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Healthcare Accreditation and Regulatory Compliance News

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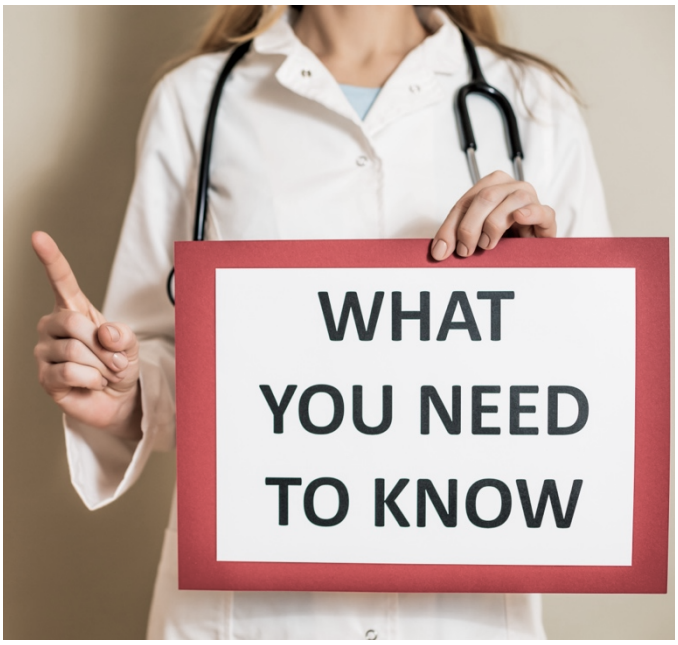
TJC PERSPECTIVES

The July issue of Perspectives contains multiple announcements about new standards that affect organizations such as behavioral health, ambulatory surgery, assisted living, home care, and nursing care centers. None of these changes directly affect hospital readers, however if you have a program accredited under these TJC standards or are a hospital that has one or more tailored programs accredited under these other standards, the changes will also affect your organization.

The changes announced are not actually published in *Perspectives*, however links to each revision are provided and they are reviewable on the TJC website under prepublication standards. We believe the most significant changes are in the behavioral health manual, with two sets of changes.



New CAMBHC EPs on Addiction:
The first set of changes are for behavioral health organizations that treat individuals with addictions. There are four (4) new elements of performance under standard CTS.04.02.33 that will require that the organization have the ability to provide medications to treat opioid use disorder, coordination of a referral if you need to send the patient elsewhere, education of the patient about the risk of abrupt discontinuation of these medications, and education of staff to assess, plan and deliver services with an understanding of evidence-based treatment for opioid use disorder.

While most organizations already offer medication treatment for opioid addiction, some may not, and the timeline to implement these changes is rather sudden. *Perspectives* and the prepublication page announced these changes effective as of August 1, 2024. As the accreditation contract with organizations calls for six (6) months advance notice for standards changes, unless it is a patient safety concern, we assume this is perceived as an important patient safety concern.

Barrins & Associates published a succinct article, Joint Commission Releases New Medications for Opioid Use Requirements, which provides more depth on each new requirement, the rationale, and valuable implementation recommendations. Please read and share this Barrins Blog with your BH Leaders.

CAMBHC Physical Hold of a Child:
The second set of behavioral health standard changes is in CTS.05.05.01 - CTS.05.05.21. The prepublication announcement is ten (10) pages in length, however there is only one consistent message or theme throughout these pages and that is that special standards requirements for physical hold of a child are gone.

As of January 1, 2025, such situations will just be considered physical restraint and evaluated using restraint standards. *Perspectives* indicates that TJC is also modifying their glossary definition of restraint to include any method that immobilizes or reduces the ability of an individual to move their arms, legs, body, or head freely. If you had two separate policies and/or requirements you will want to modify those policies prior to January 2025.

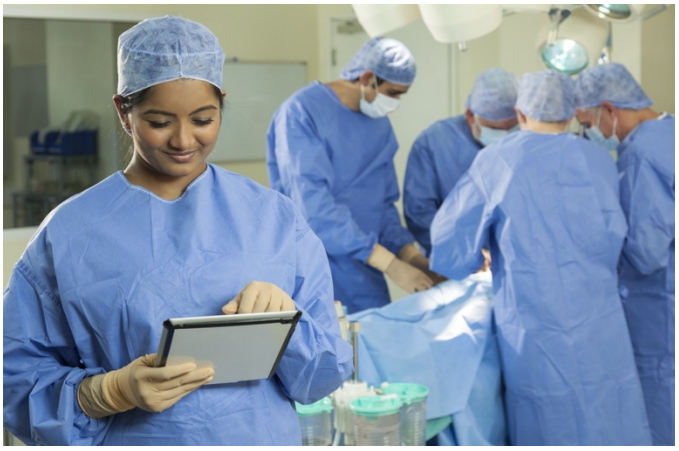
New EPs for OME, ALC, & NCC:
There are new infection control EPs for home care, assisted living and nursing care centers. Each set of revisions contains multiple "D" elements of performance which require documentation and, as you design your processes, you will want to ensure that the process includes documentation of effort. Policies are of course easier to document because the policy itself provides the documentation.

