

The Joint Commission

# Perspectives®

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## PROJECT REFRESH: Phase II of EP Review Project

The Joint Commission recently completed the second phase of its EP Review Project, resulting in the deletion of 51 additional elements of performance (EPs) for **hospitals**. These deletions are **effective January 1, 2017**.

The EP Review Project is a multiphased component of Project REFRESH, a series of interrelated process improvement initiatives The Joint Commission is conducting throughout 2016 and 2017. Phase I of the EP Review Project (see May 2016 *Perspectives*, page 5) resulted in the deletion of 225 hospital EPs. A majority of these deletions—131—became effective July 1, 2016; the deletion of the remaining 94 EPs (see July 2016 *Perspectives*, page 5) will become effective January 1, 2017.

As with the Phase I deletions, deleting the 51 Phase II EPs is not expected to change hospitals' current patient care processes or to affect quality and safety. The Phase II deletions are a result of further evaluation of the current requirements; for the most part, the deletions fall into one or more of the categories established during Phase I:

- Are similar to, implicit in, or duplicative of other existing EPs
- Address issues that, having been covered by standards for many years and are now a routine part of operations or clinical care processes, no longer need to be addressed in standards. Some of them no longer address contemporary quality and safety concerns, and how they are managed can be left to the discretion of the organization.



- Are adequately addressed by law and regulation or other external requirements, so separate Joint Commission requirements are not needed

The deleted requirements (and reasons for each deletion) are listed in the table that begins on page 3 and posted on The Joint Commission website at [http://www.jointcommission.org/standards/information/prepublication\\_standards.aspx](http://www.jointcommission.org/standards/information/prepublication_standards.aspx).

Continued on page 3

## Contents

- 1 **PROJECT REFRESH:** Phase II of EP Review Project
- 2 In Sight
- 6 CMS Publishes Final Rule on Emergency Management
- 7 Revisions Announced for Environment of Care and Life Safety Chapters
- 7 Understanding the PSO Mandate in CMS Final Rule Effective January 1
- 8 **APPROVED:** Revisions to Advanced Certification Requirements for Inpatient Diabetes Care
- 10 "Clarifications and Expectations" Column on Hiatus
- 11 **REMINDER:** New CSTK-09 Performance Measure Effective January 1
- 11 Joint Commission Awards First Integrated Care Certification
- 12 **Joint Commission Connect™:** Information Security on the Extranet
- 12 **APPOINTED:** Vice President of Joint Commission Center for Transforming Healthcare
- 13 **LAUNCHED:** Online Learning Programs for Quality-Focused Nursing Homes
- 13 Transitions of Care Portal Expanded
- 14 Consistent Interpretation



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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.

### ACCEPTED

#### STANDARDS

- Revised Environment of Care (EC) and Life Safety (LS) requirements for the **hospital, critical access hospital, ambulatory care, and home care** programs to align with the Centers for Medicare & Medicaid Services' (CMS) adoption of the 2012 editions of the National Fire Protection Association's (NFPA) *Life Safety Code* and *Health Care Facilities Code* (see article on page 7 of this issue)

### APPROVED

#### STANDARDS

- Deletion of 51 additional elements of performance for **hospitals** as Phase II of the EP Review Project component of Project REFRESH (see article on page 1 of this issue)
- Revised and new requirements for Advanced Certification for Inpatient Diabetes Care in the **disease-specific care** program (see article on page 8 of this issue)
- Revised EC and LS requirements for the **behavioral health care and nursing care center** programs to align with the aforementioned revisions to hospital, critical access hospital, ambulatory care, and home care requirements resulting from CMS's adoption of the 2012 editions of NFPA's *Life Safety Code* and *Health Care Facilities Code* (see article on page 7 of this issue)

### CURRENTLY IN FIELD REVIEW

- Proposed additions and revisions to National Patient Safety Goals (NPSGs) addressing health care-acquired infections in the **ambulatory care, critical access hospital, hospital, nursing care center, and office-based surgery practice** programs to reflect 2014 updates to the *Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals* (field review ends November 15, 2016)

**Note:** Please note that field review dates are tentative and subject to change. To participate in or read more about field reviews, please visit The Joint Commission website at [http://www.jointcommission.org/standards/information/field\\_reviews.aspx](http://www.jointcommission.org/standards/information/field_reviews.aspx).

### 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 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 revisions to clarify language of several requirements for **behavioral health care** organizations
- Proposed deletions to requirements for the **ambulatory care, behavioral health care, critical access hospital, home care, laboratory, nursing care center, and office-based surgery practice** programs as part of the EP Review Project component of Project REFRESH


*Project REFRESH: Phase II of EP Review Project (continued)*  
*Continued from page 1*

These requirements will be removed from the fall E-dition® update as well as from *2016 Update 2* and the *2017 Comprehensive Accreditation Manual for Hospitals*.

### Next Steps

The third phase of the EP Review Project will include EP deletions from the accreditation programs for ambulatory care, behavioral health care, critical access hospitals, home

care, laboratories, and nursing care centers. These EP deletions will become effective in July 2017. The next stage will involve consolidations of existing requirements across accreditation programs.

Questions may be directed to Maureen Carr, MBA, project director, Department of Standards and Survey Methods, The Joint Commission, at [mcarr@jointcommission.org](mailto:mcarr@jointcommission.org). 

