a dead link at this time. Using a search engine, we did find an EEOC link directly discussing Covid vaccination requirements, What You Should Know About Covid 19 and ADA Rehabilitation Act. In addition, the EEOC provided a link to its own Religious Accommodation Request Form.

The need to have your policies and vaccine statistics immediately available has not yet been added to the required day one documentation list, but our advice is to compile it and have it at your fingertips. If you have to go searching for it, calling different departments to get it organized after TJC or CMS arrive, you will be starting off at a disadvantage.

EC NEWS

EM Standards Effective July 2022:

This month's issue of *EC News* has two articles on the new emergency management standards due to take effect in July. The first article is really just a reminder about the implementation date, including some links to earlier publications on the subject. The second article is much more in depth and includes one of their checklists for self-assessing your level of compliance with the new standards.

This latter article and its checklist should be shared with your EM team leader and a formal evaluation of readiness should be conducted. We know from past experience that self-evaluations can at times be too superficial, and the subject matter expert looks at the requirement and to easily says: "yes, we have that, or yes we do that."

We would encourage the EM team to "drill down" or take a more granular approach by asking:

- Can you show me that document?
- Where exactly within that document is this issue addressed?
- Can you read that specific sentence(s) to us?
- What is the date of that document?
- How did you prioritize these potential hazards?
- Who from senior leadership, nursing, medical staff, etc. participated and helped develop this approach?
- What did not work adequately in our 2021 exercises and what has been modified in the 2022 design to improve those issues?

EC News provides a link to the tool and we would encourage our readers to follow that link to obtain and use the tool. In the past we have shared the internet links to resources that TJC provided in their newsletters in our newsletter to make it easier for accreditation leaders to obtain the resource, but TJC's attorneys have advised us to discontinue this practice, so be sure to directly use the link in this month's *EC News* to download EM checklist document.

Top Scored EC/LS Standards in Ambulatory:

This month's issue of *EC News* has an article on the top scored EC/LS standards in programs accredited using the ambulatory standards. Now you might think, "didn't I just read something on this?" You may be thinking of the April issue of *Perspectives* that provided insight on the most frequently scored elements of performance in each accreditation program.

This is somewhat different in that it is at the standard level, and focuses on just the EC/LS standards, not the clinical standards. While the article provides scoring data only from ambulatory accredited organizations, the issues identified are a high risk for hospital readers also. We would encourage our readers to share this month's article with your facilities leadership and as many of these EC and LS standards have a huge number of elements of performance, use this as an opportunity to rigorously self-evaluate.

We would suggest the same granular, questioning, show me the evidence techniques described above in the discussion on emergency management standards. For example, the most frequently scored standard is EC.02.05.07, which requires inspection, testing and maintenance of emergency power systems.

There are ten (10) elements of performance under this standard in both ambulatory and hospital accreditation. This standard was scored noncompliant in 37% of ambulatory programs last year. Superficially you might look at this standard and confidently say: "we are compliant, we test our generator each month." But in reality, there is much more to this than just the generator.

For example, to drill down for just the first 2 EPs in this standard you might ask:

Do we have documentation that we tested our emergency lighting, exit signs required for egress and task lighting for a minimum of 30 seconds each month?

- What are the dates of those tests? Show me.
- Do we have an inventory for each of those devices? Show me.
- Does the documentation make it clear the tests were for 30 seconds? Show me.
- Does the documentation make it clear one test each year was for 90 minutes? Show me.

- In newly constructed areas where deep sedation or anesthesia is administered do we have documentation that we performed a 30-minute test at least once a year? Show me.
- TJC supplied two NFPA references for conducting these tests, NFPA 101-2012:7.9.3;7.10.9, and NFPA 99-2012:6.3.2.2.11.5. Can you show me those requirements and were our tests performed in accordance with those references?

As you can see, a very granular self-assessment can be time consuming but can be helpful in finding any gaps in your process and documentation. The top ten most frequently scored EC/LS standards described in this article are scored noncompliant between 37%-19% of organizations surveyed. Thus, there is a high risk of a similar finding at your organization.

There is one other standard in this listing that we should specifically mention and that is EC.02.03.05, which was scored noncompliant in 30% of surveys. In addition to a similar drill down technique, this standard warrants additional focus because the documentation is so difficult to organize.

This standard examines the documentation of inspection and testing of fire safety systems and some tests are performed annually, some quarterly, some monthly, some by your staff, some by vendors, and some by the landlord in a leased building. To further complicate this one standard, there are over 20 elements of performance in both the ambulatory and hospital programs. Making sure you have your documentation logically organized and readily retrievable is a significant part of the compliance burden.

Some organizations have developed computerized databases, and while these can help, we sometimes see these being too difficult for staff to navigate and present evidence of testing in a rapid fire, granular analysis. In some respects, readiness for the evaluation of these standards is like the old joke asking, "how do you get to Carnegie Hall?" Practice, practice, practice.

CONSULTANT CORNER

Dear Readers,

We are here for you before, during, and after survey to assist you in accreditation and compliance – we can help, no matter your current state of readiness. We will simplify the many challenges for you, so you can deliver safe and compliant patient care.

Contact us for a confidential discussion of your needs and how we can help you achieve success!

Thank You,

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