Perspectives also announced that the home care program has new workplace violence standards you will want to download and analyze. As we are writing this newsletter, these have not yet been posted to the prepublication website but do look for them in the days ahead. The workplace violence and

infection prevention standards all take effect January 1, 2025.

AHC Standards Changes:
There were also changes in the ambulatory care program affecting ambulatory surgery centers to align with CMS requirements. There was one clinical change in the HR chapter relative to granting of privileges to perform surgery, in accordance with "approved policies and procedures." There are three (3) patient rights edits relative to informing or planning care with a patient's representative and multiple edits in the life safety code chapter with two consistent notes relative to deemed status or non-deemed status situations.

In non-deemed status situations, four (4) or more patients rendered incapable of self-preservation requires compliance with the life safety code. In deemed situations all organizations must comply with the life safety code regardless of the number of patients served. These changes take effect August 1, 2024.



Change to the ESC Process?
We have seen organizations being asked to include information in their ESC about "other patients potentially affected" by a single identified noncompliance situation. For example, a surveyor notes the problem with one specific patient, but it could be the problem only occurred with one patient or it could be the problem was more widespread, but not observed by the surveyor.

We checked the posted ESC instructions and did not see this detail described. Joint Commission staff explained to the client organization, it was something CMS wanted, but thus far this has not been detailed.

Keep a close eye on new communications from The Joint Commission on this subject as changes to required ESC submission content without a formal published notice from the Joint Commission or a modification to the published ESC instructions is not consistent with previous practice.

Staffing Standards:
Last month we mentioned that TJC was analyzing potential new standards relative to staffing. This month the *Consistent Interpretation* column discusses the scoring of current staffing standards, and it is really minimal.

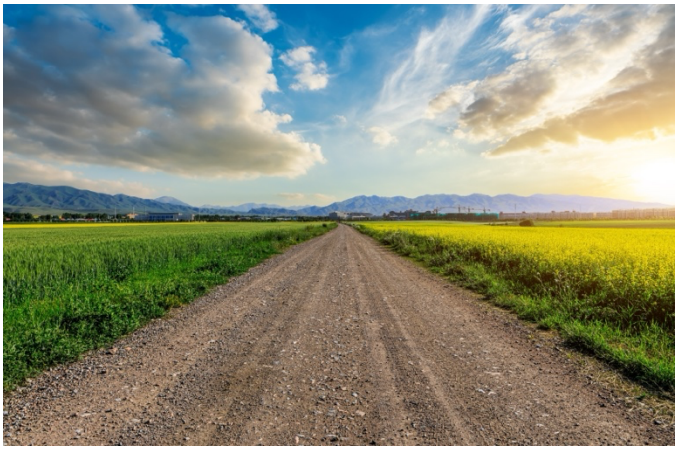
PI.03.01.01, EPs 12, 13 and 14 are each under 1% with EP 13 being entirely unscored in the prior year. While staffing is a hugely important issue for all readers, the current standards approach is not helping to identify problems. We do sometimes on consultation visits see lesser compliance and

awareness of EP 14, which calls for an annual report to leadership summarizing the findings and actions taken from the individual Root Cause Analysis analyses done throughout the year.

Do continue to be on the lookout for draft standards that are anticipated to be coming in this area, as prior methods may not be sensitive enough or productive.

TJC EC NEWS

Rural Health Clinic EC Standards:
The lead article in the July edition of EC News is about the new Rural Health Clinic (RHC) accreditation program's environment of care standards (EC). These are only applicable to organizations/programs seeking Rural Health Clinic accreditation, but it was interesting to see that they genuinely have developed a reduced set of standards for EC, appropriate to smaller, rural providers.



CAMBHC Workplace Violence Standards:
There is a second article on the newly applicable, July 1st, workplace violence standards (WPV) for behavioral health, but this is mostly just a restatement of the standards and EPs rather than additional implementation or interpretation guidance. There are two links at the end of the WPV article on to a JCR developed workplace violence assessment checklist and a second to what they call a workplace violence compendium of resources that may be useful to behavioral health or other settings.