Standard	Deleted EP	Topic	Reason for Deletion		
			Duplicative of (or implicit in) EP shown	Addresses routine part of operations or clinical care processes	Adequately addressed by external requirements
EC.02.04.01	EP 8	Monitoring and reporting incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual			X
EC.02.05.01	EP 12	Having procedures that address how to obtain emergency repair services		X	
EC.02.06.01	EP 23	Providing emergency access to all locked and occupied spaces		X	
EC.03.01.01	EP 1	Making sure staff and LIPs can describe or demonstrate methods for eliminating and minimizing physical risks in the environment of care		X	
EC.03.01.01	EP 3	Making sure staff and licensed independent practitioners can describe or demonstrate how to report environment of care risks		X	
EC.04.01.01	EP 12	Conducting environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities		X	
EC.04.01.01	EP 13	Conducting annual environmental tours in nonpatient care areas to evaluate the effectiveness of previously implemented activities		X	
EC.04.01.01	EP 14	Using tours to identify environmental deficiencies, hazards, and unsafe practices		X	
EC.04.01.03	EP 1	Making sure representatives from clinical, administrative, and support services participate in environment of care data analysis		X	
EC.04.01.05	EP 2	Determining whether changes resolved environmental safety issues	EC.04.01.05, EP 1		
HR.01.02.05	EP 6	Uses information from HR.01.02.05, EPs 1–5, to make decisions about various staff job responsibilities		X	

*Continued on page 4*

Project REFRESH: Phase II of EP Review Project (continued)  
Continued from page 3

Standard	Deleted EP	Topic	Reason for Deletion		
			Duplicative of (or implicit in) EP shown	Addresses routine part of operations or clinical care processes	Adequately addressed by external requirements
HR.01.02.05	EP 17	Making sure social workers have certain education qualifications and experience (for orgs with deemed status and swing beds)	Moving to Glossary		
HR.01.05.03	EP 13	Providing education and training on how to identify early warning signs of a change in a patient's condition and how to respond to a deteriorating patient	PC.02.01.19		
IC.01.05.01	EP 8	Identifying methods for reporting infection surveillance and control information to external organizations	IC.02.01.01, EP 9		
IM.02.02.03	EP 1	Having written policies addressing data capture, display, transmission, and retention		X	
IM.04.01.01	EP 1	Having processes to check health information accuracy	RC.01.04.01, EP 1		
LD.01.04.01	EP 2	Making sure chief executive provides for staff recruitment and retention	LD.03.06.01, EP 3		
LD.01.05.01	EP 3	Making sure medical staff structure conforms to its guiding principles	MS introduction; MS.01.01.01		
LD.01.05.01	EP 5	Making sure organized medical staff oversees quality of care, treatment and services provided by individuals with clinical privileges	MS.03.01.01		
LD.02.03.01	EP 1	Discussing various issues (such as performance improvement, safety and quality issues) that affect the hospital and its population(s)	LD.04.04.05	X	
LD.02.03.01	EP 2	Establishing time frames for discussing issues that affect the hospital and its population(s)		X	
LD.04.01.03	EP 6	Making sure independent public accountant conducts annual audit of hospital's finances		X	
LD.04.01.05	EP 1	Making sure leaders of program, service, site, or department oversee operations	LD.04.01.05, EPs 2-5		
LD.04.01.11	EP 2	Using arrangement and allocation of space to support care, treatment, and services	LD.04.01.11, EP 3		
LD.04.02.03	EP 3	Following ethical practices for marketing and billing		X	
LD.04.02.03	EP 7	Giving patients information about charges they are responsible for		X	


Standard	Deleted EP	Topic	Reason for Deletion		
			Duplicative of (or implicit in) EP shown	Addresses routine part of operations or clinical care processes	Adequately addressed by external requirements
LD.04.04.07	EP 1	Considering the use of clinical practice guidelines when designing or improving processes		X ("not surveyable")	
MM.03.01.01	EP 10	Making sure medications in patient care areas are available in the most ready-to-administer forms commercially available or in unit doses repackaged by pharmacy or licensed repackager	MM.05.01.11		
NR.01.01.01	EP 2	Giving nurse executive same authority to speak on behalf of nursing that other leaders have for their disciplines, departments, or service lines	NR.01.01.01, EP 1		
NR.01.01.01	EP 4	Making sure nurse executive participates in defined and established meetings of hospital's corporate (and other senior clinical and managerial) leaders	NR.01.01.01, EP 5		
NR.01.02.01	EP 1	Establishing process for selecting, electing, or appointing a qualified nurse as the nurse executive		X	
NR.02.01.01	EP 1	Making sure nurse executive coordinates development of hospital-wide plans to provide nursing care, treatment, and services	NR.02.01.01, EP 4		
PC.02.02.03	EP 8	Accommodates a patient's special diet and altered diet schedule	PC.02.02.03, EP 7		
PC.02.02.03	EP 10	Offering substitutes of equal nutritional value when a patient refuses food	PC.02.02.03, EP 7		
PC.02.03.01	EP 4	Providing education and training to patients based on assessed needs	PC.02.03.01, EP 10		
PC.03.01.01	EP 8	Having resuscitation equipment available for operative or other high-risk procedures	PC.02.01.11, EP 2		
PC.04.01.01	EP 3	Describing mechanisms for external transfer of patient	PC.04.01.01, EP 2		
PC.04.01.01	EP 4	Making sure hospital and receiving organization agree about their roles in keeping patients safe during transfer	PC.04.01.01, EP 2		
PC.04.01.05	EP 3	Providing patients with information about why they are being discharged or transferred	Other EPs in standard		

