Joint Commission Resources
Quality & Safety Network
Resource Guide

The CMS and Joint Commission Crosswalk: An Update

September 22, 2011
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Program Summary

This page provides an overview of the program content and learning objectives. Please refer to the Table of Contents and Program Outline for a detailed list of the topics covered. The information included in this Resource Guide is intended to support but not duplicate the video presentation content. There may be additional information available online for this topic.

Program Description

Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC) both regulate the same administration aspects of healthcare, and most facilities cannot or do not choose to follow one or the other. Healthcare organizations must meet federal requirements outlined by CMS if they want to receive Medicare or Medicaid reimbursement for services. In addition, most hospitals and healthcare systems participate in a voluntary survey process through TJC.

To keep up in this fast-changing environment, organizations must maintain a constant state of readiness and ongoing compliance. Doing so can seem overwhelming when there are two different surveys for which to be ready, but healthcare facilities do not necessarily need to prepare different documents or different processes to meet CMS and TJC standards.

To help healthcare organizations maintain preparations for both surveys, this program outlines the Conditions of Participation and TJC standards and elements of performance. Its goal is to provide a tool to help organizations understand the requirements, see the similarities and differences between the requirements, and identify the documents or processes that are already in place so that you can prepare for one or both surveys without duplicating efforts.

This 60-minute activity features a discussion of these standards by Joint Commission experts.

Program Objectives

After completing this activity, the participant should be able to:

1. Describe the relationship between CMS and TJC.
2. Discuss the requirements and how these requirements apply to your organization.
3. Identify strategies to implement these requirements.

Target Audience

This activity is relevant to medical staff, organization leaders, managers, supervisors, and staff responsible for performance improvement, patient safety, and risk management initiatives.
Continuing Education (CE) Credit

After viewing the JCR Quality & Safety Network presentation and reading this Resource Guide, please complete the required online CE/CME credit activities (test and feedback form). The test measures knowledge gained and/or provides a means of self-assessment on a specific topic. The feedback form provides us with valuable information regarding your thoughts on the activity’s quality and effectiveness.

NOTE: Effective January 1, 2009, the Learning Management System web site URL changed as noted below.

Prior to the Program Presentation Day

1. Login to the JCRQSN Learning Management System web site at http://jcrqsn.mcnlearning.com/
2. Enroll yourself into the program
   Note: Your administrator may have already enrolled you in the program
   • Select All Courses from the courses menu.
   • Select the course category for the current year, 2011 Programs.
   • Select the course for this program, The CMS and Joint Commission Crosswalk: An Update
   • When prompted, choose Yes to confirm that you would like to enroll yourself.
3. Display and print the desired documents (Resource Guide, etc.).

Online Process for CE/CME Credit

1. Read the course materials and view the entire presentation.
2. Login to the JCRQSN Learning Management System web site at http://jcrqsn.mcnlearning.com/
3. Select The CMS and Joint Commission Crosswalk: An Update from the courses menu block.
   Note: This assumes you have already been enrolled in the program as described above
4. If you didn’t view the broadcast video presentation, view it online.
5. Complete the online post test.
   • You have up to three attempts to successfully complete the test with a minimum passing score of 80%.
   • Physicians must take the post test to obtain credit.
6. Complete the program feedback form.
7. On the top right corner of the main course page, you will see your completion status in the Status block.
8. Select Print Certificate from within the Status block to print your completion certificate.

Process for VA Knowledge Network Participants

1. Read the program’s Resource Guide and view the entire video presentation (speak with your administrator for broadcasting times – do NOT log in to view the program).
2. Complete the Viewer Response form (speak with your administrator to obtain a paper copy that will be completed manually – do NOT log in to take the online test).
3. Complete the Program Evaluation.
4. Record the answers to the post test where indicated on the Viewer Response form.
5. Return the Viewer Response form by the program due date listed in the upper left corner of the page.
   Forms received after this due date will not be eligible for CE credit.
6. Please allow 6 weeks for processing your Viewer Response Form.

* If you have any questions please contact Rose Monfore at 714-283-4746.
Program Outline

The CMS and Joint Commission Crosswalk: An Update
September 22, 2011

I. Introduction
   A. Program Content
   B. Objectives
   C. Faculty

II. What's Changed? The Relationship Between CMS And TJC

III. What's Challenging? The CMS and TJC Crosswalk

IV. What's Challenging? Strategies to Implement the Requirements

V. Conclusion

VI. Live Question and Answer Session
   A. Audio only telephone seminar with program faculty – for 30 minutes following the program.
   B. Call 1-888-206-0090; enter conference code: 7925428.
      Or e-mail your questions or comments to: Questions@jcrqsn.com

<table>
<thead>
<tr>
<th>Program Broadcast Time</th>
<th>Eastern:</th>
<th>Central:</th>
<th>Mountain:</th>
<th>Pacific:</th>
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<td>2:00 p.m. to 3:00 p.m.</td>
<td>1:00 p.m. to 2:00 p.m.</td>
<td>12:00 p.m. to 1:00 p.m.</td>
<td>11:00 a.m. to 12:00 p.m.</td>
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During the live airing of this program on September 22, 2011, you may be able to talk directly with the faculty when prompted by the program’s host. After this date, your message will be forwarded to the appropriate personnel.

Immediately following the program, we invite you to join in a live discussion with the program presenters. Call 1-888-206-0090 and enter Conference Code: 7925428 to be included in the teleconference.

To submit your question ahead of time or for additional details, please send an e-mail to questions@jcrqsn.com. If you submit your questions after this date, your message will be forwarded to the appropriate personnel.

You can also receive answers to your questions by calling The Joint Commission’s Standards Interpretation Hotline at 630-792-5900, option 6.
Toward a Common Goal: Implementing Revised Standards Aligned with CMS Requirements

In 2010 the Centers for Medicare & Medicaid Services (CMS) extended The Joint Commission’s deeming authority. This four-year CMS designation means that hospitals accredited by The Joint Commission may choose to be “deemed” as meeting Medicare and Medicaid certification requirements without an additional survey by either CMS or the state and thereby receive payments from CMS for care, treatment, and services provided to Medicare and Medicaid patients.

To ensure alignment of its standards with CMS Conditions of Participation (CoPs), The Joint Commission revised several elements of performance (EPs) and developed a number of new EPs in the Spring update to the Comprehensive Accreditation Manual for Hospitals. The following sections take a closer look at many of these changes and provide tips and strategies for compliance.

Hospital EPs

The following two EPs apply to all hospitals seeking deemed status as well as to distinct part units (DPUs) in critical access hospitals.

**IM.02.02.03, EP2**

This Information Management (IM) standard requires organizations to retrieve, disseminate, and transmit health information in useful formats. The Joint Commission has added a new note to EP 2 that requires hospitals seeking deemed status to have medical record systems that allow for timely retrieval of patient information by diagnosis and procedure. This note better clarifies the expectations of the associated CoP, specifically those expectations relating to retrieving patient information to support medical care evaluation studies.

“If an organization has robust information technology (IT) and coding systems, compliance with this EP may be less challenging because the systems may be able to extract important clinical information, using codes such as DRGs, ICD-9 codes, modifiers, and CPT codes, and so on,” says John Wallin, M.S., R.N., associate director, Standards Interpretation Group at The Joint Commission. “Those organizations without such systems may have difficulty here because retrieving information by diagnosis and procedure will be more challenging. In these cases, hospitals should consider how they will retrieve this information and put plans in place to support a timely effort.”

**TS.02.01.01, EP 2**

This Transplant Safety (TS) standard addresses organ transplant responsibilities, and EP 2 clarifies what is required from a regulatory standpoint. The additions to this EP require hospitals to be prepared to submit all data related to an organ transplant to the U.S. Department of Health & Human Services.

“What hospitals do not need to transmit information to the federal government for every transplant, they must be prepared to do so if asked,” says Wallin. “This information should include a detailed audit that shows where the organ or tissue came from and the process used to acquire it.” To comply with this standard, hospitals should make sure they have a solid audit trail starting with the origins of a transplant organ or tissue. They also must be able to produce the information upon request.

Psychiatric Hospital EPs

In addition to the general hospital EPs, The Joint Commission revised EPs for psychiatric hospitals to capture the level of specificity found in two special psychiatric CoPs (42 CFR 482.60, 482.61, and 482.62). Because the language in these special CoPs is the same as the language required for psychiatric DPUs in critical access...
hospitals found in section 42 CFR 412.27 of the CoPs, these revisions also apply to psychiatric DPUs in critical access hospitals. Note that these EPs do not apply to general acute care hospitals with psychiatric units, but only to psychiatric hospitals that choose to be surveyed for compliance with the psychiatric hospital special CoPs.

**PC.01.02.13, EP 2**

This Provision of Care, Treatment, and Services (PC) standard pertains to the assessment of patients with emotional and behavioral disorders. The additional information in EP 2 requires psychiatric hospitals to ensure that the patient assessment includes a particular reason for admission. “This reason must be specifically stated by either the patient or someone significantly involved with the patient, such as a family member or surrogate,” says Cynthia Leslie, A.P.R.N., B.C., M.S.N., associate director in the Standards Interpretation Group of The Joint Commission. To comply with this EP, organizations should make sure that staff understand the need to identify the specific reason for admission. Including a prompt on the assessment form may be helpful with this.

**PC.01.02.13, EP 6**

This EP relates to identifying the need for a complete neurological exam and determining when such an exam is warranted. “Physicians in a psychiatric hospital must determine when a complete neurological exam is indicated and what elements should be included in such an evaluation,” says Leslie. “After identifying the triggers for an exam, organizations should determine how those triggers should be included in the assessment so that a neurological exam is performed when necessary.”

To help with compliance, psychiatric hospitals may want to consider adding the requirements for this exam into the Medical Staff rules and regulations as part of required elements in a history and physical. (Further information on the required elements can be found at Medical Staff Standards MS.03.01.01, EP 6, and MS.01.01.01, EP 16.)

**PC.01.03.01, EP 5**

This standard discusses the process of planning the patient’s care. The note added to EP 2 requires psychiatric hospitals to include the patient’s short-term and long-term goals in the written plan of care. An example of a short-term goal may be to orient the patient to a unit and ensure that he or she understands the rules of the unit. Depending on the organization, this effort may involve using an orientation packet, which lists the various rules of the department. A long-term goal might require the patient to know his or her medications and understand any side effects associated with them.

“This standard and EP are not just about establishing the plan of care, but also maintaining and updating it as the patient progresses through treatment,” says Wallin. “Organizations must ensure the plan of care is based on the assessed needs of the patient. This will require more than just filling out a standardized form. The plan of care processes must result in a detailed, customized, and flexible document that specifically addresses the needs of the particular patient.”

**PC.01.03.01, EP 43**

This EP also relates to the plan of care, requiring psychiatric hospitals to include a description of the roles and responsibilities of the treatment team in the plan of care. This description may be a few sentences or more detailed. Depending on the organization and the patient, a treatment team may include the following members:
- Physician
- Social worker
- Case manager
- Nurse
- Physical therapist/occupational therapist/speech therapist
- Activity therapist
- Mental health counselor (including substance abuse counselor)
“When determining roles and responsibilities, organizations should look at any state rules and regulations, specific CMS requirements, and their own policies and procedures,” says Leslie. “This review will ensure that the designated roles and responsibilities meet all the various requirements affecting the hospital.”

**LD.04.01.05, EP 10**

This Leadership (LD) standard addresses the role of leaders in managing programs, services, sites, and departments. This new EP requires psychiatric hospitals to have a director of social work services who monitors and evaluates services furnished in the organization and makes sure they are provided in accordance with accepted standards of practice and established policies and procedures. “To comply with this EP, psychiatric hospitals must have policies and procedures regarding the role of social work in the organization, and these policies and procedures must adhere to standards of practice and any relevant regulations, such as those of the state,” says Leslie.

