The Joint Commission
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Reminder: SAFER™ Matrix Effective January 1, 2017

New Scoring Methodology for All Programs

As previously announced in *Perspectives*,[1,2] The Joint Commission's multiphase Project REFRESH includes the launch of the new Survey Analysis for Evaluating Risk™ (SAFER™) matrix, **effective January 1, 2017,** for **all accreditation and certification programs**.

The SAFER matrix (*see* figure on page 3) replaces the current scoring methodology, which is based on predetermined categorizations (Category A or Category C; direct or indirect impact) of elements of performance (EPs), allowing surveyors and reviewers to perform real-time, on-site evaluations of deficiencies. To coincide with the roll-out of the SAFER approach, the Measure of Success (MOS) requirement is also being eliminated; therefore, all MOS submissions due on or after January 1, 2017, are no longer required as the tool will be closed out. However, organizations are encouraged to continue to monitor the effectiveness of their corrective actions through future measurement as they find value in doing so.

Operational Definitions

The SAFER matrix represents a shift from the historical approach of "counting" observations to an evaluative approach of assessing the scope of patients impacted (or potentially impacted) by an issue of noncompliance. As they use the SAFER matrix, surveyors and reviewers will place each Requirement for Improvement (RFI) within the matrix according to the likelihood of the issue to cause harm to patients, staff, or visitors and according to the scope of a cited deficiency. Implementing this approach includes incorporating the operational definitions shown along the *x* and *y* axes of the SAFER matrix.

Operational definitions along the *y* axis—"Likelihood to Harm"—are as follows:

- **High**—Occurrence of harm is likely; that is, the finding could directly lead to harm without the need for other significant circumstances or failures.
- **Moderate**—Occurrence of harm is possible; that is, the finding could cause harm directly but is more likely

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The Joint Commission

Joint Commission Resources

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In Sight

This column lists developments and potential revisions that can affect accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

APPROVED

STANDARDS

- Revisions to Care, Treatment, and Services (CTS) Standard CTS.03.01.09 on outcome measures for accredited **behavioral health care** organizations (*see* article on page 10 of this issue)
- Revisions to several requirements for accredited **behavioral health care** organizations as the first phase of a maintenance review project (*see* article on page 8 of this issue)
- Revision to the definition of *designated equivalent source* for accredited **ambulatory care** and **behavioral health care** organizations, **critical access hospitals**, **hospitals**, **nursing care centers**, and **office-based surgery practices** (*see* article on page 4 of this issue)

CURRENTLY IN DEVELOPMENT

STANDARDS

- Proposed new Human Resources (HR) Standard HR.02.01.03, EP 37, for **ambulatory care** organizations that provide sleep study services
- Proposed revisions to clarify language of several requirements for **behavioral health care** organizations as the second phase of a maintenance review project
- Proposed new and revised requirements for **laboratories** that address the following: molecular and genetic testing, clinical chemistry and toxicology, and aligning various requirements with Clinical Laboratory Improvement Amendments (CLIA) Interpretive Guidelines
- Proposed deletions to requirements for the **ambulatory care**, **behavioral health care**, **critical access hospital**, **home care**, **laboratory**, **nursing care center**, and **office-based surgery programs** as Phase III of the EP Review component of Project REFRESH

Survey Changes Announced for Deemed-Status Ambulatory Surgical Centers

Effective January 1, 2017, in order to better align with the Centers for Medicaid & Medicare Services (CMS) surveyor guidelines, approximately two-thirds of **ambulatory surgical centers** (ASC) electing to use the Medicare-deemed option may receive adjustments to their survey complements (number of days and/or surveyors). The Joint Commission is adjusting its current survey team structure for ASCs to further enhance the already effective and rigorous survey process.

Changes to the survey complement are designed to accomplish the following:

- Add time for the clinical component of ASC Medicare-deemed surveys, ensuring that surveyors have sufficient time to perform a thorough, credible evaluation
- Allow time to cover Joint Commission as well as CMS requirements, conduct patient tracers, review medical records and credentialing files, and complete CMS-required worksheets
- Provide ASCs with a more meaningful, educational, and consultative experience that includes the sharing of leading practices
- Provide the ASC with a survey team made up of two clinical surveyors (in the majority of survey events) with a real-time ability to work together to assure consistency of interpretation
- Better prepare ASCs for their CMS state survey (validation or other), which will lead to better success with possible CMS survey event