Continued on page 6

Standard	Deleted EP	Topic	Reason for Deletion		
			Duplicative of (or implicit in) EP shown	Addresses routine part of operations or clinical care processes	Adequately addressed by external requirements
PC.04.01.05	EP 5	Providing patients with information about any alternatives to a transfer	Other EPs in standard		
PI.01.01.01	EP 12	Collecting data on behavior management and treatment		X	
PI.01.01.01	EP 30	Considering data collection on staff opinions and needs, perceptions of risk to individuals, suggestions for improving patient safety, and willingness to report adverse events		X	
PI.02.01.01	EP 1	Compiling data in usable formats		X	
PI.02.01.01	EP 2	Identifying data analysis frequency		X	
PI.02.01.01	EP 5	Comparing data with available external sources		X	
PI.03.01.01	EP 1	Prioritizing identified improvement opportunities		X	
PI.03.01.01	EP 3	Evaluating actions to confirm they resulted in improvements	PI.03.01.01, EPs 2 and 4		
RC.01.01.01	EP 9	Using standardized formats to document the care, treatment, and services it provides		X	
RC.01.01.01	EP 12	Tracking the location of all components of the medical record		X	
RI.01.06.05	EP 15	Offering patients telephone and mail service (based on setting and population)		X	
RI.01.06.05	EP 16	Providing access to telephones for patients who desire conversations in a private space, based on setting and population		X	

## CMS Publishes Final Rule on Emergency Management

The Centers for Medicare & Medicaid Services (CMS) recently published the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers. \* This final rule establishes national emergency preparedness requirements for Medicare- and

Medicaid-participating providers and suppliers to plan for natural and man-made disasters and to coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It is designed to help providers and suppliers prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations. The final rule becomes effective November 15, 2016, and the implementation deadline is November 15, 2017. Details about how the final rule will affect Joint Commission accreditation requirements will be published in a future issue of *Perspectives*. 

\* Centers for Medicare & Medicaid Services. *Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers*. Accessed Oct 12, 2016. <https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicare-programs-emergency-preparedness-requirements-for-medicare-and-medicare>



# Revisions Announced for Environment of Care and Life Safety Chapters

As announced in the June 2016 *Perspectives*, the Centers for Medicare & Medicaid Services (CMS) recently adopted the 2012 editions of the National Fire Protection Association's NFPA 101: *Life Safety Code*<sup>\*</sup> and NFPA 99: *Health Care Facilities Code*.<sup>†</sup> The August 2016 *Perspectives* announced that CMS and The Joint Commission will begin surveying to these standards on November 1, 2016.


To maintain alignment with CMS's adoption of the 2012 codes, The Joint Commission recently revised several requirements in the "Environment of Care" (EC) and "Life Safety" (LS) chapters of the *Comprehensive Accreditation Manuals* for the **ambulatory care, behavioral health care, critical access hospital, hospital, home care, and nursing care center** programs. The revisions incorporate new and revised elements of performance (EPs) that correspond to the 2012 codes and allow for a more logical flow of the requirements for customer and surveyor use.

The Joint Commission posted draft versions of the new LS and EC standards to customers' *Joint Commission Connect*<sup>™</sup> extranet sites in August; the official prepublication

versions will be posted by early November on The Joint Commission website at [http://www.jointcommission.org/standards\\_information/prepublication\\_standards.aspx](http://www.jointcommission.org/standards_information/prepublication_standards.aspx). The print accreditation manuals publishing in late fall 2016 will include the revised chapters, which will then be updated on E-dition<sup>®</sup> on January 9, 2017. Between November 1, 2016, and January 9, 2017, surveyors will use the current LS and EC standards to survey to the 2012 code requirements.

## Looking to the Future

Future standards revisions planned for 2017 will include additional new and revised EPs in the LS and EC chapters. These EPs will encompass the survey procedures (K-Tags) that CMS has recently written to coincide with the 2012 *Life Safety Code* (NFPA 101) and *Health Care Facilities Code* (NFPA 99). Incorporating the CMS K-Tags into The Joint Commission's accreditation requirements will result in surveys that more closely align with CMS expectations, thereby providing better survey outcomes for our customers.

Questions may be directed to Kenneth A. Monroe, PE, MBA, CHC, PMP, associate project director, Department of Standards and Survey Methods, The Joint Commission, at [kmonroe@jointcommission.org](mailto:kmonroe@jointcommission.org). 

<sup>\*</sup> Life Safety Code<sup>®</sup> is a registered trademark of the National Fire Protection Association, Quincy, MA.

<sup>†</sup> Chapters 7 (Information Technology), 8 (Plumbing), 12 (Emergency Management), and 13 (Security) were extracted from this adoption.

## Understanding the PSO Mandate in CMS Final Rule Effective January 1

Under a final rule issued by the Centers for Medicare & Medicaid Services (CMS),<sup>\*</sup> effective January 1, 2017, health insurance plans certified by the Health Insurance Marketplace may only contract with hospitals (with more than 50 beds) that are engaging in either of the following:

- Working with a Patient Safety Organization (PSO), thereby sharing what is learned from patient safety events in a multihospital, multiprovider collaborative that is federally protected against legal discoverability and disclosure, or
- Meeting the "reasonable exception" alternative by implementing an evidence-based initiative to improve health care quality through the collection, management, and analysis of patient safety events.