Depending on the organization, a social worker may provide a range of services, including the following:

- Serve as an active member of the patient care team
- Arrange for obtaining needed adaptive equipment, clothing, and personal items
- Maintain contact with family (with patient’s permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning
- Assist/make referrals to obtain services from community resources
- Assist with financial and legal matters
- Contribute to discharge planning services

Note: These are examples of possible services and are not intended to comprise a comprehensive list. Organizations first and foremost must determine any applicable law and regulation for their state related to required social services.

One final suggestion for organizations seeking to comply with any and all of these CMS–aligned requirements is to spend time reviewing the actual CMS verbiage (available at [http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html](http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr482_04.html)). According to Wallin, “While The Joint Commission has addressed the intent of these requirements in its new and revised EPs, taking the time to review the actual CoPs would certainly help an organization to further understand the specifics of the CMS requirements.”

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**Applicability of New and Revised EPs**

Not every new or revised EP applies to every type of hospital. Here is a list of the EPs and their applicability.

<table>
<thead>
<tr>
<th>EP</th>
<th>Applicability for Organizations Seeking Deemed Status</th>
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<tbody>
<tr>
<td>IM.02.02.03, EP2</td>
<td>Hospitals and DPUs in critical access hospitals</td>
</tr>
<tr>
<td>TS.02.01.01, EP 2</td>
<td>Hospitals and DPUs in critical access hospitals</td>
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<tr>
<td>PC.01.02.13, EP 2</td>
<td>Psychiatric hospitals and psychiatric DPUs in critical access hospitals</td>
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<td>PC.01.02.13, EP 6</td>
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<td>PC.01.03.01, EP 5</td>
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<td>PC.01.03.01, EP 43</td>
<td>Psychiatric hospitals and psychiatric DPUs in critical access hospitals</td>
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<tr>
<td>LD.04.01.05, EP 10</td>
<td>Psychiatric hospitals and psychiatric DPUs in critical access hospitals</td>
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**ACCEPTED: New and Revised Hospital and Critical Access Hospital Requirements to Meet Relevant CoPs**

Following a review of its application for deeming authority for psychiatric hospital special Conditions of Participation (CoPs) by the Centers for Medicare & Medicaid (CMS), The Joint Commission revised several elements of performance (EPs) and developed a number of new EPs to meet both the general Medicare hospital CoPs and the psychiatric hospital special CoPs. The Joint Commission’s Board of Commissioners recently accepted these new and revised EPs, which became effective **February 1, 2011**.

Certain EPs were revised to comply with the Medicare hospital CoPs, including the following EPs revised for hospitals and distinct part units (DPUs) in critical access hospitals: “Information Management” (IM) Standard IM.02.02.03, EP 2, and “Transplant Safety” (TS) Standard TS.02.01.01, EP 2. Joint Commission staff also took this opportunity to make editorial changes, which apply to hospitals and critical access hospitals, to the following EPs: “Emergency Management” (EM) Standard EM.03.01.03, EP 1, “Environment of Care” (EC) Standards EC.02.03.01, EPs 9 and 10, and EC.02.05.03, EPs 1–6, and “Life Safety” (LS) Standard LS.02.01.30, EPs 6 and 25.

The Joint Commission made additional revisions and developed new EPs for psychiatric hospitals to capture the level of specificity found in two special psychiatric CoPs. Because the language in these special CoPs is the same as the language required for psychiatric DPUs in critical access hospitals found in section 42 CFR 412.27 of the CoPs, these revisions also apply to psychiatric DPUs in critical access hospitals. These new and revised EPs include “Provision of Care, Treatment, and Services” (PC) Standards PC.01.02.13, EPs 2 and 6, and PC.01.03.01, EPs 5 and 43, and “Leadership” (LD) Standard LD.04.01.05, EP 10.

The new and revised EPs can be seen in their entirety below and on pages 11-13. Additions are **underlined**, while deletions are noted in **strikethrough**. These changes will appear in the 2011 Update 1 to the Comprehensive Accreditation Manual for Hospitals and Comprehensive Accreditation Manual for Critical Access Hospitals and the next E-dition® update being released in April.

### New and Revised Critical Access Hospital and Hospital Requirements

**APPLICABLE TO CRITICAL ACCESS HOSPITALS (CAH) AND HOSPITALS (HAP)**

**Effective February 1, 2011**

**Environment of Care (EC)**

**Standard EC.02.03.01**

The [critical access hospital/hospital] manages fire risks.

**Elements of Performance for EC.02.03.01**

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<td><em>(See also LS.02.01.70, EP 4)</em></td>
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**A 10.** The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire’s point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. *(See also EC.02.03.03, EP 5; EC.03.01.01, EP 2; and HR.01.04.01, EP 2)*

**Note:** *For additional guidance, see NFPA 101, 2000 edition (Sections 18/19.7.1 and 18/19.7.2).*

**Standard EC.02.05.03**

The [critical access hospital/hospital] has a reliable emergency electrical power source.
<table>
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<tr>
<th>Elements of Performance for EC.02.05.03</th>
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<tr>
<td>The [critical access hospital/hospital] provides emergency power for the following:</td>
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<tr>
<td><strong>Note:</strong> For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).</td>
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<tr>
<td>A 2. Exit route and exit sign illumination, as required by the Life Safety Code.</td>
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<tr>
<td><strong>Note:</strong> For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).</td>
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<tr>
<td>A 3. Emergency communication systems, as required by the Life Safety Code.</td>
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<tr>
<td><strong>Note:</strong> For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).</td>
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<tr>
<td>A 4. Elevators (at least one for nonambulatory patients).</td>
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<tr>
<td><strong>Note:</strong> For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).</td>
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<tr>
<td>A 5. Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems.</td>
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<tr>
<td><strong>Note:</strong> For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).</td>
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</tr>
<tr>
<td>A 6. Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms, nurseries, and urgent care areas.</td>
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</table>

**Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).

### Emergency Management

#### Standard EM.03.01.03

The [critical access hospital/hospital] evaluates the effectiveness of its Emergency Operations plan.

#### Element of Performance for Standard EM.03.01.03

A 1. As an emergency response exercise, the [critical access hospital/hospital] activates its Emergency Operations Plan twice a year at each site included in the Plan.

**Note 1:** If the [critical access hospital/hospital] activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.

**Note 2:** Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code®*) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.

**Note 3:** Tabletop sessions, though useful, are not acceptable substitutes for these exercises.

**Note 4:** In order to satisfy the twice-a-year requirement, the [critical access hospital/hospital] must first evaluate the performance of the previous exercise and make any needed modifications to its Emergency Operations Plan before conducting the subsequent exercise in accordance with EPs 13–17.

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* The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2000 for occupancy classifications.
New and Revised Critical Access Hospital and Hospital Requirements (continued)

**Information Management (IM)**

**Standard IM.02.02.03**
The [critical access hospital/hospital] retrieves, disseminates, and transmits health information in useful formats.

**Element of Performance for IM.02.02.03**

A 2. The [critical access hospital/hospital’s] storage and retrieval system make health information accessible when needed for patient care, treatment, and services. *(See also IC.01.02.01, EP 1)*

*Note: [CAH only: For rehabilitation and psychiatric distinct part units in critical access hospitals:] [HAP only: For hospitals that use Joint Commission accreditation for deemed status purposes:] The medical records system allows for timely retrieval of patient information by diagnosis and procedure.*

**Leadership (LD)**

**Standard LD.04.01.05**
The [critical access hospital/hospital] effectively manages its programs, services, sites, or departments.

**Element of Performance for LD.04.01.05**

A 10. *(CAH only: For psychiatric distinct part units in critical access hospitals:] [HAP only: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:] The [critical access hospital/hospital] has a director of social work services who monitors and evaluates the social work services furnished.

*Note: Social work services are furnished in accordance with accepted standards of practice and established policies and procedures.*

**Life Safety (LS)**

**Standard LS.02.01.30**
The [critical access hospital/hospital] provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Elements of Performance for LS.02.01.30**

C 6. Existing corridor partitions are fire rated for 1/2 hour, are continuous from the floor slab to the floor or roof slab above, extend through any concealed spaces (such as those above suspended ceilings and interstitial spaces), are properly sealed, and are constructed to limit the transfer of smoke.

*Note 1: Unsealed spaces 1/8-inch wide or less around pipes, conduits, ducts, and wires above the ceiling are permitted.*

*Note 2: In smoke compartments protected throughout with an approved supervised sprinkler system, corridor partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling. The following ceiling features also limit the passage of smoke: sprinkler piping and sprinklers that penetrate the ceiling; ducted heating, ventilating, and air-conditioning (HVAC) supply and return-air diffusers; speakers; and recessed lighting fixtures. *(For full text and any exceptions, refer to NFPA 101-2000: 19.3.6.2.1 and 19.3.6.2.2)*


*Note: For The Joint Commission’s accepted amount of alcohol-based hand rub permitted within a single smoke compartment, see http://www.jointcommission.org/lsc.*

*Note: See The Joint Commission’s Web site (http://www.jointcommission.org/assets/1/18/Acceptable%20Practices%20of%20Using%20Alcohol2.PDF) for alcohol-based hand rub (ABHR) requirements.*
### New and Revised Critical Access Hospital and Hospital Requirements (continued)

#### Provision of Care, Treatment, and Services (PC)

**Standard PC.01.02.13**

[CAH only: For psychiatric distinct part units in critical access hospitals:] The [critical access hospital/hospital] assesses the needs of patients who receive treatment for emotional and behavioral disorders.

**Elements of Performance for PC.01.02.13**

**A 2.** [CAH only: For psychiatric distinct part units in critical access hospitals:] Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:

- Current mental, emotional, and behavioral functioning
- Maladaptive or other behaviors that create a risk to the patient or others
- Mental status examination
- [HAP only: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:] Reason for admission as stated by the patient and/or others significantly involved in the patient’s care.

**C 6.** [CAH only: For psychiatric distinct part units in critical access hospitals:] Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:

- A psychiatric evaluation
- Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
- [HAP only: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:] Complete neurological examination, when indicated.

**Standard PC.01.03.01**

The [critical access hospital/hospital] plans the patient’s care.

**Elements of Performance for PC.01.03.01**

**A 5.** The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals.

**Note:** [CAH only: For psychiatric distinct part units in critical access hospitals:] [HAP only: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:] The patient’s goals include both short-term and long-term goals.

**C 43.** [CAH only: For psychiatric distinct part units in critical access hospitals:] [HAP only: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:] The plan of care includes the responsibilities of each member of the treatment team.

#### Transplant Safety (TS)

**Standard TS.02.01.01**

[CAH only: For rehabilitation and psychiatric distinct part units in critical access hospitals:] The [critical access hospital/hospital] complies with organ transplantation responsibilities.

**Element of Performance for TS.02.01.01**

**A 2.** [CAH only: For rehabilitation and psychiatric distinct part units in critical access hospitals:] If requested, the [critical access hospital/hospital] provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry, or the [critical access hospital/hospital]’s designated organ procurement organization (OPO) and, when requested by the Office of the Secretary, directly to the U.S. Department of Health & Human Services.
CMS Accepts Alternatives to Manufacturers’ Maintenance Recommendations

Joint Commission Collaborates to Allow Varied Strategies in Establishing Maintenance Frequencies

In January 2010, a consumer asked the Centers for Medicare & Medicaid Services (CMS) to respond to a disparity between CMS and Joint Commission environment of care (EC) standards and elements of performance (EPs) related to assigning maintenance activities for medical equipment and utility systems. This raised a question that affects both clinical engineering and facilities engineering.

Whereas CMS’s Interpretive Guidelines only allow organizations to follow manufacturers’ recommendations,* The Joint Commission allows health care organizations to schedule maintenance activities based on the following three criteria:

1. Manufacturer’s recommendations
2. Risk levels associated with the equipment
3. Hospital experience (EC.02.04.01, EP 4, and EC.02.05.01, EP 4)

CMS asked for a full explanation of The Joint Commission’s current process and signaled that The Joint Commission might need to eliminate the other two options allowed for assigning maintenance activities.