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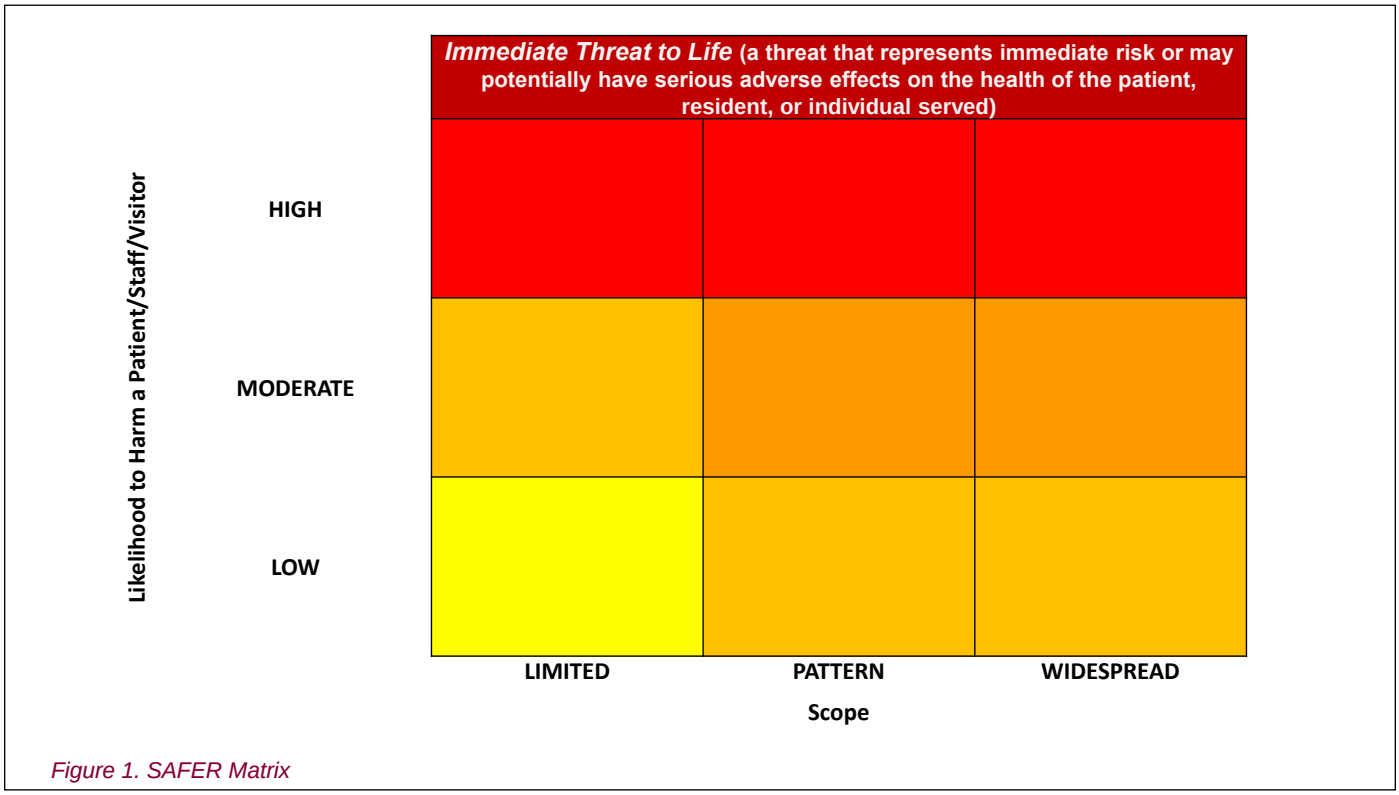

Figure 1. SAFER Matrix

to cause harm as a contributing factor in the presence of special circumstances or additional failures.

- **Low**—Occurrence of harm is rare; that is, the finding undermines safety/quality or contributes to an unsafe environment is but very unlikely to directly contribute to harm.

Operational definitions along the *x* axis—"Scope"—are as follows:

- **Widespread**—Issue is described as "pervasive at the organization"; that is, the finding is the result of a process or systemic failure and could impact a majority of patients.
- **Pattern**—Issue is described as having the potential to "impact more than a limited number of patients impacted"; that is, the finding involves process variation.
- **Limited**—Issue is described as a "unique occurrence"; that is, the finding is considered an outlier and not representative of routine or regular practice.

These operational definitions are designed to be applied at the organization level. As a reminder, the SAFER matrix is meant to be utilized as a tool in the survey process to illustrate potential risk areas at the organization. It will not be used in isolation to drive or determine the application of certain decision rules.

Resources on the Extranet

The Joint Commission provides several resources on organizations' secure *Joint Commission Connect*™ extranet site to assist with the transition to the SAFER approach. The SAFER link under the Survey Process tab (at "Post-Survey") includes these resources:

- PowerPoint presentation with speaker notes
- Matrix template to practice placing findings on the grid
- FAQs
- One-page infographic
- May and October 2016 *Perspectives* articles[1,2]
- Sample report that incorporates the SAFER approach
- Quick tips and FAQs for submitting Evidence of Standards Compliance (ESC)
- Webinar recording
- Podcast
- Quiz that includes where to place example findings on the matrix and the rationale as to why

For additional information, please contact your organization's assigned Account Executive or review the abovementioned resource documents located on the extranet site under the Survey Process tab. Questions may be submitted to safer@jointcommission.org.

