INSIDE THIS ISSUE:

PERSPECTIVES

We hope that everyone is enjoying their summer thus far. The last couple of months there has not been a lot of new requirements we needed to discuss, but this month's edition of *Perspectives* does have some weighty subjects with two new sets of standards that will take effect in January 2023.

The new and revised standards address healthcare disparities and antimicrobial stewardship (ASP) programs. TJC has simultaneously published two new editions of their R3 newsletters that help to provide context, references and rationales for the new requirements. The new standards and the R3 publications can be found through the Standards portion of the TJC website.

Health Care Disparities:
The first new set of standards discusses health care disparities and these standards will apply to hospitals, critical access hospitals, ambulatory programs providing primary care through the AHC "Medical Centers" service line as defined in the ambulatory manuals SAP, or Standards Applicability Process (grid).

These new standards will also apply to most organizations accredited under the behavioral health manual including addictions, eating disorders, intellectual disabilities/developmental delays, mental health services, and those behavioral health programs which provide primary physical health care. These programs will each have one new leadership standard, LD.04.03.08 with six (6) elements of performance.

The new standard calls for these organizations to create a new organization goal stating "reducing health care disparities for patients is a quality and safety priority."

While the prepublication standards are detailed, we would encourage readers to initiate their analysis process using the R3 report as it provides additional context and explanation about the new requirements.

EP 1 calls for the organization to designate an individual to lead the activities to reduce health care disparities. Conceptually this is a similar approach TJC has taken over the years with new priorities and operational functions that go across service lines, and while it does not necessitate a new hire, it will require identification of an individual with leadership responsibilities, commitment, and time availability to take on this duty. The EP is silent on the issue that sometimes arises with surveyors looking for a formal appointment letter. As this question can arise during survey, we would advise formally documenting in writing the appointment of your new leader for this function.

EP 2 requires the organization to "assess the patient's health-related social needs and provide information about community resources and support services." There are two important notes that further help to explain the scope of this requirement. Note 1 authorizes the organization to make a determination which health-related social needs they will need to include in the patient assessment and they provide 5 examples including transportation, financial payments for prescriptions or medical care, education/literacy, food insecurity, and housing insecurity. Note 2 then permits the scope of this analysis to be either house wide, or limited to a representative sample of the organization's patients.

EP 3 requires the organization to "stratify its quality and safety data using the sociodemographic characteristics of the organizations patients." Again, there are two important notes associated with this EP that further explain the requirement. Note 1 permits the organization to determine which clinical areas to place its focus on disparities using examples of transplantation services, maternal care, diabetes management, or other measures that are meaningful house wide such as experience of care, or communication. Note 2 authorizes the organization to make its own determination on which sociodemographic characteristics it may choose to use for stratification and TJC provides four examples of age, gender, language, and race/ethnicity.

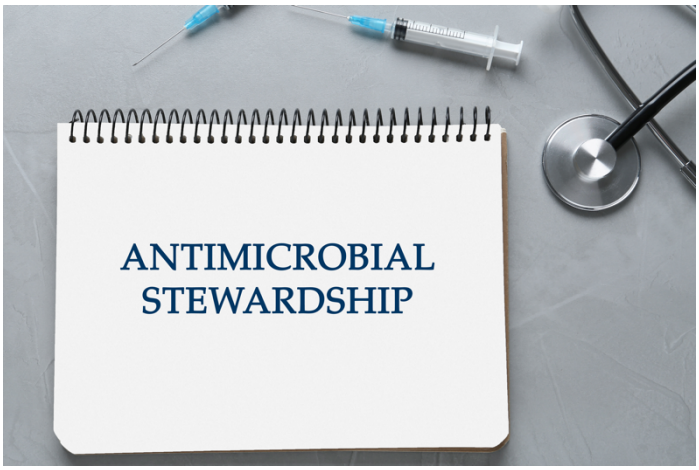
EP 4 establishes the requirement to develop a "written action plan that describes how the organization will address at least one of the health care disparities identified in its patient population." We noted that this EP has a D for documentation, but there is no mention as yet of timing as to when this EP is expected to be implemented. The new standards become effective January 2023.