Rather than simply adopting the CMS requirement, The Joint Commission engaged CMS in a collaborative exchange to explain why it is prudent to allow health care organizations to continue to employ all three strategies when establishing maintenance frequencies. Occasionally manufacturers’ recommendations are labor and parts excessive, with little or no recognized benefit to patient care or safety (see the box below for an example). The Joint Commission process is much more cost-effective and reasonable, and it relies on the expertise of expert maintainers and users in managing both clinical equipment and facilities equipment.

The Joint Commission equipment management process includes the following three parts:

• Create and manage an accurate inventory.

• Evaluate what maintenance strategy is most beneficial, such as predictive maintenance, reliability-centered maintenance, interval-based inspections, corrective maintenance, or metered maintenance (EC.02.04.01, EP 3, and EC.02.05.01, EP 3).

• Establish maintenance activities based on manufacturers’ recommendations, risk levels of the equipment, and hospital experience

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An Example of Setting Maintenance Frequencies

A hospital uses a defibrillator in an ambulance and another of the same make and model on a nursing unit. The manufacturer creates maintenance activities and frequencies to accommodate the much more equipment-destructive ambulance environment. However, hospital experience shows that the manufacturer’s recommendation, while appropriate for the ambulance, is excessive for the nursing unit. After considering risk levels and hospital experience, the organization may adjust the maintenance frequency for the device on the nursing unit.
CMS requested clarification on how Joint Commission surveyors evaluate the maintenance continuum. In response, The Joint Commission developed a training module for its surveyors and recently began informing accredited organizations at various events, such as Speaker’s Bureau presentations related to the health care environment, and in articles such as this that there may be a renewed focus on maintenance schedules during onsite surveys for hospital, critical access hospital, and ambulatory care programs.

The Joint Commission is very pleased to have successfully worked with CMS regarding the setting of maintenance frequencies and believes that this will greatly benefit its accredited organizations. Other accrediting organizations continue to enforce CMS’s restrictive requirement to follow manufacturers’ recommendations in establishing maintenance frequencies.

* §42 CFR 482.41 Hospital must maintain adequate facilities for its services.
§42 CFR 482.41(c)(2) Facilities, supplies and equipment must be maintained to ensure an acceptable level of safety and quality.

The CMS Interpretive Guidelines state “the hospital must monitor, test, calibrate, and maintain equipment periodically in accordance with the manufacturer’s recommendation and Federal and State law.”
ACCEPTED: Revisions to Hospital and Critical Access Hospital Standards for Patient Visitation Rights

Changes Made to Match Updated Conditions of Participation

After updating the Conditions of Participation (CoPs) related to patient visitation rights, The Centers for Medicare & Medicaid Services (CMS) asked The Joint Commission to revise its standards to remain aligned with the federal requirements for equal patient visitation rights in hospitals and critical access hospitals. In response, the Joint Commission’s Board of Commissioners subsequently accepted new notes to Standard RI.01.01.01, Elements of Performance (EPs) 1 and 2, which became effective July 1, 2011.

The new notes, which are underlined and shown in the box below, will be published in the 2011 Update 2 to the Comprehensive Accreditation Manual for Hospitals (CAMH) and the Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH) and the E-dition® update being released in the fall.

Official Publication of New Notes

New Notes for Patient Visitation Requirements

APPLICABLE TO HOSPITALS
Effective July 1, 2011

Standard RI.01.01.01
The hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01

A 1. The hospital has written policies on patient rights.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.

A 2. The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1-3)

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of his or her visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.

APPLICABLE TO CRITICAL ACCESS HOSPITALS
Effective July 1, 2011

Standard RI.01.01.01
The critical access hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01

A 1. The critical access hospital has written policies on patient rights.

Note: The critical access hospital’s written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.

A 2. The critical access hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1-3)

Note: The critical access hospital informs the patient (or support person, where appropriate) of his or her visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.
Effective July 1, 2011, The Joint Commission began evaluating compliance with the CMS requirements under both the current EPs and Standard RI.01.01.01, EPs 28 and 29, for hospitals (both those seeking deemed status and those not) and critical access hospitals. As described in the March 2011 *Perspectives*, organizations can find guidance on implementing Standard RI.01.01.01, EPs 28 and 29, and meeting the intent of the revised CoPs in The Joint Commission’s monograph *Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals* (available to download free of charge at http://www.jointcommission.org/Advancing_Effective_Communication_Cultural_Competence_and_Patient_and_Family_Centered_Care).

In addition to providing several recommendations addressing issues that extend beyond EPs 28 and 29, the *Roadmap for Hospitals* also includes example practices, legal and regulatory information, and links to supplemental guidance that may help both hospitals and critical access hospitals implement the requirements.
ACCEPTED: Revisions to Patient Visitation Standard in Hospitals and Critical Access Hospitals

Change Made to Match CoP Updates

The Centers for Medicare & Medicaid Services (CMS) updated their Conditions of Participation (CoPs) for hospitals and critical access hospitals to require equal visitation rights for all patients. Effective February 18, 2011, The Joint Commission began surveying for CoP changes for hospitals at 42 CFR 482.13(h) and critical access hospitals at 42 CFR 485.635(f) under existing Elements of Performance (EPs) 1, 2, 5, and 6 at Standard RI.01.01.01 and under “Leadership” (LD) Standard LD.04.01.01, EP 2. Effective July 1, 2011, The Joint Commission will align additional “Rights and Responsibilities of the Individual” (RI) EPs to the new CMS requirements.

The additional revisions needed to align Joint Commission standards with the visitation-rights CoPs were previously developed as part of an initiative to advance the issues of effective communication, cultural competence, and patient- and family-centered care in hospitals (see Perspectives January 2010, pages 5 and 6, and August 2010, page 10). The Joint Commission published Standard RI.01.01.01, EPs 28 and 29, for hospitals (both those seeking deemed status and those not) in the 2011 Comprehensive Accreditation Manual for Hospitals (CAMH) and included a note specifying that the EPs would not affect the accreditation decision at this time. Due to the new CMS requirements, EPs 28 and 29 will become effective July 1, 2011. Beginning July 1, surveyors will evaluate compliance with these EPs, and noncompliance will generate Requirements for Improvement that will be included in the accreditation decision. Revisions to EPs 28 and 29 (shown in the box on page 19 with deletions in strikethrough text) will be published in 2011 Update 1 to the CAMH and the E-dition® update being released in April.

The Joint Commission’s Board of Commissioner’s accepted EPs 28 and 29 under Standard RI.01.01.01 as new requirements for critical access hospitals in response to the new CMS requirements. They also will become effective July 1, 2011, and will be published in 2011 Update 1 to the Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH) and the E-dition update being released in April. The new EPs are shown in the box below in underline text.

Organizations can find guidance on implementing Standard RI.01.01.01, EPs 28 and 29, and meeting the intent of the revised CoPs in The Joint Commission’s monograph Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (available to download free of charge at http://www.jointcommission.org/Advancing_Effective_Communication_Cultural_Competence_and_Patient_and_Family_Centered_Care). Although the Roadmap for Hospitals provides several recommendations addressing issues that go above and beyond EPs 28 and 29, it includes example practices, information on laws and regulations, and links to supplemental information that may help both hospitals and critical access hospitals implement the new requirements.

Patient Visitation Requirements

APPLICABLE TO HOSPITALS

Effective July 1, 2011

Standard RI.01.01.01
The hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01

A 28. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.

Note 1: The hospital allows for the presence of a support individual of the patient’s choice, unless the individual’s presence infringes on others’ rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient’s surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, see RI.01.02.01, EPs 6–8.)

Note 2: This element of performance will not affect the accreditation decision at this time.

A 29. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

Note: This element of performance will not affect the accreditation decision at this time.

APPLICABLE TO CRITICAL ACCESS HOSPITALS

Effective July 1, 2011

Standard RI.01.01.01
The critical access hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01

A 28. The critical access hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.

Note: The critical access hospital allows for the presence of a support individual of the patient’s choice, unless the individual’s presence infringes on others’ rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient’s surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, see RI.01.02.01, EPs 6–8.)

A 29. The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
5 Sure-Fire Methods: Complying with RI.01.01.01

2010 presidential memorandum, new Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (COPs) pertaining to patients’ rights to have visitors during hospital stays went into effect in January 2011.* The regulations impact all hospitals that participate in CMS programs, and are designed to guarantee patients’ rights to designate visitors of their choosing and to end discrimination in visitation based on a number of factors, including sexual orientation and gender identity. The new CMS regulations require hospitals to have written policies and procedures regarding patients’ visitation rights. According to the new regulations, hospitals must do the following:

- Inform each patient of his or her right to receive visitors whom he or she designates, including a domestic partner
- Prohibit visitation restrictions or limitations based solely on sexual orientation and gender identity, among other factors
- Ensure that all visitors have full and equal visitation rights, consistent with a patient’s wishes

In response to the new CMS requirements, full implementation and scoring of Joint Commission Elements of Performance (EPs) 28 and 29 of Rights and Responsibilities of the Individual (RI) Standard RI.01.01.01 for hospitals will now be required by July 1, 2011. EPs 28 and 29 also will apply now to critical access hospitals.

In 2008 The Joint Commission received a grant from The Commonwealth Fund to begin work on advancing the issues of effective communication, cultural competence, and patient- and family-centered care. The purpose of the project was to improve the safety and quality of care for all patients through new and revised accreditation requirements for hospitals. “There were two parts to the project,” says Christina Cordero, Ph.D., M.P.H., associate project director, Department of Standards and Survey Methods, The Joint Commission. “The first was to develop accreditation standards that would help organizations to improve communication, cultural competence, and patient- and family-centered care. The second was development of the monograph Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.”†

The Joint Commission put together an expert advisory panel to begin work on the standards and the monograph. “When looking at our standards, we felt we needed to broaden the scope to include additional issues related to communication and patient- and family-centered care,” says Cordero. In 2010, EPs 28 and 29 were added (see Sidebar on page 21), and they were published in the 2010 Update 2 to the Comprehensive Accreditation Manual for Hospitals without an effective date. At the time, they applied only to hospitals.

Joint Commission surveyors began assessing compliance with Standard RI.01.01.01, EPs 28 and 29, on January 1, 2011. “The original plan was to implement a pilot phase during which time surveyors would be evaluating compliance with these EPs, but the findings wouldn’t be factored into the accreditation decision,” Cordero says. “Depending on feedback from the field, these EPs were scheduled to be fully implemented in early 2012.”

Self-Assess Compliance

Based on the new CMS regulations and the forthcoming deadline for implementation of EPs 28 and 29, it is important for hospitals, and now critical access hospitals, to review their policies and to ensure that they are compliant not only with The Joint Commission requirements, but also with the CMS COPs. Cordero provides the following five strategies to help organizations to comply with Standard RI.01.01.01, EPs 28 and 29:

† The monograph is available for download free of charge at http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf.
1. **Read the *Roadmap for Hospitals* monograph.** “The monograph is a great resource for helping organizations with compliance,” Cordero says. “There’s a section in Appendix C of the monograph that focuses on EPs 28 and 29; Appendix A includes a checklist that will help organizations to improve communication, cultural competence, and patient- and family-centered care across the care continuum; and Appendix D will help organizations to comply with laws and regulations. There’s also a resource guide in Appendix E that includes Web site links, toolkits, and other resources that organizations can use to help them improve communication, cultural competence, and patient- and family-centered care.”

2. **Review current policies for visitation and nondiscrimination.** “Compare your current policies to the new EPs and to the CMS COPs to make sure they’re consistent,” says Cordero. “If they’re not consistent, use the language in the EPs and the CMS regulations as guidelines for revisions to your policies.”

3. **Review patient satisfaction data to identify areas for improvement related to visitation and nondiscrimination.** Cordero recommends that organizations review patient satisfaction surveys for comments related to patient visitation, including restrictions or limitations. Look for patient comments regarding discrimination during care and determine how hospital policies and procedures can be modified to provide patients with equal visitation rights.

4. **Provide staff training about the organization’s policies for visitation and nondiscrimination.** “Interview staff to see if they are aware of the policies,” Cordero says. “If they are aware of the policies, ask how they’re being implemented to find out if there are any gaps in education or training.”