The Joint Commission encourages and supports health care organizations' and providers' participation in PSOs. CMS has confirmed that membership in a Quality Improvement Organization (QIO) or Hospital Engagement Network (HEN), or participation in Joint Commission accreditation, will qualify as a reasonable equivalent.<sup>†</sup> Health care organizations must demonstrate meeting "reasonable exception" criteria to receive approval from the contracting health insurance plan. Participation in Joint Commission accreditation meets the reasonable exception criteria because organizations'

<sup>\*</sup> Centers for Medicare & Medicaid Services. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*. Accessed Oct 17, 2016. <http://federalregister.gov/a/2016-04439>

<sup>†</sup> Shah NS. *Federal update and discussion: Section 1311(h) of the Affordable Care Act patient safety standards*. Presented at Hospital Inpatient Quality Reporting (IQR) Program, May 3, 2016. Accessed Aug 26, 2016. <http://www.qualityreportingcenter.com/event/federal-update-and-discussion-section-1311h-of-the-affordable-care-act-patient-safety-standards/>

Continued on page 15

# APPROVED: Revisions to Advanced Certification Requirements for Inpatient Diabetes Care

To keep its certification programs up-to-date, The Joint Commission regularly reviews program requirements alongside the latest standards of practice and professional literature for important developments that may necessitate modifications to requirements. The Joint Commission recently revised requirements for the Inpatient Diabetes Care (IDC) Certification (an advanced **disease-specific care** certification program) to reflect the 2016 American Diabetes Association's *Standards of Medical Care in Diabetes*. Reviewing the ADA recommendations resulted in strengthening the program in the following areas:

- Requiring groups of staff/practitioners to have education specific to policies, procedures, and patient management related to the diabetes program (*see* Delivering or Facilitating Clinical Care [DSDF] Standard DSDF.1, EP 1a)
- Identifying a target glucose range for patients who are critically ill (*see* DSDF.4, EP 2b)
- Following protocols regarding insulin therapy for persistent hyperglycemia and the treatment of patients with poor oral intake (*see* DSDF.4, EP 2d and DSDF.4, EP 2e)
- Scheduling follow-up appointments for patients who

have had hyperglycemia during their hospitalization (*see* DSDF.6, EP 1a)

- Reflecting particular educational topics in the plan of care for patients who are newly diagnosed with diabetes or have educational deficits related to their care (*see* Supporting Self-Management [DSSE] Standard DSSE.3, EP 5a)
- Requiring documentation of insulin pumps for patients continuing to use them in the hospital (*see* Clinical Information Management [DSCT] Standard DSCT.5, EP 3)

The IDC revisions, which become **effective July 1, 2017**, are posted on The Joint Commission website at [http://www.jointcommission.org/standards\\_information/prepublication\\_standards.aspx](http://www.jointcommission.org/standards_information/prepublication_standards.aspx). The revisions below (new text is underlined and deleted text is shown in ~~strike through~~) will appear in the fall E-dition® update and the *2017 Comprehensive Certification Manual for Disease-Specific Care*.

Questions may be directed to Tabitha Vieweg, RN, MBA, associate project director, Department of Standards and Survey Methods, The Joint Commission, at [tvieweg@jointcommission.org](mailto:tvieweg@jointcommission.org).



Official Publication of Joint Commission Requirements

## Revisions to Advanced Certification Requirements for Inpatient Diabetes Care

APPLICABLE TO INPATIENT DIABETES CARE CERTIFICATION

Effective July 1, 2017

### Program Management (DSPR)

Standard DSPR.1

The program defines its leadership roles.

#### Elements of Performance for DSPR.1

1. The program identifies members of its leadership team.

#### Requirements Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. ~~An interdisciplinary program team is identified, and a team leader is designated.~~ The program identifies a leader(s).
- b. The program leader(s) has the knowledge and experience in the care of patients with diabetes to provide administrative leadership and clinical guidance to the program.

5. The program leader(s) participates in designing, implementing, and evaluating care, treatment, and services.

#### Requirements Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. If insulin pens are used in the organization, a policy on insulin pen use is developed, which includes at least the following:
  - Patient identifiers required for labeling of an insulin pen
  - Process for storing insulin pens
  - Education of staff on safe and appropriate use of an insulin pen, including infection control
  - Information on maintaining the integrity of an insulin pen, which can only be used for a single patient
- b. The program has a protocol in place to address when a patient is unable to manage his or her insulin pump.



# Revisions to Advanced Certification Requirements for Inpatient Diabetes Care (continued)

## Delivering or Facilitating Clinical Care (DSDF)

### Standard DSDF.1

Practitioners are qualified and competent.

#### Element of Performance for DSDF.1

1. Practitioners have education, experience, training, and/or certification consistent with the program's scope of services, goals and objectives, and the care provided.

#### Requirement Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. The following groups who care for patients with diabetes have education specific to policies, procedures, and patient management related to the diabetes program:
  - Dietitians and others involved in medical nutrition therapy
  - Staff involved in point-of-care testing
  - Medical staff Physicians involved in the management of patients' diabetes
  - Nursing staff, including advanced practice nurses
  - Pharmacists
  - Physician assistants
  - Interdisciplinary team

### Standard DSDF.2

The program develops a standardized process originating in clinical practice guidelines (CPGs) or evidence-based practice to deliver or facilitate the delivery of clinical care.

#### Element of Performance for DSDF.2

5. The program demonstrates evidence that it is following the clinical practice guidelines when providing care, treatment, and services.

#### Requirements Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. A glycated hemoglobin (HbA1c) is drawn at the time of during the admission unless the results of the patient's glycated hemoglobin (HbA1c) drawn within the last three months are known, or the patient has a medical condition or has received therapy that would confound the results.