Case Study: Workplace Violence:
If you have limited time, probably the most useful article to review is the case study from the Salem Health System's workplace violence initiative they called HWA, or harmful words and actions. They had noted an increase in reported violence incidents during the pandemic and realized they needed a better approach.

One factor they identified is the time needed to complete a workplace violence incident report or HWA report. They simplified their process and changed that burden from more than 15 minutes to only 2-3 minutes. This makes sense, similar to what hospitals learned about incident reports in general or medication error reports. People will fill out the reports if the process and time commitment is reasonable. They also reported that some staff did not feel empowered to address behaviors and they needed to provide tools, resources, and provide support to staff to feel comfortable in reporting harmful behaviors.

The organization provided training for staff to help them identify disrespectful behaviors from patients, families, and even coworkers. They also developed a door sign designed to warn visiting staff from centralized departments to check with the direct care staff before entering the room for certain

patients with a history of aggressive behavior.

To provide confidentiality, the sign was simply an exclamation point, no specific language that might breach confidentiality. The modified reporting process combined with better training and recognition of harmful behaviors lead to more reporting as well as better data and more useful data for analysis.

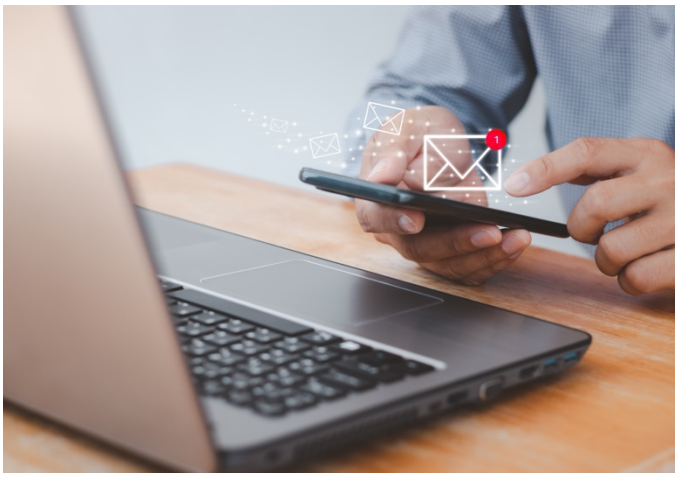
Safety and Security Risk Assessments:
EC News also has a useful article discussing how to obtain information to perform the safety and security risk assessments required by EC.02.01.01, EP 1. They start off by analyzing the data streams that should be available to perform this analysis, such as:

- EC tours and rounds
- OSHA required job hazard analyses
- Annual workplace violence (WPV) worksite analysis
- Incident reports
- Patient satisfaction data
- Nationally trending safety risks from OSHA, TJC sentinel events, ECRI
- Results of internal RCAs
- PI data
- IC data
- Interviews with department heads
- Staff feedback and complaints

The authors also provide links to two more JCR developed checklist tools, one for a Safety Risk Assessment and a second for a Security Risk Assessment. The use of data sources such as above plus potential use of the JCR tools should be risk-assessed to prioritize risk points or issues for mitigation.

TJC *EM Leader*

Top 4 Most Frequently Scored Standards:
TJC published their new bimonthly emergency management newsletter in June. The lead article is



on scoring within the EM chapter and the four most frequently scored standards. Overall, less than 10% of hospitals surveyed in the prior year had any EM standards scored noncompliant, which is surprising. This minimal scoring may be due to the newness of the chapter or time allocation and competing priorities on survey, however scoring is less than we would have anticipated as consultants evaluating this same chapter.

1. The most frequently scored standard is EM.16.01.01, EP 2 which requires the two annual exercises, one full scale and the other which can be discussion-based. Missing the requirement for conducting the exercise, or to evaluate a genuine emergency with an

activation of your EM plan could lead to secondary RFIs such as failure to evaluate the exercise or active disaster.