5. **Talk to patients about their rights.** “Designate a time to make patients aware of their right to have an individual support person present and their right to nondiscrimination based on all of the factors in EP 29,” says Cordero.

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**Standard RI.01.01.01**

The hospital respects, protects, and promotes patient rights.

**Elements of Performance for RI.01.01.01**

28. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of a stay.

**Note:** The hospital allows for the presence of a support individual of the patient’s choice, unless the individual’s presence infringes on others’ rights or safety, or it is medically or therapeutically contraindicated. The individual may or may not be the patient’s surrogate decision-maker or legally authorized representative.

29. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

Talking to the World: Treating Patients with Limited English Proficiency—During Emergencies and Every Day

Imagine being treated by hospital staff members who speak to you in a language you can’t understand very well. The struggle to comprehend a language in which you are only marginally proficient compounds your apprehension about your medical situation.

Some 47 million Americans ages five and older used a language other than English in 2000, according to the U.S. Census Bureau. That translates into nearly one in five, compared with roughly one in seven 10 years earlier. Health care organizations need to provide for all patients with limited English proficiency (LEP). The preferred language of minor or incapacitated patients’ parent(s), guardians, or surrogate decision makers should also be determined because these individuals have the legal authority to make decisions on the patient’s behalf and must be able to understand what is being communicated.

For many years, Joint Commission standards have supported the provision of care, treatment, and services in a manner that is sensitive and responsive to individual patient needs. In 2008, The Joint Commission began an initiative to advance the issues of effective communication, cultural competence, and patient- and family-centered care in hospitals. New standards related to patient-centered communication and cultural competence were published in the 2011 Comprehensive Accreditation Manual for Hospitals: The Official Handbook (CAMH) and in the 2010 Update 2 for CAMH. Joint Commission surveyors will evaluate compliance with the Patient-Centered Communication standards beginning January 1, 2011; however, findings will not affect the accreditation decision. The information collected by Joint Commission surveyors and staff during this implementation pilot phase will be used to prepare the field for common implementation questions and concerns. Compliance with the Patient-Centered Communication standards will be included in the accreditation decision no earlier than January 2012.

In addition, the Joint Commission monograph Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals describes effective communication as “the successful joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood.”

The monograph also stresses that “successful communication takes place only when providers understand and integrate the information gleaned from patients and when patients comprehend… messages from providers in a way that enables them to participate responsibly in their care.”

The monograph further explains that effective communication includes identifying the patient’s preferred language for discussing health care at the time of admission. This can be challenging at any time but especially during a major emergency.

The following description is an example of how one hospital meets the need for patient-centered communication every day—and particularly how it communicated with LEP patients during the emergency surge of medical evacuees following the January 2010 earthquake in Haiti.

Broward Health and Patient-Centered Communication

Broward Health is a large public health system made up of 4 hospitals plus 32 ambulatory centers, clinics, and physician offices in the area just north of Miami, Florida. The mission of this tax-assisted system is to serve as the health care safety net for the northern two-thirds of Broward County. The system includes two trauma centers, a behavioral health center, mother-and-children facilities, and a major children’s hospital.
“We’re very close to South and Central America, as well as the Caribbean nations, and we’re a cauldron of cultures,” says Jeanne Eckes-Roper, R.N., M.B.A., who most recently was director of emergency preparedness at Broward Health and is now Region VII health/medical chair of Florida’s Southeast Domestic Security Task Force, a function of the Florida Department of Law Enforcement. “It’s not unusual to have almost any language come through the door at any of our four hospitals.”

**Everyday LEP Communication**

Broward Health offers several ways to communicate with LEP patients. The first is through accessing the language skills of members of Broward’s highly diverse staff. “In all of these facilities, it’s common for staff members to be proficient in languages other than English,” says Eckes. “Our staff is as diverse as our patient populations, which means we can rely on our staff to serve as licensed translators.” She explains that among the languages of patient populations are Russian and Portuguese at one medical center, while another medical center has large Hispanic, Latin American, Caribbean, and Spanish populations, using various dialects. A third location has Creole-speaking and Jamaican patois-speaking populations.

Broward periodically sends out queries to its licensed staff to determine how many other languages they speak besides English. Sharon Cohen, R.N., the clinical nurse specialist for Broward Health’s emergency preparedness, cites a trauma surgeon who speaks five languages in addition to English. “When he’s on call, this doctor is available 24 hours a day, and he’s more than happy to translate for us,” says Cohen. “This can serve as a bridge until the patient is admitted and we can arrange for something less temporary.”

In the rare instances when no staff members can translate, Broward uses over-the-phone translation services called language lines, which offer more than 1,000 different languages. One of those language lines is provided by the Red Cross, and another is a commercial service that is available under contract. This text telephone (TTY) line is available to those who are hearing impaired and is also HIPAA compliant, which means the translators have undergone training in protecting patient privacy. The translators are also medically trained to avoid miscommunication. “The downside is that using a language line may involve a wait while they reach out to their base of translators,” says Cohen.

**Where Translation Services Are Needed**

“People sometimes think that LEP translation services are needed only in a hospital’s emergency department (ED),” says Cohen. “But that’s only phase one. After patients are admitted, they face a great many more challenges.” She explains that in the ED, all services—such as X-ray, lab, and respiratory services—are available to patients right there, mostly with on-the-spot translation services.

But once admitted, they are transported throughout the hospital to receive various services, which makes providing translation services more challenging. “The language lines that we usually use aren’t available on a cell phone, which makes communication a great deal harder,” says Cohen.

**LEP Communication in the Haiti Crisis**

On January 12, 2010, Haiti was hit by a catastrophic 7.0-magnitude earthquake, which had its epicenter near Port-au-Prince, the island’s densely populated capital city. The quake and its aftershocks resulted in 230,000 deaths and an estimated 300,000 injuries, virtually crippling Haiti’s already challenged and overburdened health care system. South Florida immediately became a destination for the critically injured. Many of the Haitian-born staff members at Broward Health and other area hospitals wanted to return to Haiti to help stricken family members and residents. “But we had to keep our hospitals running, so when the medical evacuees began arriving, if we had a Haitian-born nurse or therapist working on the same floor where a Haitian refugee was a patient, we asked them to work with that patient,” says Eckes. “This gave a purpose to our Haitian employees far beyond the everyday, because now we needed them to translate for their compatriots.”
Case management services for the medical evacuees were coordinated through the Florida Department of Children and Families, which also worked with family members or nonmedical attendants who accompanied the patients to this country. “We were quite concerned to make sure the physical and emotional needs of minor patients were met,” says Eckes. “In addition to their injuries and illnesses, most of these patients were facing the emotional stress of leaving their home country and being separated from their families. So we assigned to them a staff member/translator who would be available on the floor round-the-clock.” In addition, working through the Red Cross and through faith-based communities, Broward Health was often able to find other 24-hours-a-day translators.

Advice on LEP Communication

When asked how she’d advise other hospitals to handle the need for LEP services in an emergency, Eckes says, “Make sure you understand fully the nature of the need and what language resources you can access within your community.”

Among the resources on which Broward Health relies is the National Incident Management System (NIMS). If a hospital gets a surge of LEP casualties for any kind of incident and the resources of that hospital are exceeded—including the need for translation services—the hospital contacts its local emergency operations center, which then assumes responsibility for finding the LEP services that the hospital needs.

Eckes explains that NIMS was developed and refined after the 9/11 crisis. She says, “If the local level can’t fill the hospital’s needs, the request moves up to the state level. If need be, the process of finding translation services can go all the way up to the federal government.”

Concludes Eckes, “The important thing is speaking to patients in their own language.”

References
REMINDER: Accreditation Requirement for Hospitals Issuing Durable Medical Equipment to Patients

Meeting CMS Supplier Standards Via Home Care Accreditation Program

The Centers for Medicare & Medicaid Services (CMS) requires all suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including hospitals, to be accredited by a CMS-approved accreditation organization. As one of the CMS-approved DMEPOS accreditation organizations, The Joint Commission offers hospitals that provide DMEPOS the option of being surveyed to determine compliance with CMS standards. This type of survey is offered under The Joint Commission’s home care accreditation program.

The Medicare Improvement for Patients and Providers Act of 2008 stipulates that to enroll or maintain Medicare billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Act) must comply with Medicare’s supplier standards (found at 42 CFR § 424.57(c)) and quality standards. The requirement specifically applies to suppliers of the following who want to bill under Medicare Part B:

- Durable medical equipment
- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral/enteral nutrition
- Transfusion medicine
- Prosthetic devices
- Prosthetics and orthotics


The Joint Commission home care accreditation program integrates CMS’s quality standards into its requirements for home medical equipment providers and is recognized by CMS to accredit suppliers of DMEPOS as meeting new quality standards under Medicare Part B.

In such situations, accreditation by The Joint Commission under its home care accreditation program is required to evaluate a hospital’s DMEPOS program and determine compliance with the CMS quality standards as delivered in the home or at facility locations because current hospital accreditation program standards do not address DMEPOS suppliers.

For more information, contact your account executive or Margherita Labson, executive director of home care accreditation at 630/792-5284 or mlabson@jointcommission.org, or Wayne Murphy, associate director of home care accreditation at 630/792-5283 or wmurphy@jointcommission.org.
ACCEPTED: Revised Laboratory Proficiency Testing Requirement

In response to a request from the Centers for Medicare & Medicaid Services (CMS), The Joint Commission recently revised its requirement for notification of receipt of proficiency testing samples from another laboratory for testing. Modifications to “Quality System Assessment for Nonwaived Testing” (QSA) Standard QSA.01.04.01, Element of Performance (EP) 3, reflect the existing Clinical Laboratory Improvement Amendments (CLIA) of 1988 regulation that now require accredited laboratories to notify both CMS and The Joint Commission of proficiency testing samples received from another laboratory for testing. This modification applies to laboratories and becomes effective July 1, 2011.

The revision to QSA.01.04.01, EP 3, is shown below, with additions in underline and deletions noted in strikethrough. This change will appear in the 2011 Update 1 to the Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing and the next E-dition® update being released in April.

<table>
<thead>
<tr>
<th>APPLICABLE TO LABORATORIES</th>
<th>Element of Performance for QSA.01.04.01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective July 1, 2011</td>
<td>A 3. The laboratory notifies the Centers for Medicare &amp; Medicaid Services (CMS) or and The Joint Commission of proficiency testing samples received from another laboratory for testing.</td>
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The laboratory performs its proficiency testing independent of other laboratories.
ACCEPTED: Updated Fire Protection Systems Requirements for Hospitals

The Joint Commission is required to demonstrate that its standards and elements of performance (EPs) are equivalent to the Conditions of Participation (CoPs) to maintain Centers for Medicare & Medicaid Services (CMS) deeming authority. As part of the ongoing process to ensure this equivalency, The Joint Commission Board of Commissioners recently accepted a revision to “Environment of Care” (EC) Standard EC.02.03.05 under existing EP 2 and added new EP 25 for hospitals that use Joint Commission accreditation for deemed status purposes. These revisions will be effective July 1, 2011, unless otherwise directed by CMS.

EP 2 was changed to require quarterly (as opposed to semi-annual) testing of water-flow devices. New EP 25 was added to address CMS’s request to specifically delineate the actual documentation requirements previously implied under Standard EC.02.03.05.

The change to EP 2 and the new EP 25 are indicated in underline and strikethrough text in the box below. These changes appear in 2011 Update 1 to the Comprehensive Accreditation Manual for Hospitals and the E-dition® update released in April.

### Testing Fire Protection Systems

**APPLICABLE TO HOSPITALS THAT USE JOINT COMMISSION ACCREDITATION FOR DEEMED STATUS PURPOSES**

**Effective July 1, 2011**

**Standard EC.02.03.05**

The hospital maintains fire safety equipment and fire safety building features.

**Elements of Performance for EC.02.03.05**

#### A 2.

D For hospitals that use Joint Commission accreditation for deemed status purposes: At least quarterly every six months, the hospital tests waterflow devices. Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of the tests is documented.