**Note:** *This requirement excludes the gestational diabetes population.*
- b. A hypoglycemia protocol is developed and implemented.
- c. The program determines a glucose range for patients receiving intravenous insulin according to their clinical status.
- d. The program has an insulin safety protocol in place for preventing insulin errors.

### Standard DSDF.4

The program develops a plan of care that is based on the patient's assessed needs.

#### Elements of Performance for DSDF.4

1. The plan of care is developed using an interdisciplinary approach and patient participation.

#### Requirement Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. The program develops a plan written protocol for transitioning a patient from intravenous insulin infusion to other glucose lowering agents.
2. The program individualizes the plan of care for each patient.

#### Requirements Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. Written blood glucose monitoring protocols for patients with known diabetes are developed and include, at a minimum, the following:
  - Measuring blood glucose upon admission
  - A plan for subsequent monitoring based on the patient's:
    - Type of diabetes
    - Desired level of control
    - Current treatment(s) (for example, use of steroids, total parenteral nutrition [TPN])
    - Comorbidities and medical illnesses
    - Dietary status, including when the patient cannot have anything by mouth (NPO)
- b. The program identifies a target glucose range for patients who are critically ill.
- ~~b.c.~~ A plan for the treatment of hypoglycemia and hyperglycemia based on clinical practice guidelines is established for each patient.
- d. The program follows a protocol for initiating insulin therapy to treat persistent hyperglycemia.
- e. The program follows a protocol for treatment of patients with poor oral intake or who are NPO.

### Standard DSDF.6

The program initiates discharge planning and facilitates arrangements for subsequent care, treatment, and services to achieve mutually agreed upon patient goals.

#### Element of Performance for DSDF.6

1. In preparation for discharge, the program discusses and plans with the patient and family the care, treatment, and services that are needed in order to achieve the mutually agreed upon self-management plan and goals.

#### Requirement Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. Prior to discharge, a program team member collabo-

*Continued on page 10*

## Revisions to Advanced Certification Requirements for Inpatient Diabetes Care (continued)

rates with patients to arrange a follow-up diabetes-management appointment is made for the for those patients who have had hyperglycemia in the hospital.

**Note 1:** The program defines criteria for identifying patients for follow-up appointments based on clinical practice guidelines.

**Note 2:** The follow-up appointment should be within one month of discharge with the patient's primary care provider, endocrinologist, or diabetes educator.

**Note 3:** A follow-up appointment does not need to be made if the patient is discharged to another facility with a primary care provider, endocrinologist, or diabetes educator who is able to manage the patient's diabetes.

obtain a blood glucose meter, and instruction on use of the blood glucose meter

- Importance of HbA1c monitoring
- Sick day guidelines
- Proper use and disposal of lancets and needles/syringes or insulin pens, if appropriate
- Information about whom to contact in case of emergency or for more information
- Potential long-term complications (such as retinopathy, kidney disease, neuropathy, foot care)
- Plan for post-discharge education or self-management support

### Supporting Self-Management (DSSE)

Standard DSSE.3

The program addresses the patient's education needs.

#### Element of Performance for DSSE.3

5. The program addresses the education needs of the patient regarding his or her disease or condition and care, treatment, and services.

#### Requirement Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. Patients with newly diagnosed diabetes or educational deficits have at least the following educational components reflected in the plan of care:
  - Medication management, including how to administer insulin (when appropriate) and potential medication interactions
  - Nutritional management, ~~including the role of carbohydrate intake in blood glucose management~~
  - Exercise
  - Signs, symptoms, and treatment of hyperglycemia and hypoglycemia
  - ~~Prevention, recognition, and treatment~~ of hyperglycemia and hypoglycemia
  - Importance of blood glucose monitoring, how to

### Clinical Information Management (DSCT)

Standard DSCT.5

The program initiates, maintains, and makes accessible a medical record for every patient.


#### Element of Performance for DSCT.5

3. The medical record contains sufficient information to support the diagnosis.

#### Requirement Specific to Management of Patients with Diabetes in the Inpatient Setting

- a. For those patients who continue to use their insulin pump while hospitalized, at a minimum, the following are documented:
  - Assessment of the patient's ability to manage his or her insulin pump
  - ~~Physician~~ Order for insulin pump therapy to continue while hospitalized
  - Basal rates
  - Bolus doses, including correctional doses
  - Frequency at which to change infusion set
  - Date of each infusion set change
  - Date of insertion site change (if not the same as set change date)
  - Condition of the insertion site
  - Location of the insertion site


### "Clarifications and Expectations" Column on Hiatus

The column "Clarifications and Expectations," authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission, is on hiatus. It is scheduled to return, with the 41st installment of the series, in the December 2016 issue of *Perspectives*. 

# REMINDER: New CSTK-09 Performance Measure Effective January 1

As previously announced (see the April 2016 *Perspectives*, page 9), The Joint Commission will implement a new Comprehensive Stroke (CSTK) measure CSTK-09: Arrival Time to Skin Puncture **effective January 1, 2017**.

CSTK-09 measure is one of eight mandatory comprehensive stroke measures required (in addition to the eight stroke [STK] measures) to meet performance measure requirements for Comprehensive Stroke Center Certification (see sidebar at right for the CSTK measure set). Details regarding CSTK-09 measure specifications are available in the *Specifications Manual for Joint Commission National Quality Measures, Version 2016B*, on The Joint Commission website at <https://manual.jointcommission.org/releases/TJC2016B/>.