References

1. The Joint Commission. The SAFER matrix: A new scoring methodology. *Jt Comm Perspect*. 2016 May;36(5):1, 3.
2. The Joint Commission. The SAFER™ matrix and changes to the post-survey process. *Jt Comm Perspect*. 2016 Oct;36(10):1, 3, 4.

Change to Definition of *Designated Equivalent Source*

Recently, the American Osteopathic Association (AOA) contacted The Joint Commission and asked that its definition of *designated equivalent source* be modified to reflect the AOA as a designated equivalent source for information on completion of residency training segments through programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

The AOA indicated that currently, at the request of a physician, its Department of Education contacts the directors of training programs accredited by the ACGME to obtain primary source verification of completion of residency training segments by doctors of osteopathic medicine (DOs). The primary source information on these segments is then added to the AOA Physician Database and appears on the physician's report. Also, beginning in 2020, there will be a single residency training pathway for doctors of medicine (MDs) and DOs under the ACGME umbrella. Because of these factors, it would be beneficial to make the requested change to the definition.

Because The Joint Commission definition of *designated equivalent source* already recognizes the AOA as a designated equivalent source for several other items, and the AOA has indicated that it performs primary source verification for the additional information for which it would like to be recognized, and The Joint Commission currently recognizes the same information in the American Medical Association (AMA) Physician Masterfile, the decision has been made to amend the definition of *designated equivalent source* as requested by the AOA. The edit reads as follows (new text is underlined):

> **designated equivalent source** Selected agencies that have been determined to maintain a specific item(s) of credential(s) information that is identical to the information at the primary source. Designated equivalent sources include but are not limited to the following:
>
> - The American Medical Association (AMA) Physician Masterfile for verification of a physician's United States and Puerto Rican medical school graduation and postgraduate education completion
> - The American Board of Medical Specialties (ABMS) for verification of a physician's board certification
> - The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school
> - The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; postdoctoral education approved by the Accreditation Council for Graduate Medical Education (ACGME); and Osteopathic Specialty Board Certification
> - The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license
> - The American Academy of Physician Assistants (AAPA) Profile for physician assistant education, provided through the AMA Physician Profile Service (https://profiles.ama-assn.org/amaprofiles/)

This change to the glossary is **effective immediately** and will appear in the spring 2017 E-dition® updates to the accreditation manuals for **ambulatory care**, **behavioral health care**, **critical access hospitals**, **hospitals**, **nursing care centers**, and **office-based surgery practices**. (This change will also appear in the print publications for the 2017 Update 1 to the *Comprehensive Accreditation Manuals* for ambulatory care, behavioral health care, and hospitals.)

Please contact Lynn Berry, project director, Department of Standards and Survey Methods, at lberry@jointcommission.org for more information.

Survey Changes Announced for Deemed-Status Ambulatory Surgical Centers (continued)

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The *Life Safety Code®** component of the survey will continue to be conducted by one surveyor for one day unless extenuating circumstances call for any additional time. On-site survey fees for Medicare-deemed ASCs will be adjusted as needed to reflect the number of surveyors on site and the length of the survey.

For more information, please contact your organization's assigned Account Executive.

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Clarifications and Expectations

Understanding Key Changes to the Life Safety Standards

An introduction from George Mills, MBA, FASHE, CEM, CHFM, CHSP, Director, Department of Engineering, The Joint Commission: *This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care, but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your organization's facilities leadership.*

Effective July 5, 2016, all Joint Commission–accredited hospitals, critical access hospitals, ambulatory surgical centers, behavioral health care organizations, and inpatient hospices are required to comply with the 2012 edition of the National Fire Protection Association's (NFPA) *Life Safety Code*®* (NFPA 101-2012) and *Health Care Facilities Code* (NFPA 99-2012). The Joint Commission has recently rewritten the "Life Safety" (LS) chapter to align with this requirement and made changes to the "Environment of Care" (EC) chapter as well. This is the second installment of a series of columns that address the updated standards, covering interim life safety measures as well as LS.01.02.01, Elements of Performance (EPs) 1–15.

The "Life Safety" (LS) chapter contains Joint Commission requirements associated with the 2012 *Life Safety Code* (NFPA 101-2012). The *Life Safety Code* addresses features designed to minimize danger to life from the effects of fire, including minimum criteria for the design of egress facilities to allow the prompt escape of occupants from buildings, or where desirable, into safe areas within buildings. The *Life Safety Code* also addresses other considerations essential to life safety such as protective features, maintenance activities, and other provisions. (*See* NFPA 101-2012, 1.1 Scope.) The Joint Commission standards support these features by requiring compliance with the *Life Safety Code*. Periodic building inspections and ensuring that design and construction align with the *Life Safety Code* is an expected condition (*see* LS.01.01.01).