**Note:** For additional guidance on performing tests, see NFPA 25, 1998 edition (Sections 2-3.3 and 3-3.3) and NFPA 72, 1999 edition (Table 7-3.2).

For hospitals that do not use accreditation for deemed status purposes: Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of these tests is documented.

**Note:** For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

C 25. D For hospitals that use accreditation for deemed status purposes: Documentation of maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems includes the following:

- Name of the activity
- Date of the activity
- Required frequency of the activity
- Name and contact information, including affiliation, of the person who performed the activity
- NFPA standard(s) referenced for the activity
- Results of the activity

**Note:** For additional guidance on documenting activities, see NFPA 25, 1998 edition (Section 2-1.3) and NFPA 72, 1999 edition (Section 7-5.2).
Joint Commission Updates EC, EM, and LS Standards
Elements of Performance Refined to Better Reflect CMS Requirements

The Joint Commission is required to demonstrate that its standards and elements of performance (EPs) are equivalent to the Conditions of Participation (CoPs) to maintain Centers for Medicare & Medicaid Services (CMS) deeming authority. To ensure this equivalency and better reflect the intent of the CoPs, Joint Commission staff have made editorial updates to several notes in standards applicable to the physical environment. The updates, which apply to critical access hospitals and hospitals, are to the following EPs: “Environment of Care” (EC) Standards EC.02.03.01, EPs 9 and 10, and EC.02.05.03, EPs 1-6; “Emergency Management” (EM) Standard EM.03.01.03, EP 1; and “Life Safety” (LS) Standard LS.02.01.30, EPs 6 and 25. These updated EPs became effective February 1, 2011.

The updated EPs for critical access hospitals and hospitals can be seen in their entirety below and on page 29. Additions are underlined, and deletions are noted in strikethrough. These changes will appear in the 2011 Update 1 to the Comprehensive Accreditation Manual for Hospitals and Comprehensive Accreditation Manual for Critical Access Hospitals and the next E-dition® update being released in April.

### Updated Hospital Requirements

**APPLICABLE TO CRITICAL ACCESS HOSPITALS (CAH) AND HOSPITALS (HAP)**

**Effective February 1, 2011**

**Environment of Care (EC)**

**Standard EC.02.03.01**

The [critical access hospital/hospital] manages fire risks.

**Elements of Performance for EC.02.03.01**

A 9. The [critical access hospital/hospital] has a written fire response plan. (*See also LS.02.01.70, EP 4*)

A 10. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire’s point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, and how to evacuate to areas of refuge. (*See also EC.02.03.03, EP 5; EC.03.01.01, EP 2; and HR.01.04.01, EP 2*)

**Note:** For additional guidance, see NFPA 101, 2000 edition (Sections 18/19.7.1 and 18/19.7.2).

**Standard EC.02.05.03**

The [critical access hospital/hospital] has a reliable emergency electrical power source.

**Elements of Performance for EC.02.05.03**


*Note:* For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).

A 2. Exit route and exit sign illumination, as required by the Life Safety Code. ☐

*Note:* For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).

A 3. Emergency communication systems, as required by the Life Safety Code. ☐

*Note:* For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).

A 4. Elevators (at least one for nonambulatory patients).

*Note:* For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).
A 5. Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems.

Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).

A 6. Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms, nurseries, and urgent care areas.

Note: For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99, 1999 edition (Section 12-3.3).

Emergency Management (EM)

Standard EM.03.01.03

Element of Performance for Standard EM.03.01.03

A 1. As an emergency response exercise, the [critical access hospital/hospital] activates its Emergency Operations Plan twice a year at each site included in the plan.

Note 1: If the [critical access hospital/hospital] activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.

Note 2: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code®*) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.

Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.

Note 4: In order to satisfy the twice-a-year requirement, the [critical access hospital/hospital] must first evaluate the performance of the previous exercise and make any needed modifications to its Emergency Operations Plan before conducting the subsequent exercise in accordance with EPs 13.17.

Life Safety (LS)

Standard LS.02.01.30
The [critical access hospital/hospital] provides and maintains building features to protect individuals from the hazards of fire and smoke.

Elements of Performance for LS.02.01.30

C 6. Existing corridor partitions are fire rated for 1/2 hour, are continuous from the floor slab to the floor or roof slab above, extend through any concealed spaces (such as those above suspended ceilings and interstitial spaces), are properly sealed, and are constructed to limit the transfer of smoke.

Note 1: Unsealed spaces 1.8-inch wide or less around pipes, conduits, ducts, and wires above the ceiling are permitted.

Note 2: In smoke compartments protected throughout with an approved supervised sprinkler system, corridor partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling. The following ceiling features also limit the passage of smoke: sprinkler piping and sprinklers that penetrate the ceiling; ducted heating, ventilating, and air-conditioning (HVAC) supply and return-air diffusers; speakers; and recessed lighting fixtures. (For full text and any exceptions, refer to NFPA 101-2000: 19.3.6.2.1 and 19.3.6.2.2)


Note: For The Joint Commission’s accepted amount of alcohol-based hand rub permitted within a single smoke compartment, see http://www.jointcommission.org/lsc.

Note: See The Joint Commission’s Web site (http://www.jointcommission.org/assets/1/18/Acceptable%20Practices%20of%20Using%20Alcohol2.PDF) for alcohol-based hand rub (ABHR) requirements.
### Updated Fire Protection Systems Requirements for Hospitals

**Standard EC.02.03.05 Quarterly Testing of Water-Flow Devices, Other Changes, Help Meet CMS Equivalency**

The Joint Commission is required to demonstrate that its standards and elements of performance (EPs) are equivalent to the Conditions of Participation (CoPs) to maintain Centers for Medicare & Medicaid Services (CMS) deeming authority. As part of the ongoing process of ensuring this equivalency, the Joint Commission Board of Commissioners recently accepted a revision to “Environment of Care” (EC) Standard EC.02.03.05 under existing EP 2 and added new EP 25 for hospitals that use Joint Commission accreditation for deemed status purposes. These revisions will be effective **July 1, 2011**, unless otherwise directed by CMS.

EP 2 was changed to require quarterly (as opposed to semi-annual) testing of water-flow devices. New EP 25 was added to address CMS’s request to specifically delineate the actual documentation requirements previously implied under Standard EC.02.03.05.

The change to EP 2 and the new EP 25 are indicated in underline and strikethrough text in the box below. These changes appear in 2011 Update 1 to the Comprehensive Accreditation Manual for Hospitals and the E-dition® update released in April.

#### Testing Fire Protection Systems

**APPLICABLE TO HOSPITALS THAT USE JOINT COMMISSION ACCREDITATION FOR DEEMED STATUS PURPOSES**

**Effective July 1, 2011**

**Standard EC.02.03.05**

The hospital maintains fire safety equipment and fire safety building features.

**Elements of Performance for EC.02.03.05**

| A 2. | For hospitals that use Joint Commission accreditation for deemed status purposes: At least quarterly, every six months, the hospital tests water-flow devices. Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of the tests is documented. **Note:** For additional guidance on performing tests, see NFPA 25, 1998 edition (Sections 2-3.3 and 3-3.3) and NFPA 72, 1999 edition (Table 7-3.2). |
| C 25. | **D** For hospitals that use accreditation for deemed status purposes: Documentation of maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems includes the following:  
- Name of the activity  
- Date of the activity  
- Required frequency of the activity  
- Name and contact information, including affiliation, of the person who performed the activity  
- NFPA standard(s) referenced for the activity  
- Results of the activity. **Note:** For additional guidance on documenting activities, see NFPA 25, 1998 edition (Section 2-1.3) and NFPA 72, 1999 edition (Section 7-5.2). |

**For hospitals that do not use accreditation for deemed status purposes:** Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of these tests is documented. **Note:** For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).
Joint Commission to Review Its Telemedicine Requirements

Implementation Delayed to Ensure Standards Align with CMS

The Joint Commission is evaluating its telemedicine credentialing and privileging requirements for hospitals and critical access hospitals to reaffirm that they remain aligned with the requirements of the Centers for Medicare & Medicaid Services (CMS).

In early May, CMS published its new telemedicine credentialing and privileging requirements, which become effective July 5, 2011. With these new requirements, CMS has taken a giant step in removing unnecessary barriers to the use of telemedicine for medically necessary interventions. These updates respond to The Joint Commission’s stance on the need to limit overly burdensome requirements that may impede patient access to health care services. The requirements, which apply to all hospitals that participate in Medicare and critical access hospitals, upholds The Joint Commission’s current practice of allowing a hospital or critical access hospital to use information from the distant-site hospital or other accredited telemedicine entity when making credentialing or privileging decisions for the distant-site telemedicine practitioners.

The Joint Commission will review and make changes to its standards in accordance with the regulation and will notify its accredited hospitals and critical access hospitals of the time frame expected for implementation in alignment with the new CMS regulations. Perspectives will provide updates on this issue of telemedicine as further information becomes available.

Flexibility and Ease of Burden

For the past three years, The Joint Commission has engaged CMS and members of Congress regarding CMS’s approach to credentialing and privileging of telemedicine providers. The Joint Commission took the position that there would be an adverse effect on access to telemedicine services if Joint Commission–accredited hospitals were not allowed to use, for telemedicine practitioners, the credentialing and privileging decisions made by other Joint Commission–accredited facilities, especially since these facilities are held to the same rigorous requirements. The Joint Commission believes that the previous CMS requirements placed an undue burden on many organizations because they did not improve the quality of services, the accountability of physicians and practitioners, or the effectiveness of the credentialing and privileging processes.

“The Joint Commission is very pleased that CMS has revised its telemedicine requirements to provide more flexibility to hospitals and lessen their regulatory burden. This is an especially positive step for improving access to care for patients in rural areas,” says Mark R. Chassin, M.D., FACP, M.P.P., M.P.H., president, The Joint Commission. “Of particular importance is the fact that critical access hospitals will have additional avenues to benefit from the services of particularly skilled physicians and practitioners.”
Updates Related to CMS

Authored by Mary Brockway, R.N., M.S. and Phavinee Park, R.N., Ph.D.

Objectives
At the end of this session participants will be able to:
- Identify recent revisions to standards related to CMS changes.
- Understand how these standards may be surveyed.

Presentation Assistance
Some material depicted in these slides reflects information received from the Centers for Medicare & Medicaid Services and is used with their permission.

Background
- July 1965 President Lyndon Johnson signs the Social Security Act Amendments which creates Medicare.
- Accreditation serves to meet the Conditions of Participation (CoPs).
- The Joint Commission received deeming authority from the Centers for Medicare & Medicaid (CMS) for the hospital program in 2009.
- The Joint Commission Standards and elements of performance must meet or exceed the Conditions of Participation.
- The Joint Commission may revise standards based on changes to the CoPs.

Overview of Joint Commission Standards and CoPs

Joint Commission Standards and Medicare Requirements: A Similar Foundation

<table>
<thead>
<tr>
<th>The Joint Commission</th>
<th>Federal Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard</td>
<td>Condition</td>
</tr>
<tr>
<td>Element of Performance</td>
<td>Standard</td>
</tr>
<tr>
<td>Element of Performance</td>
<td>Standard</td>
</tr>
</tbody>
</table>
Conditions of Participation

Federal Citation Levels
Noncompliance is cited at:

- Condition Level
  §482.42 Condition of Participation: Infection Control

- Standard Level
  §482.42(a) Standard: Organization and Policies

CoP/Standard Example

**A-0385**

§482.23 *Condition of Participation*: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

**TAG**

**A-0386**

§482.23(a) *Standard*: Organization

The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.
CoP/Standard Example (cont.)

A-0700

§482.41 **Condition of Participation**: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

A-0701

§482.41(a) **Standard**: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

TAG A-0702

§482.41(a)(1) - There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.