The CSTK measures were developed for the management of both ischemic and hemorrhagic stroke patients in hospitals equipped with the clinical expertise, infrastructure, and specialized neurointerventional and imaging services needed to provide the next level of stroke care. Questions may be asked via the website <https://manual.jointcommission.org>. 

## Comprehensive Stroke (CSTK) Measure Set

CSTK-01	National Institutes of Health Stroke Scale (NIHSS) Score Performed for Ischemic Stroke Patients)
CSTK-02	Modified Rankin Score (mRS at 90 days)
CSTK-03	Severity Measurement Performed for Subarachnoid Hemorrhage (SAH) and Intracerebral Hemorrhage (ICH) Patients (Overall Rate)
CSTK-04	Procoagulant Reversal Agent Initiation for ICH
CSTK-05	Hemorrhagic Transformation (Overall Rate)
CSTK-06	Nimodipine Treatment Administered
CSTK-07	Median Time to Revascularization— <b>SUSPENDED 1/1/16</b>
CSTK-08	Thrombolysis in Cerebral Infarction (TICI Post-Treatment Reperfusion Grade)
CSTK-09	Arrival Time to Skin Puncture— <b>EFFECTIVE 1/1/17</b>

## Joint Commission Awards First Integrated Care Certification


The Joint Commission earlier this year recognized Parrish Medical Center, a public, not-for-profit facility in Titusville, FL, as the first hospital in the United States to be awarded Integrated Care Certification.

“On behalf of The Joint Commission, I want to congratulate Parrish Medical Center on becoming the first organization in the country to earn the Integrated Care Certification,” says Mark Pelletier, RN, MS, chief operating officer, Accreditation and Certification Operations, The Joint Commission. “This certification recognizes Parrish Medical Center’s dedication to improving patient outcomes with better coordinated care. It is also a benefit to the surrounding community Parrish serves, and it reflects its commitment to ensuring high-quality care transcends the walls of its hospitals.”

The Integrated Care Certification program was launched in July 2015 to recognize organizations that excel at integrating transitions of care, hand-off communications, and other key activities as a patient moves between hospital or critical access hospital and ambulatory care settings. However, as announced in the October 2016 issue of *Perspectives*, The Joint Commission has updated the program’s standards

and expanded its applicability to include the post-acute care environments of home care and nursing care centers effective January 1, 2017.

In order to be eligible for this voluntary certification, at least one component of the health care system must be accredited by The Joint Commission. The certification period is for three years, and organizations are evaluated by reviewers who specialize in integrated care in a range of settings: inpatient, ambulatory, and post-acute care. This certification is separate from the accreditation process and does not affect the accreditation status of an organization.

Joint Commission–accredited organizations that would like to pursue Integrated Care Certification can e-mail [integratedcare@jointcommission.org](mailto:integratedcare@jointcommission.org) or visit The Joint Commission website at [https://www.jointcommission.org/certification/integrated\\_care\\_certification.aspx](https://www.jointcommission.org/certification/integrated_care_certification.aspx). Until January 2017, the prepublication version of the revised ICC standards is available on The Joint Commission website at [https://www.jointcommission.org/prepublication\\_standards\\_-\\_revisions\\_to\\_the\\_integrated\\_care\\_icc\\_program/](https://www.jointcommission.org/prepublication_standards_-_revisions_to_the_integrated_care_icc_program/). 

# Joint Commission Connect™: Information Security on the Extranet

The *Joint Commission Connect*™ extranet site is a secure, safeguarded portal for the direct and confidential exchange of information between The Joint Commission and its accredited and/or certified health care organizations. Each health care organization designates a primary contact person and additional security administrators to receive unlimited access to the extranet site. The primary contact and designated security administrator(s) in turn are responsible for registering and deactivating any other users of the site. To fully protect the integrity of the site's information, each user must be provided with his or her own unique user ID, password, and specific site permission—all of which must be deactivated as soon as a user is no longer employed by the organization or has no business need to view the portal.


The Joint Commission has become aware that some users may be sharing their user IDs and passwords. Account executives sometimes find themselves talking to an individual who, although not designated as an official user, can access the extranet with a shared ID and password. ***Joint Commission Connect* users should never share the same user name and password.** The Joint Commission can only allow access to the extranet—and to an organization's confidential information—to users authorized by the primary contact or a security administrator.

According to Intercede, a global software company specializing in identity and credential management, approximately 52% of business customers surveyed indicate that information security is a top priority; however, 51% of

respondents to the same survey admitted to sharing user names and passwords for websites. When users share website credentials, an organization's risk of exposing its data, confidential reports, correspondence, and financial and other information greatly increases in the following ways:

- Malicious software from unauthorized users may be allowed to enter the system.
- Investigating and tracking potential compromises that might arise—and tracing issues to a single source—becomes more difficult.
- If an organization utilizes a single sign-on, employees may access each other's potential applications within the health care system.
- The computer's auto save feature can “remember” shared user names and passwords, allowing the security of the extranet site to be compromised by numerous people within an organization.

**Employees who share extranet user IDs and passwords are responsible for putting their organization's confidential information at risk.** Giving exclusive *Joint Commission Connect* access to designated staff—and immediately removing access for those who no longer need or require it—is the best way to protect the reliability and confidentiality of private information and to prevent its inadvertent disclosure.

Questions may be directed to Fran Carroll, PA, MBA, JD, corporate compliance and privacy officer, The Joint Commission, at [fc Carroll@jointcommission.org](mailto:fc Carroll@jointcommission.org). 