EP 5 is a classic PI expectation that requires the organization to act when it does not achieve or sustain the goals in its action plan to reduce healthcare disparities. This EP also appears to a future score-able issue after you have implemented your improvement plan if outcomes have not improved.

EP 6 establishes an "annual reporting process to key stakeholders, senior leadership, providers and staff about the progress to reduce identified health care disparities."

Antimicrobial Stewardship:

Antimicrobial stewardship has been around for about a decade now with the first-generation requirements being somewhat rudimentary, such as start a program, conduct some analysis and try to make antibiotic use a little better. For the most part hospitals really seemed to take this issue to heart as proper antibiotic use had both quality-of-care opportunities and budgetary opportunities.



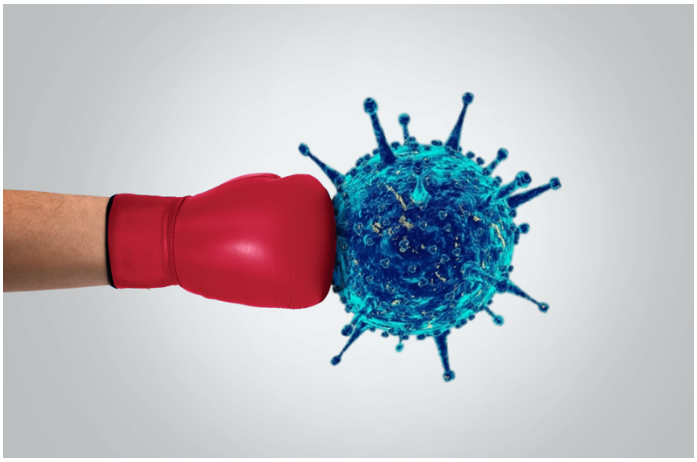
As with any PI initiative, once you have made things a little better, it's time to ramp up the scrutiny and advance the improvement and the new standard and its new elements of performance

appropriately look like a significant new generation expectation. The standard currently states that you should have an ASP program based on scientific literature. The revised standard states that the organization establishes antibiotic stewardship as an organizational priority through support of its ASP.

You might question how that differs from the current requirement and the elements of performance will help to explain the new emphasis. Our interpretation is that today you might see an ASP where pharmacist, physician, or nursing support is the 99th task on their daily "to do list."

The new standard and EP appear to create an expectation that there should be greater leadership resource support for the program. The new standard contains 12 new elements of performance, 10 through 21, some of which are entirely new and some of which revise earlier requirements. Do take a look at the R3 Report which helps to identify the EPs and concepts that have been revised vs those that are entirely new.

EP 10 states that the hospital "should allocate financial resources for staffing and information technology to support its ASP. " We often use a phrase "show me" in this newsletter and in our educational programs to help explain how to organize compliance data and documentation. Think about that concept in terms of this new EP. How many FTEs are dedicated to ASP for physician, pharmacist and nurse time for this function and how much money is allocated to the IT budget for ASP?



EP 11 is a refinement of an earlier requirement but it now states: "The **governing body** appoints a physician and or pharmacist who is qualified through education, training, or experience in infectious diseases and or antibiotic stewardship as the leader of the ASP. We emphasized the term governing body to point out that nuance.

EP 12 is also a refinement of an earlier requirement, but somewhat more specific in its detail. It states: "The leaders of the ASP are responsible for the following:

- Developing and implementing a hospital wide ASP that is based on nationally recognized guidelines to monitor and improve the use of antibiotics.
- Documenting ASP activities, including any new or sustained improvements.
- Communicating and collaborating with the medical staff, nursing leadership, pharmacy leadership as well as the hospitals infection prevention and QAPI programs on antibiotic use.
- Providing competency-based training and education for staff, including medical staff, on the practical applications of ASP guidelines, policies and procedures."