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</tbody>
</table>
**Demonstrating Equivalency (cont.)**

<table>
<thead>
<tr>
<th>CFR Number</th>
<th>Medicare Standards</th>
<th>Joint Commission Equivalent Number</th>
<th>Joint Commission Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>§482.12(a)(6)</td>
<td>TAG: A-0076</td>
<td>LD.04.03.03</td>
<td>The leadership develops an annual operating budget and any needed long-term capital expenditure plans.</td>
</tr>
<tr>
<td>§482.12(a)(7)</td>
<td>TAG: A-0077</td>
<td>EP 1</td>
<td>The governing body approves an annual operating budget and any needed long-term capital expenditure plans.</td>
</tr>
<tr>
<td>§482.12(a)(8)</td>
<td>TAG: A-0077</td>
<td>EP 1</td>
<td>Leaders solicit comments from those who work in the hospital when developing the operational and capital budgets. (See also LD.01.03.01, EP 3.)</td>
</tr>
<tr>
<td>§482.12(a)(9)</td>
<td>TAG: A-0077</td>
<td>EP 1</td>
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</tr>
<tr>
<td>§482.12(a)(10)</td>
<td>TAG: A-0083</td>
<td>EP 2</td>
<td>The hospital has a leadership structure.</td>
</tr>
<tr>
<td>§482.12(a)(11)</td>
<td>TAG: A-0083</td>
<td>EP 2</td>
<td>The governing body identifies those responsible for planning, management, and operational activities.</td>
</tr>
<tr>
<td>§482.12(a)(12)</td>
<td>TAG: A-0083</td>
<td>EP 2</td>
<td>The hospital has a leadership structure.</td>
</tr>
</tbody>
</table>

**Non-Compliance with Joint Commission Standards**

Non-compliance is cited at the level of the element of performance (EP).
Survey Reports

Survey Activity and Reports
The Joint Commission standards, survey process and reports remain the focus of your organization for quality and patient safety.

Reports display relationship to federal requirements
Survey Activity and Reports (cont.)

- Condition level deficiencies are clearly displayed in the CoP Summary.
- Careful review and oversight with this level of finding.
- Resolution through on site survey.

Survey Process Change Records

For hospitals that use The Joint Commission for deemed status, our surveyors must review a minimum of 30 patient records or 10% of ADC whichever is greater.

- Small general hospitals with ADC of less than 20 must have at least 20 records reviewed.
- Small hospital exception does not apply to specialty hospitals.
- **Became effective July, 2009.**

Condition Level Deficiencies

- Governing body CoP (hospital):
  - When any condition level deficiencies are identified during the survey, we are required by CMS to include a condition level deficiency in the leadership standards.
  - Expect to see an RFI and Condition Level Deficiency at LD.01.03.01 EP 2.
- Determination is based on manner and degree.
  - **Manner:** prevalence, how pervasive, how widespread, number, frequency.
  - **Degree:** magnitude, how severe, how significant, how bad.
  - Collaboration among team members AND Central Office staff.

CMS Interpretive Guidelines

- CMS issues interpretive guidelines (IGs) for most of the CoPs.
- IGs are used for guidance and may include an explanation of compliance or a reference related to the CoP.
- IGs may be changed by CMS without going through the same process as the CoPs.
Recent Changes and Updates

Recent Updates

Rehabilitation Services

- **482.56(b) Standard: Delivery of Services**
  - Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws.
  - (b)(1) All rehabilitation services orders must be documented in the patient’s medical record in accordance with the requirements at 482.24.
  - (b)(2) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirement of 409.17 of this chapter.

Rehabilitation Services

The Joint Commission did not make any changes to its standards or EPs related to this CoP change. Our standards met equivalency even after the CoP change.

Respiratory Services

- **482.57(b)(3)**
  - Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures, and State laws.
- **482.57(b)(4)**
  - All respiratory care services orders must be documented in the patient’s medical record in accordance with the requirements at 482.24.
Respiratory

- The Joint Commission engaged CMS in discussion regarding this CoP prior to its revision because it required that respiratory services be provided only on the orders of an MD or DO.
- The change in the CoP reflected more contemporary practice.
- The Joint Commission revised its standards by deleting the EP that was created to meet the CoP.
- PC.02.01.03 EP 14 was deleted.
- For hospitals that use Joint Commission accreditation for deemed status: Respiratory services are provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy. This deletion coincides with CMS’s revision to this requirement, which is more inclusive regarding who may order respiratory services.
- Observations related to respiratory service orders are addressed at PC.02.01.03, EP 1.

Patient Provider Communication Standards

CMS and Visitation Rights

Patient-Provider Communication Standards

- Surveyors have been evaluating implementation as of January 2011.
- Most will not count toward your accreditation decision until January 2012.
- Found in:
  - Human Resources: HR.01.02.01, EP 1
  - Provision of Care: PC.02.01.21, EPs 1 and 2
  - Record of Care: RC.02.01.01, EP 1
  - Rights and Responsibilities: RI.01.01.01 EPs 28 and 29, RI.01.01.03 EPs 2 and 3
- Changes due to recent CoP update:
  - RI.01.01.01 EPs 28 and 29 will become effective July 1, 2011.
  - Those requirements will be surveyed under the following standards/EPs beginning February 18, 2011:
    - RI.01.01.01 EPs 1, 2, 5 and 6
    - LD.04.01.01 EP 2
  - These changes will affect accreditation decisions beginning in February.
- Addresses:
  - Patient access to chosen support individual.
  - Allowed to be present with the patient for emotional support during course of stay.
    - Unless the presence infringes on rights of others or is medically or therapeutically contraindicated.
  - Non-discrimination in patient care.
    - Prohibited based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
  - Collecting race and ethnicity data.
  - Collecting language data.
    - Including preferred language for discussing health care.
    - If patient is a minor, is incapacitated or has designated advocate, those communication needs are documented in the medical record.
Patient-Provider Communication Standards (cont.)

- Addresses (cont.):
  - Providing language services.
    - Can include:
      - Hospital employed language interpreters.
      - Contract interpreters.
      - Trained bilingual staff.
      - May be provided in person or via telephone or video.
  - Qualifications for language interpreters.
    - Can be met through language proficiency assessment, education, training and experience.
  - Identifying patient communication needs.
    - Includes need for personal devices such as hearing aids or glasses, language interpreters, communication boards, etc.
  - Providing language services.
    - The hospital determines which translated documents and languages are needed based on its patient population.

- Resources:
  - *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals* is now available to download at:
    - http://www.jointcommission.org/Advancing_Effective_Communication/
      - Joint Commission requirements
      - Laws and regulations
      - Sample policies and documents
      - Resource guide with references and links

Utilization Review

Utilization Review

Medicare requirement:

- §482.30 Condition of Participation: Utilization Review
- The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.
EPs for Utilization Review

- New EP at LD.04.01.01 – The hospital complies with law and regulation.
  
  a. EP 17 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a utilization review plan that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

  **Note 1:** The hospital does not need to have a utilization review plan if: A Quality Improvement Organization (QIO) has assumed binding review of the hospital OR CMS has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 456.50 through 456.245.

  **Note 2:** For guidance regarding the requirements at 42 CFR 482.30, refer to the “Medicare Requirements for Hospitals” appendix.

- EP 18 For hospitals that use Joint Commission accreditation for deemed status purposes: Utilization review activities are implemented by the hospital in accordance with the plan.

  **Note 1:** The hospital does not need to implement utilization review activities itself if: A Quality Improvement Organization (QIO) has assumed binding review for the hospital. OR CMS has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 456.50 through 456.245.

  **Note 2:** For guidance regarding the requirements at 42 CFR 482.30, refer to the “Medicare Requirements for Hospitals” appendix.

Anesthesia IGs

Anesthesia Interpretive Guidelines (IGs)

- Clarifications continue to be issued.

- IGs have been compared to Joint Commission requirements.

- May see some additional language added to introductions, rationales, notes, etc. to help clarify.

- Some FAQs are being developed.

- Pre and post anesthesia assessments, supervision, Monitored Anesthesia Care, qualifications, etc.
Telemedicine Update

Telemedicine
• Since the Hospital deeming application process began, The Joint Commission has engaged CMS in dialogue regarding their position on credentialing and privileging of telemedicine providers.
• The Joint Commission provided commentary on their proposed rule.
• During the deeming process The Joint Commission was required to revise its requirements.
• The Joint Commission continued discussion with CMS.

Telemedicine Final Rule
• CMS published a final rule for Telemedicine requirements regarding credentialing and privileging of telemedicine providers in the Federal Register on May 5th 2011.
• CMS effective date is July 5th 2011.
• The Joint Commission was pleased with the revisions CMS has made in this area.

Final Rule Summary

Hospital CoPs
• Changes are at 42 CFR 482.12 Condition of participation: Governing Body.
• CFR 42 482.22 Condition of participation: Medical Staff.

Critical Access Hospitals
• Changes are at 42 CFR 485.616 Condition of participation: Agreements.
• 42 CFR 485.635 Condition of participation: Provision of services.
• 42 CFR 485.641 Condition of participation: Periodic evaluation and quality assurance review.

Final Rule Summary
• The final rule permits hospitals and critical access hospitals to use the credentialing and privileging decision of the distant site telemedicine provider when granting telemedicine privileges.
• The level of burden to the originating site (where the patient is located) has been reduced.

The Joint Commission’s Response
• The Joint Commission has made minor revisions to LD.04.03.09 and MS.13.01.01.
• The Joint Commission is in the process of reviewing and responding to CMS regarding the final rule and any other potential changes to standards.
• Any updates to the field will be communicated via Perspectives as soon as available.
Hot Topics

Standing Orders/Protocols

Nurse initiated standing orders/protocols:

• CMS October, 2008 Survey and Certification memo
• The use of standing orders must be documented as an order in the patient’s medical record and authenticated by the practitioner responsible for the care of the patient, as the regulations at 42 CFR §482.23(c)(2) and §482.24(c)(1) require, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances. We would expect to see that the standing order had been entered into the order entry section of the patient's medical record as soon as possible after implementation of the order (much like a verbal order would be entered), with authentication by the patient's physician.
• The Joint Commission will expect to see:
  – Meet criteria defined by CMS.
  – Approval by MEC, P&T and CNO (scope of practice in your state).
  – Performance Improvement process to ensure nurse initiated protocols are appropriately implemented and that patient specific order is being obtained within defined timeframe.

30 Minute Rule for Medication Administration

In CMS Interpretive Guidelines:

• Require all medications be administered within 30 minutes of scheduled time.
• ISMP did a survey (mostly nurses responding).
  – Showed dangerous practices have developed as nurses tried to meet this requirement.
  – ISMP published recommendations for change.
• The Joint Commission continues to discuss with CMS.
• Our surveyors will look for patterns/trends and use common sense approach until this issue is resolved.

APRNs and PAs

• APRNs and PAs that provide a “Medical Level” of care must be credentialed and privileged through the Medical Staff process.
• Can no longer use the HR “equivalent” process.
Applicable Standards for Competency Evaluation: Physicians, Other Licensed Independent Practitioners and Others Who Provide a Medical Level of Care*+^ 

The Joint Commission Disclaimer Statement

• These slides are current as of June 15, 2011. The Joint Commission reserves the right to change the content of the information, as appropriate.

• These slides are only meant to be cue points, which were expounded upon verbally by the original presenter and are not meant to be comprehensive statements of standards interpretation or represent all the content of the presentation. Thus, care should be exercised in interpreting Joint Commission requirements based solely on the content of these slides.

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*Involves making medical diagnosis and medical treatment decisions.
+Does not apply to telemedicine providers.
^All other individuals are evaluated using the human resources standards.
Is Your Hospital Prepared?: New CMS Hospital Quality Measures, Reporting Requirements, and Reimbursements for 2011-2014

Overview of New CMS Measures

The Centers for Medicare & Medicaid Services (CMS) issued the Hospital Inpatient Prospective Payment System (IPPS) Final Rule in August 2010, which addresses three consecutive payment years. Hospitals have been aware of many tenets in the final rule for some time, including new quality measures, reporting requirements, and a new system of reimbursement (see the article beginning on page 1 for details about these legislative requirements); however, many of the requirements are only now taking effect. In addition, although previous rule-making cycles have addressed only one fiscal year at a time, the new rule addresses changes for fiscal years 2011 through 2014. Therefore, it is imperative that hospitals have a well-developed, well-executed strategic plan to meet these requirements.