The *Life Safety Code* recognizes that there are times when building features are not compliant, allowing time for compliance: "A limited but reasonable time, commensurate with the magnitude of the expenditure, disruption of services, and degree of hazard shall be allowed for compliance with any part of this *Code* for existing buildings" (NFPA 101-2012 4.6.6).

For those times of noncompliance, identified either during a building inspection or construction/renovation/modernization condition creating building deficiencies, The Joint Commission requires interim life safety measures (ILSM) to be in effect as defined by the organization's policy (*see* LS.01.02.01).

The following discussion will explore the policy that defines the ILSM process and the 14 administrative actions associated with these requirements.

Interim Life Safety Measures (ILSM) Policy (LS.01.02.01, EP 1)

The LS chapter begins with a new administrative requirement—a building assessment to determine compliance with the LS chapter (LS.01.01.01, EP 2). During this assessment, or during normal building rounds, *Life Safety Code* deficiencies may be discovered. Also, during construction/renovation/modernization, building deficiencies may be created as systems or construction features are reduced or are being changed. Survey activity may also identify noncompliance.

The next standard, LS.01.02.01, states that the "hospital protects occupants during periods when the *Life Safety Code* is not met or during periods of construction." To accomplish this, The Joint Commission requires the organization to have a written ILSM policy for situations when *Life Safety Code* deficiencies cannot be immediately corrected or during periods of construction.

The ILSM policy includes written criteria for evaluating when and to what extent the organization implements ILSM to compensate for increased life safety risk. Although it is up to the organization to define the criteria, the criteria must include the written assessment process to determine implementation. The assessment process should include how to assess the potential risk to patients and associated ILSM to mitigate the risk. The greater the risk, the more substantial the interim measures would be. All of those EPs identified as interim measures (LS.01.02.01, EPs 2–15), when selected, must be documented while implemented. In some situations, the scope of deficiencies differs, depending on where the project is or the staging of corrective actions. The organization may consider incorporating Environment of Care (EC) EC.02.06.05, EPs 2 and 3, into the ILSM assessment creating a safe patient care environment while corrective actions are being completed.

The Joint Commission also has a requirement for a preconstruction risk assessment based on potential infection prevention and control risk related to construction. Many organizations combine the ILSM assessment of *Life Safety*

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Code impact and the impact to the patient and the patient care environment. EC.02.06.05, EP 2 states, "When planning for demolition, construction, renovation, or general maintenance, the organization conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. **Note 1:** *See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.*"

When deficiencies from the LS chapter are identified during survey, organizations must implement their ILSM policy with their corrective action. Beginning November 17, 2016, a surveyor writing a Requirement for Improvement (RFI) will discuss the deficiency with the organization, and its impact on patient safety. At the same time the surveyor will also discuss which ILSM, according to its ILSM policy, the organization will be selecting and implementing to protect patients, staff, and visitors until the deficiency is corrected. These ILSM actions will be included in the observation with the following statement:

> The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following Interim Life Safety Measure(s) should be implemented until the deficiency has been resolved. Evidence of implementation should be available for Evidence of Standards Compliance (ESC) documentation.

To document the selection of the appropriate ILSM, the organization should open the Statement of Conditions™ and create a Survey-related Plan for Improvement (SPFI). In the SPFI are the 14 ILSM actions listed in a series of check boxes. The 15th ILSM, identified as "OTHER," is provided to accommodate an ILSM action not found in the previous actions listed. When the "OTHER" check box is selected, a text box opens and the other action is entered.

When submitting a Time-Limited Waiver request: When deficiencies are identified and the organization may need more than 60 days to complete, they will need to request a Time-Limited Waiver, using the Statement of Conditions Survey-Related Plan for Improvement (SPFI) process. A key component to the submission, which will be reviewed by the Joint Commission Department of Engineering, is the selection and implementation of ILSM. Failure to do so may result in the request being denied. After review by the Joint Commission Department of Engineering, the Time-Limited Waiver request is forwarded to the appropriate CMS Regional Office for their final review and decision. For other organizations that are not seeking accreditation for deemed status purposes, the review will be completed quickly by the Engineering Department.

To compensate for the increased risk to patients, staff, and visitors, the ILSM policy must include identifying and applying the corrective actions found in EPs 2–15. Each of these EPs is reviewed here.