The functional linkage to QAPI appears stronger to us in the new EP and the term "competency" based training denotes a greater sense of rigor than the prior term training.

EP 13 is also a revision of a prior requirement and discusses ASP committee structure. There are two notes added to the EP, the first of which suggests participation by medical, nursing, and pharmacy staff, infection prevention, microbiology, information technology, and QAPI. The second note simply states, permissively, that the participants can be part time or consultant staff and that participation can be on site or remote.

EP 14, also a revision of an earlier requirement simply states that there should be ASP coordination among all the components of the hospital. Again, we would suggest using the phrase "show me, " taking a look at your minutes of the ASP committee, attendance lists, and subsequent reports from the ASP team to key discipline and leadership meetings.

EP 15, also a revision of an earlier requirement states that the ASP "documents the **evidence-based** use of antibiotics in **all** departments and services of the hospital." The bold code and underlining is our emphasis, in an attempt to point out an apparent difference in the revised EP.

EP 16 is entirely new requiring the ASP to "monitor the hospitals antibiotic use by analyzing days of therapy per 1000 days present or 1000 patient days, or by reporting to the NHSN Antimicrobial Use and Resistance Module." The CDC updated this module in March of this year and you can access the document using this link: https://www.cdc.gov/nhsn/pdfs/pscmanual/11pscaurcurrent.pdf

EP 17 is new, but it discusses two techniques ASPs currently use to effect change. The EP states that the "ASP should implement one or both (of the following) strategies to optimize antibiotic prescribing.

- Preauthorization for specific antibiotics that includes an internal review and approval process prior to use.
- Prospective review and feedback regarding antibiotic prescribing practices, including the treatment of positive blood cultures, by a member of the ASP. "

EP 18 is new and requires hospitals to "implement at least **two** evidence-based guidelines to improve antibiotic use. " Note 1 then provides 7 examples which includes community acquired pneumonia, UTI, skin and soft tissue infection, C diff colitis, asymptomatic bacteriuria, parenteral to oral antibiotic conversion, and surgical prophylaxis. There is a second note that states the "evidence-based guideline should be based on a national guideline but can also reflect local susceptibilities, formulary options and patients served. "

EP 19 is new and adds an evaluation component to EP 18. EP 19 requires the ASP to evaluate adherence to at least one of the evidence-based guidelines selected. There are two notes that help to explain this requirement. Note 1 allows the hospital to measure adherence at a departmental, unit, clinician subgroup or at the individual prescriber level. Note 2 permits the use of sampling using EHR record analysis.

EP 20 is a revision of an earlier requirement. EP 20 requires the hospital to "collect, analyze and report data to hospital leaders and prescribers". There is a note that provides examples of the types of data that should be collected including "antibiotic resistance patterns, antibiotic prescribing practices or an evaluation of ASP activities." Again, think of that phrase "show me. " What reports went to other key hospital leadership, committees and disciplines and do you and or others have a copy?

EP 21 is also a revision and it simply requires the hospital to "take action on improvement opportunities identified by the ASP. " Here we would encourage readers to take a look at meeting minutes, reports to leadership and evaluate how long identified issues remain unresolved or unimproved.

Interior Spaces:

This month's Consistent Interpretation column discusses one of the most generic elements of performance, EC.02.06.01, EP 1. The EP states that "interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment and services provided. " We used the term generic because just about anything in the physical environment that seems inappropriate, tacky, dirty, torn, or dingy can be scored against this EP.

TJC identified that this EP was scored in 63% of hospitals surveyed in 2021! This month's column does not point out any new revelations, but the surveyors' observations and the scoring guidance from their software identifies a huge array of diverse issues that can be scored at this EP. These types of issues may be useful for those who perform quality, infection prevention, EC or administrative rounds as things to look for.

EC NEWS

Workplace Violence:
In terms of standards compliance issues, safety, and program improvement we would suggest carefully reviewing the article in this month's EC News on workplace violence. This is a national issue, with new standards that some organizations are still working their way through.