## APPOINTED: Vice President of Joint Commission Center for Transforming Healthcare

The Joint Commission Center for Transforming Healthcare recently appointed Anne Marie Benedicto, MPP, MPH, to the position of vice president. In this senior leadership position, Benedicto will lead the Center's initiatives to transform the health care industry into a high reliability industry through systemic approaches to addressing today's most critical safety and quality issues.

Benedicto served as chief of staff and executive vice president of Support Operations for The Joint Commission from 2008 through 2015. In that role, she was integral to the building of the company's internal Robust Process Improvement®

(RPI®) program, a systematic, data-driven methodology that incorporates Lean Six Sigma and formal change management. She also oversaw the launch of the company's first external RPI training engagement.

“I am delighted that Anne Marie Benedicto has returned to The Joint Commission in the role of vice president for the Center for Transforming Healthcare,” says Mark R. Chassin, MD, MPP, MPH, FACP, president and chief executive officer, The Joint Commission and Joint Commission Center for Transforming Healthcare. “Anne Marie's leadership, her passion for utilizing the tools and methodologies of Robust

Process Improvement to systematically improve health care quality and safety, and her keen insight into the potential for the Center to grow and magnify its impact make her ideal for this position.”

Most recently, Benedicto served as assistant vice president of hospital operations at Montefiore Medical Center in New York. Prior to joining The Joint Commission in 2008, she was the administrator for both the Office for Excellence in Patient Care at the Mount Sinai Medical Center and the Mount Sinai School of Medicine Department of Health Policy. She also held finance-related positions at the New York City Health and Hospitals Corporation.

Benedicto is a trained Green Belt and Change Leader. She can be reached at [abenedicto@jointcommission.org](mailto:abenedicto@jointcommission.org). 



*Anne Marie Benedicto, MPP, MPH, vice president, The Joint Commission Center for Transforming Healthcare*

## **LAUNCHED:** Online Learning Programs for Quality-Focused Nursing Homes


The Joint Commission and Relias Learning recently launched a set of eight online learning programs for quality-focused nursing homes. The programs are designed to help organizations learn the step-by-step details of Joint Commission requirements related to Nursing Care Center Accreditation, Post-Acute Care Certification, and Memory Care Certification.

Each 60-minute module covers the guiding rationale of Joint Commission standards and requirements, including how they are structured and what is expected to successfully demonstrate compliance and required written documentation. Learners receive one continuing education (CE) credit for each completed module. The modules include the following:

- Module 1: Powering Performance Excellence, An Overview of the Process
- Module 2: Powering Performance Excellence in the Environment of Care, Emergency Management and Life Safety
- Module 3: Powering Performance Excellence in Provision of Care, Treatment and Services, and Medication Management
- Module 4: Powering Performance Excellence in Leadership and Human Resources

- Module 5: Powering Performance Excellence in Infection Prevention and Control, National Patient Safety Goals and Information Management
- Module 6: Powering Performance Excellence in the Record of Care, Rights and Responsibilities of the Individual, Performance Improvement and Waived Testing
- Module 7: Powering Performance Excellence in Post-Acute Care Certification
- Module 8: Powering Performance Excellence in Memory Care Certification

“The online learning programs provide a how-to guide in a convenient and affordable manner,” said Gina Zimmermann, executive director, Nursing Care Center Services, The Joint Commission. “While the modules are a great resource for quality-focused nursing homes preparing for accreditation or certification, they also can assist those struggling with specific quality issues or needing to orient new employees to the accreditation and certification process.”


Select modules of interest or the entire series may be purchased to fit an organization’s individual and unique needs. For complete pricing information, please visit <http://jcaho.academy.reliaslearning.com/>. 

### Transitions of Care Portal Expanded

The Joint Commission has expanded and updated its Transitions of Care Portal, which houses resources from The Joint Commission enterprise and other health care organizations on transitions of care (the movement of patients between various health care settings). Expanded content includes more than 20 new articles, 8 new tools and resources, and information on standard performance measurement requirements for palliative care programs. Visit the expanded content of the portal at <http://www.jointcommission.org/toc.aspx>.

# Consistent Interpretation

## Joint Commission Surveyors' Observations on EC.02.05.01, EP 15

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 sixth in the series; the box at right lists the previous EPs featured in the column) highlights Environment of Care (EC) Standard EC.02.05.01, EP 15. **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

**Environment of Care (EC) Standard EC.02.05.01:** The hospital manages risks associated with its utility systems.

**EP 15\*†:** In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, relative humidity, and temperature. (See also EC.02.06.01, EP 13 and EC.02.06.05, EP 1)

**Note:** Areas designed for control of airborne contaminants include spaces such as all classes of operating rooms, special procedure rooms that require a sterile field, caesarean delivery rooms, rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, airborne infection isolation rooms, rooms for patients with pulmonary or laryngeal tuberculosis, bronchoscopy treatment rooms), patients in "protective environment" rooms (for example, rooms for patients receiving bone marrow transplants), laboratories, pharmacies, sterile supply/processing rooms, and other sterile spaces. For further information, refer to *Guidelines for Design and Construction of Health Care Facilities, 2010 edition*, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).


\* For the first six months of 2016, the noncompliance percentage for this requirement is 31%. The noncompliance percentage for the entire Standard EC.02.05.01 (for the same time period) is 56% (see September 2016 issue of *Perspectives*, page 6).