LS.01.02.01, EP 2: When the hospital identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the hospital either evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4-out-of-24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text and any exceptions, refer to NFPA 101-2012: 9.6.1.6 and 9.7.6 and NFPA 25-2011: 15.5.2)

EP 2 The fire alarm system provides occupant notification, which then allows staff to mobilize the fire plan. The sprinkler system is designed to activate and put out a fire. Together these two building features provide occupant protection from fire. If either of these systems is compromised as defined in the EP, the building owner needs to assess the impact and either evacuate or implement a fire watch.

A fire watch includes communication with the local fire response agency, alerting them of the compromised protection and establishing a scheduled tour of affected areas. The documented fire watch is to be completed as per the organization policy, which needs to align with state and local authorities having jurisdiction. The NFPA's Healthcare Interpretations Task Force (HITF) provided interpretation to the question, "Can the normal clinical staff in an area affected by a fire alarm impairment or a sprinkler system impairment be used to satisfy the requirements for a fire watch?" The interpretation of the HITF was "YES. Clinical staff may fulfill this role provided, as determined by the authority having jurisdiction, there is an adequate staffing level to continuously patrol the affected area and that they have the means to make proper notification to other occupants in the event of fire."

EP 3 The *Life Safety Code* requires that floors and compartments have at least two exits arranged remotely from one another (*see* LS.02.01.20, EP 13). Whenever the means of egress, including the exit enclosure, is compromised, the organization needs to post signage that identifies the alternative exits to all patients, staff, and visitors. The signage should be inspected as per policy to ensure that it is there and communicates accurately the alternative exit route.

EP 4 While EP 3 addresses compromised means of egress and signage for alternative egress, EP 4 ensures that the exits are protected by daily inspections following the ILSM policy. Verification of these daily inspections must be maintained. Keeping the exit protected and clear of materials allows the exit to be used. The ILSM policy must establish conditions when the exit is potentially compromised, and establish how and when the daily inspection must occur.

EP 5 During scheduled events, such as construction, the design team should evaluate the project impact on the fire alarm and detection systems. For both scheduled and

unscheduled conditions that disrupt these systems, the ILSM policy should provide criteria to determine if a temporary but equivalent fire alarm or detection system needs to be installed. These temporary systems are to provide an equivalent level of safety and reliability for protection of the building and its occupants. If a temporary but equivalent fire alarm or detection system is installed, the temporary system must be tested monthly as per established testing criteria (*see* EP 12).

EP 6 Construction materials and waste create additional fire load to the construction site, possibly exceeding the existing fire protection system capabilities. Some *Life Safety Code* deficiencies may also create the need for additional firefighting equipment. For example, if additional fire extinguishers are added, they will need to be properly secured and inspected, and the staff or contractors that are expected to use the equipment will need appropriate training. The organization needs to have a process, included in the ILSM policy, to provide additional firefighting equipment to compensate as needed.

EP 7 The protection of patients, staff, and visitors must be a priority. The ILSM policy shall establish the use and implementation of partitions to segregate the risk to the occupants until the corrective action or construction project is complete. These partitions shall not contribute to the risk to the occupants but are to be smoke-tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. Often these partitions are adjacent to the exit access and should be included in the daily exit inspections.

Occasionally these partitions have gaps or are in disrepair, and the ILSM policy should address how they are maintained. This may include a regular inspection, which many organizations combine with the daily exit inspections (EP 4) or surveillance (EP 8).

Some state authorities having jurisdiction have not allowed temporary partitions that reduce the means of egress clear width. In this situation organizations may have to divert occupants to alternative exit routes. The Joint Commission expects all organizations to comply with local, state, and federal requirements.

EP 8 Construction areas generate many hazards throughout the project. Materials on site for staging, equipment, and debris may restrict exiting, or create an unusual fire load. Site excavation may create a risk to those unfamiliar with the project. All appropriate safeguards must be in place during excavation. Field offices, where site management and meetings occur, also present unusual risks. Placement of the field office should not compromise access or the path to the public way.

The ILSM policy must include a process to assess the risks these conditions may present. Other EPs require daily exit inspection, which should be considered while determining the scope and frequency of surveillance of the buildings and construction areas.

EP 9 Management of storage and debris removal must focus on reduction of risk, including the impact on fire loading. Fire loading occurs when an unusual amount of materials is gathered in one location, exceeding the ability of the existing fire suppression system. Also, transporting debris from demolition through the building may create an increase in airborne contaminates, so consider covering the transport to reduce exposure. Site housekeeping practices to mitigate these conditions may also present additional risk. Cleaning materials and staging of general waste could contribute to accumulating materials in one place that could also contribute to fire risk. Cleaning rags, solvents, and other materials must also be managed.

The ILSM policy should include a process to provide site management for storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level.