This article describes the efforts of the SSM St. Anthony Hospital in Oklahoma which included a legislative effort to pass a Medical Provider Protection Act. They also describe additional actions underway which include personal panic devices for all staff that make noise and send an alert for assistance. We have seen these in forensic behavioral health settings, but use in acute hospitals is much less common.

They also describe design features for their ED, with one point of access, and reassignment of the security office to the ED. They used another technique we have seen in behavioral health settings looking at environmental features and equipment that are potentially weaponizable, so that these devices could be removed. This article would be well worth sharing with your workplace violence prevention team.

Anesthesia-Related Greenhouse Gas Emissions:
While not directly linked to a current standards compliance issue, there is a second article that is very informative on Anesthesia-Related Greenhouse Gas Emissions. This initiative was developed by the Providence Health System. Many organizations are already working on energy efficiency and reduction efforts on CO2 emissions, but the potential impact of inhaled anesthetic agents was new to us.

The inhaled anesthetic agents, desflurane, isoflurane, and sevoflurane are what are called halogenated anesthetics. Hospitals have scavenging systems to take exhaled vapors out of the operating room; however, these captured vapors are then released into the atmosphere. While these agents do not directly release any CO2, they have a blanketing effect in the atmosphere that limits release of heat into the upper atmosphere, much like CO2.

These anesthetic agents then have what is called a CO2 equivalency that provides insight on a comparative carbon footprint for each agent. The article identifies that desflurane has approx. 24X as much CO2 equivalency per hour of use as either isoflurane or sevoflurane. As you might imagine the system then worked with anesthesia to try and reduce the use of desflurane. While their first-year success was modest, the reduction in greenhouse gas was very substantial because of the huge difference in CO2 equivalency among these agents.

They also pointed out that nitrous oxide a less frequently used agent is another greenhouse gas. The EPA identifies nitrous oxide to be 7% of all greenhouse gases released into the atmosphere. While hospitals use a limited amount of nitrous oxide for medical use, a much larger percentage is released from farming activities.

The Providence System found that they did not have preferred alternatives and were not seeing any reduction in use, they were able to identify that they could reduce leakage of nitrous oxide by switching from a cryogenic liquid system to smaller E cylinders at the point of use.

The ideas presented here appear worth sharing with your EC committee and anesthesia department for their consideration.

FAQs on Emergency Management Standards:
TJC released 24 FAQs this past month on the new EM standards that take this month. Currently you can find these in the FAQ section of their website, under the "Featured" section. While this placement will be time limited, they will findable in the EM chapter. Our suggestion is to have your EM team leader download and analyze them now to ensure compliance and access to some of the resources mentioned in the FAQs.

Commercially Prepared Sterile Supplies and Devices:
On June 14, TJC published a new Quick Safety #65 on the use of commercially prepared sterile supplies and devices. This newsletter came with a great infographic translating all the manufacturers symbols that appear on labels. The most essential symbol from a standards compliance perspective is the circle with a 2 in it, and a diagonal line through the 2, meaning it is a single use device. We continue to see survey related problems when single use devices are sent back down to central sterile for reprocessing, which is prohibited.

This newsletter should be read carefully and content incorporated into staff education programs so that direct care staff know not to send these devices back to central sterile and central sterile staff know that this should be reported, so that re-education can take place.

CMS

Fortunately, TJC and CMS appear to be taking turns issuing new content (if only the coordination of effort were true!) This month, there were no new QSO memos from CMS.

CONSULTANT CORNER

Dear Readers,

The HBS family is growing! We are excited to announce they have acquired the Transition Planning Division of Healthcare Technical Services, LLC. The HTS team has a national presence providing transition planning, facility activation, and move planning services to hospitals helping ensure a safe transition and patient relocation into a new environment of care. To learn more about HTS, visit them at https://consulthts.com/

Contact us today for any of your regulatory compliance, transition planning, or facility activation needs!

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