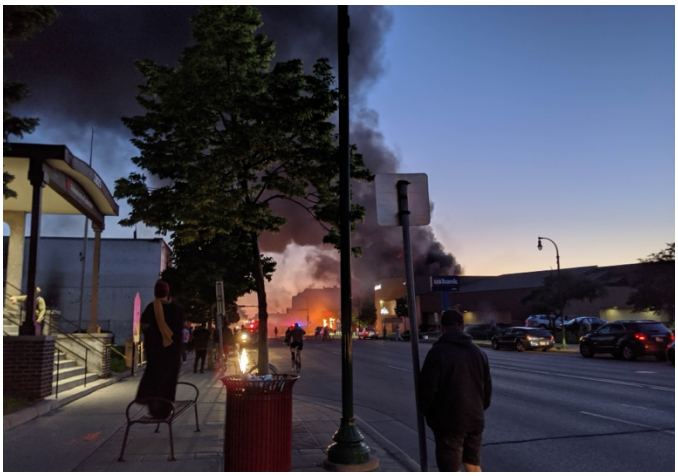
2. The second and third most frequently scored issue is the written continuity of operations plan (COOP) EM.13.01.01, EPs 3 and 1 respectively. This idea of a COOP has been a difficult concept for some organizations and surveyors to understand. It requires a written order-of-succession plan describing who assumes authority and responsibility for particular leadership roles when the primary individual cannot be present due to the emergency. Fortunately, this same issue of EM Leader has a second article describing Seven Steps for Developing a COOP.

3. EM.15.01.01, EP 4 is tied for the third most frequently scored EM issue. This EP requires the incident command staff to have education and training specific to their duties in the hospitals incident command system.

4. EM.11.01.01, EP 2 requiring a hazard vulnerability assessment is the fourth most frequently scored EM standard and it is an issue that was frequently scored in the prior version of the chapter also. In an HVA the organization should identify the potential hazards that pose a risk to them, and this includes natural disasters, human caused disasters such as bomb threats or cybercrimes, technological disasters such as utility or IT outages, hazardous materials such as chemical, radiological or nuclear, and lastly emerging infectious diseases such as Ebola, Zika, or SARS-CoV-2. Again, there is a nice synergy in EM Leader with a second article on Creating an Effective HVA. In addition to describing how to develop an HVA, links are provided to the ASHE HVA and Kaiser Permanente HVA tools.

EM.12.02.09, EP 3 is tied for the fourth most frequently scored issue. This EP requires the hospital to have a plan for managing its resources and assets to sustain the organization for up to 96 hours based on calculations of current resource consumption. We sometimes see declarative statements that yes, we have resources and assets for 96 hours, but there is no science behind that statement such as daily utilization and/or inventory levels from key departments, or there is an assumption that we will obtain additional supplies from remote wholesalers/vendors regardless of the nature of the most likely disasters prioritized in the HVA.

Case Study: Coping with Civil Unrest:
EM Leader also has an article on Coping with Civil Unrest describing the work done at Hennepin County Medical Center in Minneapolis, MN several years ago. They also described their work in a prior article published in EC News back in September of 2020. As protests or civil unrest situations are still common there are good suggestions here for preparing in your own organization.



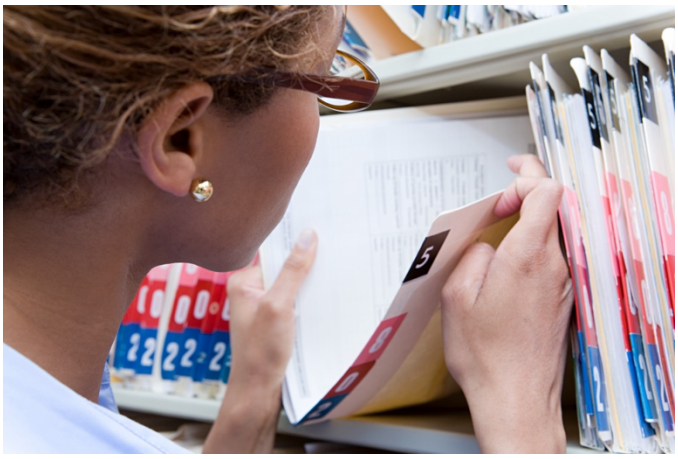
Accreditor News

ACHC: Free Webinars: AI & Cybersecurity:
ACHC has announced two free webinars this month. The first is on July 17th discussing Generative AI in Patient Safety and Risk Management. The learning objectives indicate that attendees will be able to assess the risks and benefits of AI in patient safety and risk management. As more young clinicians learn to utilize AI this certainly sounds useful to have a handle on. To learn more and register visit: ACHC Generative AI in Patient Safety and Risk Management.

The second free webinar is on July 18th discussing cybersecurity for non-IT leaders. With recent healthcare attacks and attacks in other industries, this too sounds like a useful subject to know more about to prevent similar situations in your own organization. Registration is available on the ACHC website. To register for this presentation visit: ACHC Cybersecurity for non IT Leaders.