The following is a high-level summary of the IPPS Final Rule; it is important to remember that although measures have been finalized for three consecutive years, measures may be added or removed in future rule-making cycles in response to agency and statutory changes:

- **Fiscal Year 2011:** 1 measure was retired, 45 measures will be used for payment determination.
- **Fiscal Year 2012:** 45 measures used in 2011 have been retained, 10 claims-based measures have been added (see below for additional information on the new measures).
- **Fiscal Year 2013:** 55 measures used in 2012 will be retained, 1 chart-abstracted measure and 1 health care-associated infection (HAI) measure (to be collected via the National Healthcare Safety Network) will be added.
- **Fiscal Year 2014:** 57 measures used in 2013 will be retained, two measures will be retired, 4 chart-abstracted and 1 HAI measure (to be collected via the National Healthcare Safety Network) will be added.

Payment Implications

Previously in the IPPS Fiscal Year 2009 Final Rule, CMS selected 10 categories of conditions for a hospital-acquired condition (HAC) payment provision. According to this rule, hospitals no longer received additional payment for cases in which one of the selected conditions was not present on admission (POA) beginning with discharges occurring on or after October 1, 2008. That is, the case would be paid as though the secondary diagnosis was not present. As part of the IPPS Fiscal Year 2011 Final Rule, 8 of these 10 HACs have been adopted for the Hospital Inpatient Quality Reporting Program (HIQRP)—originally called Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU).

CMS also issues annual market basket updates, which determine payments and cost limits for hospitals that are reimbursed through the IPPS. For Fiscal Year 2011, the projected market basket update will be 2.4%; however, a −2.9% rate adjustment will be applied, resulting in a decline of 0.1% in actual payments to acute care hospitals for operating expenses. There will be additional adjustments in 2012 and possibly in future years.

To receive the full 2.4% market basket percentage, hospitals must submit data for specific quality measures, while others are calculated by CMS using other data sources. For example, the recently adopted 8 HACs are calculated by CMS using Medicare claims data. It will be important for hospitals to ensure that they accurately report their ICD-9-CM diagnoses and present-on-admission coding that is used from Medicare claims data to calculate the rates for these measures. These data are then submitted to CMS as part of HIQRP.
For Fiscal Year 2012, 10 new claims-based measures are being adopted to qualify for the full market basket increase (see Sidebar 1 on page 5). Two of the new measures are patient safety indicators developed by the Agency for Healthcare Research and Quality, while the other eight are previously identified HACs. The Joint Commission has several programs and initiatives in place that may assist hospitals to prepare for and support the new HAC reporting requirements.

CMS originally planned to make HAC rates collected via HIQRP available to the public on its Hospital Compare Web site (http://www.hospitalcompare.hhs.gov). However, public reporting was postponed due to a discrepancy between submitted claims data and the CMS data file used to calculate the measures. CMS has targeted publication of HAC rates by the end of March 2011.

HACs and the POA Indicator Reporting program, as well as HIQRP will be important components in CMS’s future efforts to encourage higher quality and more efficient patient care under the Patient Protection and Affordable Care Act, which was signed into law March 2010. Improvement plans include measuring performance, using payment incentives, publicly reporting performance results, enforcing Conditions of Participation, applying national and local coverage policy decisions, and providing direct support for providers through Quality Improvement Organization activities. Thus, it will be important for hospitals and other health care organizations to closely scrutinize CMS requirements, keep abreast of changes or revisions, and develop comprehensive plans to comply with them. These requirements have important implications not only for patient safety, but also directly impact an organization’s financial viability.

Sidebar 1. New Measures Adopted for Fiscal Year 2012 Payment Determination

**Hospital-Acquired Conditions**
- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma (including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock)
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection
- Manifestations of poor glycemic control (including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity)

**Patient Safety Indicators**
- Postoperative respiratory failure
- Postoperative pulmonary embolism or deep vein thrombosis
The newly enacted Patient Protection and Affordable Care Act will change more than just health care insurance and coverage. The law demands increased quality data reporting and a shift to “pay-for-performance,” which proponents say will lead to better methods of performance measurement and, ultimately, better quality of care for patients.

The law has several new mandates. First, the law will establish a system of reimbursement bonuses and penalties for physicians and hospitals that will be dictated based on indicators of quality of patient care rather than quantity of patients treated. A second mandate requires increased public reporting of organization and physician performance. Another requirement specifies that hospital systems with high readmission rates in specific areas will be penalized with lower reimbursement. And finally, the law establishes two new centers for research within the Centers for Medicare & Medicaid Services (CMS), which are intended to explore ways to reduce costs and improve patient care through quality assessment. Each of these mandates will be explored in the sections that follow.

“Finally we are going to have a national strategy for measurement,” said Jerod Loeb, Ph.D., executive vice president in the Division of Healthcare Quality Evaluation at The Joint Commission. “Until this point it’s been ad hoc—let’s target a little thing here, a little thing there. Now we are figuring out what those national standards are. That’s an extraordinarily important step forward.”

(Continued on page 2)
The Future Is Now: Health Care Reform and Its Implications for Measurement, Reporting, and Performance
Continued from page 1

Reimbursement Bonuses and Penalties to Hospitals
Title III of the Affordable Care Act (ACA) will link an organization’s payment from CMS to its performance beginning in October 2012 when the law establishes a Hospital Value-Based Purchasing (VBP) program for acute care hospitals that are paid under the Medicare Inpatient Prospective Payment System (IPPS) for inpatient services furnished to Medicare beneficiaries. The new program, which was required by the ACA of 2010, would provide value-based incentive payments to hospitals beginning in 2013 based on their achievement or improvement on a set of clinical and patient experience of care quality measures. The new program, which was required by the ACA of 2010, would provide value-based incentive payments to hospitals beginning in 2013 based on their achievement or improvement on a set of clinical and patient experience of care quality measures. The new program, which was required by the ACA of 2010, would provide value-based incentive payments to hospitals beginning in 2013 based on their achievement or improvement on a set of clinical and patient experience of care quality measures. The new program, which was required by the ACA of 2010, would provide value-based incentive payments to hospitals beginning in 2013 based on their achievement or improvement on a set of clinical and patient experience of care quality measures.

In January 2011 CMS issued a proposed rule that established the Hospital VBP program. Under this program, hospitals that achieve certain performance standards during the performance period or that improve their performance over prior performance during a baseline period would receive incentive payments for discharges occurring on or after October 1, 2012. The proposed rule is open for public comment through March 8, 2011, and subsequently, CMS will review all comments and respond to them in a final Hospital VBP rule scheduled to be released in 2011. By statute, the aggregate Hospital VBP payments across all hospitals must be funded through a reduction in base operating diagnosis-related group (DRG) payments for each discharge. These incentives start at 1% of total payments in 2013 and increase to 2% by 2017.

Also under the ACA, hospital-acquired conditions (HACs) will be subject to reduced Medicare payments, with hospitals in the lowest performing quartile of HACs receiving a 1% reduction equal to 1% for hospitals in the top quartile of harm rates beginning in 2015. The Congressional Budget Office reports that this change will save $1.4 billion over a 10-year period. The Joint Commission addresses HACs in several ways: Foreign objects retained after surgery, blood incompatibility, and falls and trauma are reportable as sentinel events; National Patient Safety Goals address vascular catheter-associated infections; and deep vein thrombosis is included as a core measure set.

Public Reporting of Performance Measures
Under the ACA, Medicare’s no-pay policy for HACs will be expanded to all state Medicaid programs, and starting in 2014, Medicare will publicly report all cases in which payments have been denied.

The ACA also requires hospitals to continue public reporting on performance measures, including those related to heart failure, heart attacks, surgical care, pneumonia, health care–associated infections, and patients’ perception of care. The Joint Commission has core measures in common with CMS for these measures sets (heart failure, acute myocardial infarction, surgical care improvement project, and pneumonia), which organizations can use to meet ACA reporting requirements. The Joint Commission also publicly reports the 30-day mortality measures for heart attack, heart failure, and pneumonia and the patient perception of care measures on Quality Check (http://www.qualitycheck.org).

Reducing Hospital Readmission Rates
Reducing preventable hospital readmission rates is a key objective of the new
law. Twenty percent of Medicare acute-care hospital patients are readmitted to the hospital within 30 days of discharge, and almost a third are readmitted within 60 days. The annual cost of Medicare hospital readmissions is $15 billion; it is estimated that 80% of these readmissions are potentially avoidable.

Beginning in October 2012, hospitals with excessively high 30-day readmission rates for pneumonia, heart failure, and heart attack will see their IPPS payments reduced. In 2015 the list will be extended to include numerous cardiac and vascular surgical procedures and coronary obstructive pulmonary disease. The Congressional Budget Office estimates that the change will save Medicare $7 billion over 10 years.

Advocates say that the change will prompt hospitals to improve discharge planning and better coordinate with caregivers outside the hospital to reduce readmissions. Critics, however, maintain that not all readmissions are preventable by the hospital system and that the new law will not impact the readmission rate. The Joint Commission requires organizations to have a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer and to give information about the care, treatment, and services provided to the patient to other service providers, both of which are intended to prevent readmission.

To assist hospitals that have the highest readmission rates, Medicare will offer them the opportunity to take part in a five-year pilot program to reduce readmissions. Priority will be given to hospitals serving rural, small community, or medically underserved populations. Participating hospitals will use evidence-based care-transitional interventions to target Medicare patients at high risk for readmission. In addition, Joint Commission Resources is carrying out Project Re-Engineered Discharge (RED) to improve the discharge process and reduce the number of readmissions (visit http://www.jcrinc.com/AHRQ-Project-Red/ for more information).

New Research Centers

The ACA also established two new research centers that will be at the forefront of health care reform.

The Center for Medicare and Medicaid Innovation “aims to explore innovations in health care delivery and payment that will enhance the quality of care for Medicare and Medicaid beneficiaries, improve the health of the population, and lower costs through improvement.” New methods of delivering care and reducing costs developed by the Innovation Center will strive to improve the quality of care and reduce growing costs for Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP). The Innovation Center has three primary objectives:

1. Providing Better Care for Individuals: This includes improving the care of patients in formal settings (such as hospitals and nursing homes); developing safer, more efficient, and patient-centered practices; and exploring bundled payments.

2. Coordinating Care to Improve Health Outcomes for Patients: This concept calls for health care providers across settings to coordinate a patient’s care and involves testing the health home, medical home, and accountable care organization concepts.

3. Developing Community Care Models: These models will strive to solve some of the most pressing and chronic health issues in the community such as smoking, obesity, and heart disease.

According to Loeb, “We are very hopeful that the new Center for Innovation will be a critical linchpin in helping to identify areas for quality.” The second newly established entity, the Center for Quality and Improvement and Patient Safety, supports research into challenges such as intensive care, readmissions, and hospital infections, with the charge to disseminate its findings to health care providers and the public.

Many facets of health care reform have already taken effect and are being implemented in health care organizations across the United States. Several important initiatives have not yet started, but are slated to begin in the near future. A new system of reimbursement based on the quality of patient care, public reporting of hospital and physician performance, and lowered readmission rates will be phased in over the next few years. These new legislative requirements will undoubtedly improve the quality of patient care and the health care delivery system; they will also require a great deal of time and resources on the part of hospitals to implement, necessitating that hospitals plan for the future now.

References


Appendix A: Faculty Biographies

Jane R. Schetter, R.N., M.S.N., CNS, CPCS
Senior Consultant
Joint Commission Resources, Inc./CSR®

Jane Schetter brings demonstrated expertise as a nursing executive, risk manager, human resource director, performance improvement specialist, and medical staff coordinator to her role as a senior consultant for Joint Commission Resources and the Continuous Service Readiness™ Program. She served as Vice President for Patient Care and Standards at Fostoria Community Hospital, Fostoria, Ohio for five years, where she also served as Associate Director of Quality, Director of Rehabilitation Services, and Director of Human Resources, establishing appropriate policies and reviewing and revising the job descriptions, responsibility statements, and the competence evaluation process for the organization.