EP 10 The "Environment of Care" (EC) chapter requires staff to be trained in fire response, including the fire plan and how to use a fire extinguisher (*see* EC.02.03.01, EP 9). The expectation in EP 10 is that the ILSM policy provide guidance for adding firefighting equipment to mitigate the possible fire risk. For example, if fire extinguishers are added, they will need to be properly secured and inspected, and the staff or contractors that are expected to use the equipment will need appropriate training.

EP 11 Fire drills rehearse and affirm staff response and knowledge in a fire condition. Fire drills should also simulate actual conditions that staff may encounter. These fire drills differ slightly from those required by EC.02.03.03, as these are directly related to the *Life Safety Code* deficiencies, either from construction or identified during building tours. The drills should include the area identified as potential risk and then the areas adjacent that could also be involved. Consistent with other fire drills, they should occur at varying times and conditions. The purpose and objective of these fire drills should be addressed in the ILSM policy, including how they will be documented.

EP 12 During renovation, remodeling, or alterations the features of fire safety may be scheduled to be interrupted, leaving the building and its occupants vulnerable. If a temporary but equivalent system is installed as a mitigation strategy, the temporary system must be tested monthly as per established testing criteria, including documentation. Any impairments in the temporary system must be corrected immediately.

EP 13 When planning for the construction, renovation, modernization, or repair of the building, the organization needs to do an assessment as described in the ILSM policy to determine the education needs of the staff. The education should provide, as a minimum, information about any temporary systems and their response features; an awareness of the hazards associated with the project; any other building deficiencies associated with the project; and any changes to the fire plan. Although many construction projects or corrective

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Approved: Phase I Revisions to Update Behavioral Health Care Requirements

The Joint Commission is reviewing the *Comprehensive Accreditation Manual for Behavioral Health Care* (*CAMBHC*) and identifying any standards that require maintenance. This review project, which is occurring in two phases, includes making clarifications to existing language, adding new elements of performance (EPs), and revising notes.

Phase I revisions, which are **effective July 1, 2017**, consist of the following:

- Note 2 for Care, Treatment, and Services (CTS) Standards CTS.02.01.05 and CTS.02.01.06 has been rewritten to improve its clarity.
- Standard CTS.03.01.03, EP 2 has been revised to require that organizations identify the criteria and process for each individual's transfer and/or discharge; discuss these with the individual; and incorporate this information into the individual's plan for care, treatment, or services. These revisions are designed to improve organizations' support of the individual's progress in achieving these particular goals.
- Standard CTS.03.01.07, EP 5, has been revised to require opioid treatment programs to provide education about neonatal abstinence syndrome not only to all mothers but to all women of child-bearing age. (This revision meets and exceeds a recently issued Substance Abuse and Mental Health Services Administration requirement for opioid treatment programs to educate all mothers about neonatal abstinence syndrome.)
- The applicability of Environment of Care (EC) Standard EC.02.04.03, EP 3 (on inspecting, testing, and maintaining medical equipment) for Behavioral Health Home–certified organizations has been expanded to include all behavioral health care organizations. In addition, a definition of *medical equipment* has been added to the glossary.
- Human Resources Management (HRM) Standard HRM.01.06.01, EP 3 has been rewritten to improve its clarity.

These revisions are shown below (new text is underlined and deleted text is shown with ~~strikethrough~~) and will be posted on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. The revisions will be published in the spring 2017 E-dition® and print updates for the *Comprehensive Accreditation Manual for Behavioral Health Care*.

Please contact Lynn Berry, project director, Department of Standards and Survey Methods, at lberry@jointcommission.org for more information.

Joint Commission Requirement

Official Publication of Joint Commission Requirements

Phase I Maintenance Revisions to Behavioral Health Care Requirements

Applicable to Behavioral Health Care

Effective July 1, 2017

Care, Treatment, and Services (CTS)

Standard CTS.02.01.05

For organizations providing care, treatment, or services in non–24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual's need for a medical history and physical examination.

Note 1: *This standard does not apply to foster care and therapeutic foster care. (*See also *CTS.02.04.01, EP 1)*

Note 2: ~~*This standard does not apply to*~~ *If the organizations* ~~*that provide*~~ *conducts a physical examinations* ~~*to*~~ *on all individuals served* ~~*as a matter of policy or to comply with law and regulation*~~*, it is in compliance with this standard.*

Standard CTS.02.01.06

For organizations providing residential care: The organization screens all individuals served to determine the individual's need for a medical history and physical examination.