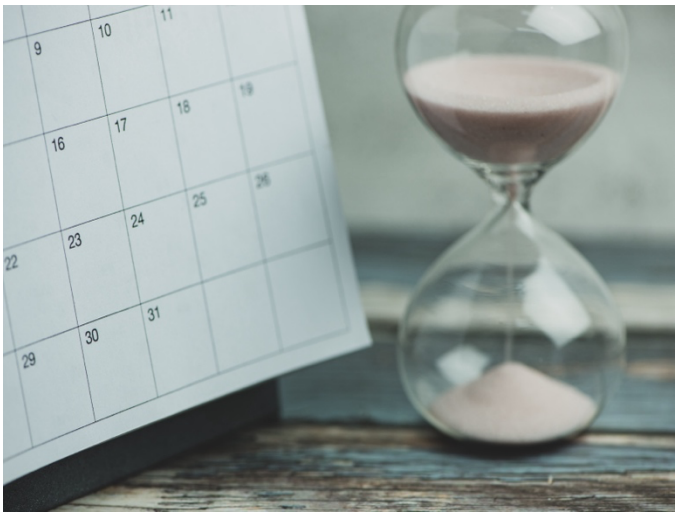
CIHQ: Medical Record Reviews:
The June CIHQ newsletter has advice for readers on preparing for medical record reviews during a survey. Finding the information the surveyor is requesting to view is a much different experience than the usual process of entering data while documenting a patient care service.

There is also a link to a CMS hardship exception application for hospitals and critical access hospitals that cannot meet the interoperability program requirements for 2023. As meeting these requirements will be linked to payment, if you were delayed due to some natural disaster, lack of internet access, or other issue, this may be useful to your organization.



DNV: Corrective Action Timeline Update:
During the past month they distributed an updated timeline for corrective action submissions for their Healthcare Certification and Credentialing (VAD) activities.

The timeline changed from 10 calendar days to 10 business days following receipt of the final report. This change does not affect their CMS deemed NIAHO accreditation or ISO 9001 activity.



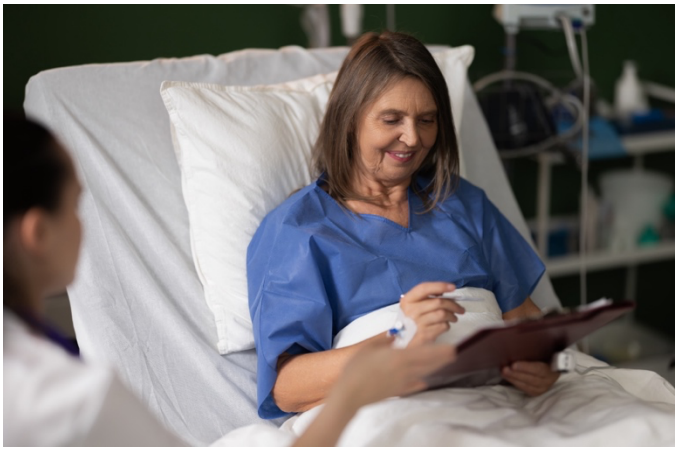
CMS

Surgical Procedure Consent Continued:
Last month we had mentioned an oddity in QSO 24-10 relative to performing additional examinations for teaching purposes during a surgical procedure. CMS had revised and expanded the content but had not gone through its usual official revision and reposting process.

We did hear from one reader that they were concerned about this unofficial change process that was now inconsistent with Appendix A of the State Operations Manual. They have been in contact with CMS to try and learn more about why the formal change process was not followed and questioned CMS if their change was actually official. As a reminder the tweak CMS had added stated:

"*A written consent form is required for patients undergoing anesthesia procedures, but patients with the ability to verbally affirm consent for procedures that do not require anesthesia should have their medical record reflect that consent was given. In both instances there is written documentation of consent for any examinations*."

Readers may want to wait and see if CMS officially approves and formalizes the change in the State Operations Manual if this poses a burden in your organization. We will publish an update if we learn more.



CONSULTANT CORNER

Dear Readers,

As you may know, the annual American Hospital Association (AHA) Leadership Summit is right around the corner, being held in San Diego, CA from July 21-23. We are excited to be an exhibitor amongst other senior health care executives, clinicians, and experts in the field.

Register to attend and come stop by our booth (#803) to celebrate Barrins & Associates' 25 Years of Excellence with us! We will have some table goodies, cupcakes, and a raffle prize at the end. We look forward to seeing you there!

Thank You,

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