Mrs. Schetter served as a Joint Commission surveyor for 15 years (1988-2003) and is trained in the Accreditation Manuals for Ambulatory Care, Home Care, Long-Term Care, Behavioral Health, and Hospitals, including Critical Access Hospitals. Combining her experience with home care and hospitals, in 1996 and 1997, Mrs. Schetter assisted in the development and piloting of The Joint Commission integrated survey process for small and rural hospitals. In 2002, she assisted in the piloting of the Shared Visions-New Pathways survey process and education of surveyors. In 2002-2003, she assisted with the education of the JCR/CSR Consultants regarding Shared Vision/New Pathways and Tracer Methodology.

Mrs. Schetter developed the Ohio Hospital Association's Continuous Service Readiness Program and continues to serve as one of their JCR consultants. Mrs. Schetter also has primary responsibilities for organizations in the northern states participating in a CSR program either through the hospital association or through direct contracting. Mrs. Schetter also serves as faculty for the Department of Education Programs with specific emphasis on the National Patient Safety Goals, Tracer and Applied Tracer Methodologies, and all the activities of the Accreditation Process and Cycle.

Mrs. Schetter is affiliated with the American Hospital Association (Section for Aging and Long-Term Care), National Association for Home Care, Hospice Association of America, Sigma Theta Tau, the American Nurse Association and the Ohio Nurse Association. She received a Bachelor of Arts degree in Music and Psychology at Mary Manse College in Toledo, Ohio; a Bachelor of Science degree in Nursing at Bowling Green State University in Bowling Green, Ohio; and a Master of Science degree in Nursing at the Medical College of Ohio at Toledo with a specialty in Community Health and Healthcare Management.

Mrs. Schetter is an employee of Joint Commission Resources.
Karen L. Tertell, M.S.
Coordinator, Accreditation and Licensure
Rush University Medical Center
Chicago, Illinois

Karen Tertell brings extensive experience to her role as an Accreditation Coordinator at Rush University Medical Center. Ms. Tertell has over two decades of regulatory, administrative, and instructional experience in healthcare. Since 2004, she has been working in hospital accreditation – including full surveys, validation surveys, extension surveys, for cause surveys, and initial surveys – at Rush University Medical Center and, before that, at the University of Chicago Hospitals.

Prior to her positions in hospital accreditation, Ms. Tertell’s 12-year tenure at The Joint Commission included experience within the division of operations with responsibility for surveyor education and training; survey technology development and implementation; accreditation operations; and in the division of education with field, custom, and surveyor education programs for ambulatory, network, and hospital accreditation at The Joint Commission.

Ms. Tertell’s educational background includes: a master’s degree in gerontological science from the University of Southern California; a bachelor’s degree in psychology from Boston University; and graduate level course work in education at Northern Illinois University.

Ms. Tertell has nothing to disclose.

Anne M. Guglielmo, CFPS, LEED A.P.
Associate Director
Standards Interpretation Group
The Joint Commission

Anne Guglielmo is an Associate Director in the Standards Interpretation Group at The Joint Commission, serving as one of four engineers. In this role, she provides interpretation of standards, reviews equivalency and extension requests, conducts periodic performance review conference calls, serves as faculty for educational programs, and conducts surveys.

Ms. Guglielmo came to The Joint Commission in 2010 with 10 years experience in Fire Protection Engineering. Prior to joining The Joint Commission, she worked as a Fire Protection Engineer in the Design and Construction Industry reviewing plans for fire protection and life safety code compliance, field survey and documentation, preparing and presenting project submittals, energy code compliance modeling, and project equivalency identification and preparation.

Ms. Guglielmo is a Certified Fire Protection Specialist (CFPS) and a Leadership in Energy and Environmental Design Accredited Professional (LEED A.P.). She is a member of the National Fire Protection Association (NFPA), the Society of Fire Protection Engineers (SFPE) and the International Code Council (ICC).

Ms. Guglielmo received her Bachelor of Science degree in Civil Engineering, specialized in Fire and Life Safety Engineering, from the Illinois Institute of Technology in Chicago, Illinois.

Ms. Guglielmo is an employee of The Joint Commission.
Sophie M. Duco, R.N., B.A.
Associate Project Director Specialist
Division of Standards and Survey Methods

Sophie Duco has been a member of the Joint Commission staff since 2005. Ms. Duco currently is an Associate Project Manager Specialist in the Division of Standards and Survey Methods. In this position, she provides clinical support for the design, development, and implementation of standards and survey methods and serves as faculty for surveyor and other education programs. Ms. Duco also is a Certified Surveyor in the Hospital Accreditation Program. Preceding her current position, Ms. Duco was a member of the Standards Interpretation Group. As an Associate Director in the Standards Interpretation Group, she provided interpretation of standards for the hospital and healthcare staffing services programs, served as faculty for various education programs, and conducted Periodic Performance Review conference calls.

Prior to joining The Joint Commission, Ms. Duco served as Director of Case Management at a Chicago area hospital. Ms. Duco has extensive experience in the Case Management arena in multiple settings including hospital, managed care, and long-term acute care. Ms. Duco has over 20 years of nursing experience in both community and medical centers inclusive of multi-specialty medical and behavioral health areas.

Ms. Duco is an employee of The Joint Commission.

Laura Smith, M.A.
Associate Project Director
Department of Standards and Survey Methods

Laura Smith is an Associate Project Director in the Department of Standards and Survey Methods at The Joint Commission. In this position, she is responsible for the Hospital and Critical Access Hospital programs, deemed status for Critical Access Hospitals and Psychiatric Hospitals, and the Human Resources (HR) chapter.

Ms. Smith has been with The Joint Commission for 21 years and has held various positions such as Analysis Specialist (for the hospital and behavioral health care programs), Organization Liaison, and Research Associate.

Prior to joining The Joint Commission, Ms. Smith served as a Job Placement Counselor for Southwest Community Services in Tinley Park, Illinois. She developed and taught a competitive employment skills course to individuals with mental disorders, performed job matches between the targeted job and the individual, and assisted individuals with utilizing community resources.

Ms. Smith received her Bachelor of Arts degree in Psychology and her Masters of Arts degree in Communications from Governors State University in University Park, Illinois.

Ms. Smith is an employee of The Joint Commission.
Appendix B: Post-Test

To be eligible for CE credit, you MUST view the video presentation and read the Resource Guide first. Then complete the post-test at [http://jcrqsn.mcnlearning.com](http://jcrqsn.mcnlearning.com) by the due date listed online.

1. For hospitals that use The Joint Commission for deemed status, surveyors must review a minimum of _____ patient records or 10% of ADC, whichever is greater.
   a. 20
   b. 30
   c. 40
   d. 50

2. Determination of Condition Level Deficiencies is based on _____.
   a. manner
   b. degree
   c. collaboration among survey team members and Central Office Staff
   d. All of the above.

3. Element of Performance _____ of Standard IM.02.02.03 requires organizations to retrieve, disseminate, and transmit health information in useful formats.
   a. 1
   b. 2
   c. 3
   d. 4

4. The additions to Element of Performance _____ of Standard TS.02.01.01 has been clarified to require hospitals to be prepared to submit all data related to an organ transplant to the U.S. Department of Health and Human Services.
   a. 1
   b. 2
   c. 3
   d. 4

5. Standard EC.02.03.01 addresses how the hospital or critical access hospital _____.
   a. flooding risks
   b. loss of electrical power
   c. fire risks
   d. All of the above

6. Standard EC.02.05.03 requires the hospital or critical access hospital to _____.
   a. have a plan to manage flooding
   b. have a reliable emergency electrical power source
   c. have a plan to manage fire risks
   d. All of the above.
7. Element of Performance _____ of Standard EM.03.01.03 requires the hospital or critical access hospital to activate its Emergency Operations Plan twice a year at each site included in the Plan.
   a. 1
   b. 2
   c. 3
   d. 4

8. Standard _____ requires the hospital or critical access hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
   a. EC.02.01.30
   b. EC.02.02.30
   c. LS.02.01.30
   d. LS.02.02.30

9. The Joint Commission allows healthcare organizations to schedule maintenance activities based on _____.
   a. manufacturer's recommendations
   b. risk levels associated with the equipment
   c. hospital experience
   d. All of the above.

10. Surveyors have been evaluating implementation of the Patient-Provider Communication Standards since January 2011; however, Most will not count toward an accreditation decision until _____.
    a. October 2011
    b. January 2012
    c. March 2012
    d. June 2012
Appendix C: Resources

Electronic Resources

The Joint Commission: http://www.jointcommission.org
Joint Commission Resources: http://www.jcrinc.com/

NOTE: The Internet is an ever-evolving environment and links are subject to change without notice.
Appendix D: Continuing Education Credit Information

Accreditation Council for Continuing Medical Education
Joint Commission Resources is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Joint Commission Resources designates this educational activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Nurses Credentialing Center's Commission on Accreditation
Joint Commission Resources is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Joint Commission Resources designates this continuing nursing education activity for 1 contact hour. Accreditation by the American Nurses Credentialing Center's Commission on Accreditation refers to recognition of educational activities and does not imply approval or endorsement of any product.

American College of Healthcare Executives
Joint Commission Resources is authorized to award 1 hour of pre-approved Category II (non-ACHE) continuing education credit for this program toward advancement, or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward Category II credit should list their attendance when applying for advancement or recertification in ACHE.

Full attendance at every session is a prerequisite for receiving full continuing education credits. If a participant needs to leave early, their continuing education credits will need to be reduced.

National Association for Healthcare Quality
This activity has been approved by the National Association for Healthcare Quality (NAHQ) for 1.0 Certified Professional Healthcare Quality (CPHQ) CE credit.

Successful completion of this CE activity includes the following:
• View the presentation and read the accompanying Resource Guide.
• Complete the online Evaluation Form and Post Test.
• A CE certificate/statement of credit can be printed online following successful completion of the Post Test and the Evaluation Form.

NOTE: This information applies to The Joint Commission Resources Quality & Safety Network program titled, The CMS and Joint Commission Crosswalk: An Update, originally presented on Thursday, September 22, 2011 from 2:00 - 3:00 p.m. ET.
There is no individual participant fee for this educational activity.
Appendix E: Discipline Codes: Instructions

Some of our programs are accredited for more than one discipline. To ensure that we issue each participant a certificate by the appropriate accrediting body, we ask that you supply us with the following information:

1. The two-digit discipline code
2. Followed by the position code

Example: For a medical doctor, use: 10 MD

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<td>NP</td>
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<td></td>
<td>LPN</td>
<td>Licensed Practical Nurse (or LVN)</td>
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<td>ON</td>
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<td>Nursing Technician</td>
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<td>CFR</td>
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<td>EMTB</td>
<td>EMT, Basic Level/EMT1</td>
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<td>EMTI</td>
<td>EMT, Intermediate Level/EMT2/EMT3</td>
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<td>EMTP</td>
<td>EMT, Paramedic Level/EMT4</td>
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<tr>
<td>Health Unit Coor</td>
<td>55</td>
<td>CHUC</td>
<td>Health Unit Coordinator, Certified</td>
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<td>Other</td>
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<td>OTH</td>
<td>Other</td>
</tr>
</tbody>
</table>

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Appendix F: JCR Quality & Safety Network Contact Information

**General information, customer service issues, or program reception problems?**
If you have questions or need technical assistance, please contact the JCRQSN Customer Service Team via e-mail at support@jcrqsn.com or call toll-free 1-888-219-4678

**To provide feedback or comment on JCRQSN educational programming**
Please contact:
George Riccio
Associate Director of Video and Satellite Service
Joint Commission Resources 630-792-5428

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support@jcrqsn.com

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**Questions about JCR education or other resources?**
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**VA Knowledge Network Questions?**
Contact Rose Monfore 714-283-4746