Note 1: *This standard does not apply to foster care, therapeutic foster care, and emergency shelters. (*See *CTS.02.04.01, EP 1)*

Note 2: ~~*This standard does not apply to*~~ *If the organizations* ~~*that provide*~~ *conducts a physical examinations* ~~*to*~~ *on all individuals served* ~~*as a matter of policy or to comply with law and regulation*~~*, it is in compliance with this standard.*

Note 3: *"Residential care" includes residential settings, group home settings, and 24-hour therapeutic schools.*

Standard CTS.03.01.03

The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

Element of Performance for CTS.03.01.03

2. The plan for care, treatment, or services includes the following:
   - Goals that are expressed in a manner that captures the individual's words or ideas

- Goals that build on the individual's strengths
- Factors that support the transition to community integration when identified as a need during assessment
- The criteria and process for the individual's expected successful transfer and/or discharge, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)

Note 1: *Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.*

Note 2: ***For opioid treatment programs:*** *For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.*

Standard CTS.03.01.07

When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record. (For more information, refer to Standard CTS.04.01.01.)

Element of Performance for CTS.03.01.07

5. **For opioid treatment programs:** The program educates ~~mothers~~ all women of child-bearing age about neonatal abstinence syndrome, its symptoms, its potential effect on their infants, and the need for treatment should it occur.

Environment of Care (EC)

Standard EC.02.04.03

~~**For organizations that elect The Joint Commission Behavioral Health Home option:**~~ The organization inspects, tests, and maintains medical equipment.

Element of Performance for EC.02.04.03

3. ~~**For organizations that elect The Joint Commission Behavioral Health Home option:**~~ The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers' recommendations, risk levels, or current organization experience. These activities are documented.

Note: *This process does not encompass medical equipment owned by individuals served or other organizations.*

Human Resources Management (HRM)

Standard HRM.01.06.01

Staff are competent to perform their job duties and responsibilities.

Element of Performance for HRM.01.06.01

3. ~~As part of orientation, the~~The organization conducts an initial assessment of staff competence ~~before they assume their responsibilities~~. This assessment is documented.

CLARIFICATIONS AND EXPECTATIONS: Understanding Key Changes to the Life Safety Standards (continued)

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actions may be disruptive, proper training of staff can reduce the impact.

EP 14 In addition to general education provided in EP 13, the organization should provide specific training to staff to compensate for impaired structural or compartmental fire safety features. For example, if the fire alarm system was not working, staff would need to know how compartmentilization is maintained (for example, ensuring fire doors close).

Compartmentalization prevents the threat of fire or smoke by using various building components, such as rated walls and doors in a fire barrier, or smoke barriers to restrict the passage of smoke. These components create a safe means of egress that includes an approved exit. If the compartmentalization is compromised, staff must be instructed in patient movement during a fire or other event. Under normal conditions, a health care occupancy does not immediately evacuate but "defends in place." Re-training staff may need to occur to compensate for the disruption. Staff training should include how to ensure these features are not compromised during the period of the known deficiencies. The ILSM policy provides critera for the scope and substance of the training requirements.

EP 15 Occasionally, the deficiency might not be addressed by one of the above EPs (*see* LS.01.02.01 EPs 2–14), or when the deficiency is such that it does not require implementation of any ILSM. When this occurs, the organization's alternative methods to protect its buildings and occupants, identified here at EP 15 as "Other," will be documented in the Statement of Conditions in the SPFI section. The selection of "OTHER" during survey will be discussed with the *Life Safety Code* surveyors, and annotated in the Requirement for Improvement (RFI).

The intent of the ILSM is to provide alternative protection when one or more features of fire protection are compromised, either due to construction or when identified during building tours. Having a robust ILSM policy will ensure the organization continues to protect its patients, staff, and visitors.

This month's column also appears in the January 2017 issue of *Environment of Care® News*.

Approved: Revisions to Behavioral Health Care Outcome Measures Standard

The Joint Commission announces revisions **effective January 1, 2018**, to Care, Treatment, and Services (CTS) Standard CTS.03.01.09 for accredited **behavioral health care** organizations. Whereas the standard currently requires organizations simply to assess outcomes of care, treatment, or services, the revisions require organizations to assess outcomes by using a standardized tool or instrument. The results of these assessments will be used to inform goals and objectives identified in individual plans of care, treatment, or services (as needed) as well as to evaluate outcomes of care, treatment, or services provided to the population(s) served.

In conjunction with The Joint Commission's plan to pursue this project, several initiatives in the field have recently occurred. Among these is the Kennedy Forum's publication of the Issue Brief "Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services." The Brief states:

> All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected.*

Measurement-based care has become a high-profile issue in the behavioral health care field, and The Joint Commission believes that the enhancements to this standard will help accredited customers increase the quality of the care, treatment, and services they provide.

The revisions to Standard CTS.03.01.09 consist of the following:

- Revised element of performance (EP) 1 that requires organizations to use a standardized tool or instrument to monitor an individual's progress
- New EP 2 that requires organizations to analyze the data generated by this activity and use the results to inform the individual's goals and objectives as needed
- Revised EP 2, renumbered as EP 3, that requires organizations to use their data to evaluate outcomes of care, treatment, or services provided to the population(s) they serve

To assist organizations in complying with the revised standard, The Joint Commission is developing supplemental materials that will contain information on standardized tools and instruments that are available to organizations. In addition, The Joint Commission is providing the field with one year instead of six months to prepare for implementation of these revisions (hence the effective date of January 1, 2018).