† The EP language shown reflects the latest published manual update (July 2016). Revisions are expected as of January 9, 2017.

Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> <li>A bronchoscopy was not performed in negative pressure environment.</li> </ul>	<p>Bronchoscopy procedures should be performed in a negative pressure room. Bed-side bronchoscopy procedures may be acceptable if an effective risk assessment process has been created using evidence-based guidance and may not lead to citation.</p> <p>Surveyors should cite Standard EC.02.05.01, EP 15, when instances of noncompliance are observed in the critical care areas listed in the Note of the EP; however, for soiled utility rooms, this EP applies only to those in the OR environment.</p> <p>For instances of noncompliance in general patient care areas, surveyors should cite Standard EC.02.06.01, EP 13 ("The hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment, and services provided. [See also EC.02.05.01, EP 15]").</p> <p>Note that there are no air pressure requirements for rooms that only make use of spinal, epidural axillary, and stellate ganglion blocks; regional (such as interscalene) blocks and supracavicular, infracavicular, and intravenous regional anesthesia; and intra-articular injections.</p>
<ul style="list-style-type: none"> <li>There was no negative pressure flow from contaminated to decontaminated areas.</li> </ul>	
<ul style="list-style-type: none"> <li>The decontamination area in the operating room contained an unsealed opening between the "dirty" and "clean" areas.</li> </ul>	
<ul style="list-style-type: none"> <li>The positive-to-negative pressure differential between "clean" and "dirty" areas of the Central Processing Area was not correctly maintained.</li> </ul>	
<ul style="list-style-type: none"> <li>The required number of air exchanges in the operating room was not met.</li> </ul>	

compliance with Joint Commission standards, policies, and patient safety activities can lead to a reduction in preventable harm, prevention of hospital readmission, and improvements in care coordination. While a hospital's participation in a reasonable exception does not guarantee the strong federal privilege for the Patient Safety Work Product that PSOs can offer, The Joint Commission has successfully asserted a state-law privilege for documents in its possession, including those

used in the collection, management, and analysis of patient safety events through the Office of Quality and Patient Safety. The sidebar below describes Joint Commission accreditation policies and requirements that can help accredited organizations meet the reasonable exception criteria.

Questions may be directed to Gerry Castro, PhD, MPH, project director, patient safety initiatives, The Joint Commission, at [gcastro@jointcommission.org](mailto:gcastro@jointcommission.org). 

## Accreditation Policies and Requirements That Help Meet Reasonable Exception Criteria

### Sentinel Event Policy

Careful investigation and analysis of patient safety events (events not primarily related to the natural course of the patient's illness or underlying condition), as well as evaluation of corrective actions, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with health care organizations that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm. The following sections in the "Sentinel Events" (SE) chapter of the *Comprehensive Accreditation Manual for Hospitals (CAMH)* provide more information.

- Definition of Sentinel Event
- Responding to Sentinel Events
- Reporting a Sentinel Event to The Joint Commission
- Required Response to a Sentinel Event

The SE chapter is also available at [https://www.jointcommission.org/assets/1/6/SE\\_CAMH\\_2016Upd1.pdf](https://www.jointcommission.org/assets/1/6/SE_CAMH_2016Upd1.pdf).

### "Patient Safety Systems" (PS) Chapter

The "Patient Safety Systems" (PS) chapter is designed to clarify the relationship between Joint Commission accreditation and patient safety. As the chapter states, "The ultimate purpose of The Joint Commission's accreditation process is to enhance quality of care and patient safety. Each requirement or standard, the survey process, the Sentinel Event Policy, and other Joint Commission initiatives are designed to help organizations reduce variation, reduce risk, and improve quality. Hospitals should have an integrated approach to patient safety so that high levels of safe patient care can be provided for every patient in every care setting and service." The following sections in the PS chapter of the CAMH provide more information.

- Data Use and Reporting Systems
- Effective Use of Data
- Using Data to Drive Improvement
- A Proactive Approach to Preventing Harm

- Encouraging Patient Activation
- Appendix. Key Patient Safety Requirements

The PS chapter is also available at [https://www.jointcommission.org/patient\\_safety\\_systems\\_chapter\\_for\\_the\\_hospital\\_program/](https://www.jointcommission.org/patient_safety_systems_chapter_for_the_hospital_program/).

### Disease-Specific Care Certification

The Joint Commission's Disease-Specific Care (DSC) certification program, launched in 2002, is designed to evaluate clinical programs across the continuum of care. Joint Commission-accredited health care organizations may seek certification for care and services provided for virtually any chronic disease or condition.

For more information, visit [https://www.jointcommission.org/certification/dsc\\_home.aspx](https://www.jointcommission.org/certification/dsc_home.aspx).

### Performance Measures

The Joint Commission's ORYX initiative integrates outcomes and other performance measurement data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission-accredited organizations in their quality improvement efforts. Performance measures are essential to the credibility of any modern evaluation activity for health care organizations. ORYX data are publicly reported on The Joint Commission website at Quality Check®, <https://www.qualitycheck.org>. The public availability of performance measure data permits user comparisons of hospital performance at the state and national levels.

For more information, visit [https://www.jointcommission.org/performance\\_measurement.aspx](https://www.jointcommission.org/performance_measurement.aspx)

### Transitions of Care Portal

The portal provides resources from The Joint Commission and other health care organizations on the topic of transitions of care (the movement of patients between various health care settings).

The portal is available at <https://www.jointcommission.org/toc.aspx>.

The Joint Commission

## Perspectives

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