Revisions to Standard CTS.03.01.09 are provided below (new text is underlined and deleted text is shown with ~~strikethrough~~) and will be posted on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. The revisions will be published in the fall 2017 E-dition® and print updates for the *Comprehensive Accreditation Manual for Behavioral Health Care*.

Please contact Lynn Berry, project director, Department of Standards and Survey Methods, at lberry@jointcommission.org for more information.

** The Kennedy Forum. Fixing Behavioral Health Care in America: A National Call for Measurement-Based Care in the Delivery of Behavioral Health Services. Accessed Dec 11, 2016. https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf.*

Joint Commission Requirement

Official Publication of Joint Commission Requirements

Revisions to Outcome Measures Standard

Applicable to Behavioral Health Care

Effective January 1, 2018

Care, Treatment, and Services (CTS)

Standard CTS.03.01.09

The organization assesses the outcomes of care, treatment, or services provided to the individual served.

Element of Performance for CTS.03.01.09

1. The organization uses a standardized tool or instrument to monitor~~s~~ the individual's progress in achieving his or her care, treatment, or service goals.

Note: *Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care).*

2. The organization gathers and analyzes the data gener-

ated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed. (*See also* CTS.03.01.03, EP 4)

~~2.~~ 3. The organization evaluates the outcomes of care, treatment, or services provided to the population(s) it serves by aggregating and analyzing the data gathered through the standardized monitoring effort. (For more information, refer to Standard PI.02.01.01).

~~3.~~ 4. **For organizations that provide eating disorders care, treatment, or services:** The organization assesses outcomes of care, treatment, or services based on data collected at admission. Examples of such data include complete history and physical including height, weight, frequency of binge eating and purging (when applicable), eating disorder diagnosis, Body Mass Index (BMI), heart rate, date of last period, and other appropriate lab tests (such as potassium, phosphorus, thyroid, hemoglobin, and glucose) as determined by the organization and in accordance with the level of care provided. (*See also* CTS.02.03.11, EP 1).

Consistent Interpretation

Joint Commission Surveyors' Observations on RC.02.01.03, EP 7

The bimonthly **Consistent Interpretation** column is designed to support standards compliance efforts. Each column draws from a de-identified database containing surveyors' observations—as well as guidance from the Standards Interpretation Group on how to interpret the observations—on an element of performance (EP) in the *Comprehensive Accreditation Manual for Hospitals*. This installation (the seventh in the series; the box at right lists the requirements previously featured in the column) highlights Record of Care, Treatment, and Services (RC) Standard RC.02.01.03, EP 7.

Note: *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.*

EPs Previously Featured in "Consistent Interpretation" Column

***Perspectives* Issue**	**Featured EP(s)**
January 2016	PC.02.01.11, EP 2
March 2016	EC.02.06.01, EP 1
May 2016	PC.02.01.03, EP 1
	PC.02.01.03, EP 7
	PC.02.01.03, EP 20
July 2016	MM.03.01.03, EPs 1–3
September 2016	PC.01.02.01, EP 1
November 2016	EC.02.05.01, EP 15

Record of Care, Treatment and Services (RC) Standard RC.02.01.03: The patient's medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

EP 7*: When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

* For the first six months of 2016, the noncompliance percentage for this requirement was 8% (that is, 62 hospitals out of 772 hospitals surveyed were out of compliance with this requirement).

Surveyor Observations	Guidance/Interpretation
The immediate progress note does not contain the required elements.	This EP concerns interim op notes. Unless required by the health care organization's policy, it is not necessary to document "no specimen" or "no estimated blood loss (EBL)." Put another way, if the organization does not prescriptively require "no EBL/specimens" to be documented when this is not applicable to the procedure, this finding is not to be cited.
There was no post-procedure progress note or post-op note written before the patient was transferred to the next level of care.	The "next level of care" may be described as transition of care from one provider to another provider, such as from the operating room to the recovery area or from the recovery area to a medical/surgical unit. In the context of Standard RC.02.01.03, EPs 5–7, the intent is to ensure the next provider of care has the information needed to continue the care of the patient. Therefore, if the surgeon or anesthesia provider accompanies the patient from the operating room suite to the designated recovery area (such as a post-anesthesia care unit or an intensive care unit), a verbal report (*see* Provision of Care, Treatment, and Services [PC] Standard PC.02.02.01, EPs 1–3) may be provided to the next provider of care. In this scenario, the post-procedure note would need to be written and signed before the patient leaves the recovery area and transferred to the next level of care.

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