The Joint Commission

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The Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

Performance Measures Selected for New Heart Attack Certifications

Standardized measures have been selected for the two newly developed advanced disease-specific care certification programs—**Acute Heart Attack Ready** (AHAR) and **Primary Heart Attack Center** (PHAC). The measures are **effective July 1, 2019**, for **critical access hospitals** and **hospitals** (including freestanding emergency departments) pursing AHAR or PHAC certification.

Performance Measure Expectations

The standardized measures (listed in the following box) for both certifications have been adopted from the American Heart Association's (AHA) *Get With The Guidelines®—Coronary Artery Disease*. Data collection for these measures must commence four months prior to the initial certification review visit for organizations seeking certification. For example, hospitals whose initial certification review visit is scheduled in September must begin data collection in the previous May. Data collection is then ongoing thereafter for all AHAR– or PHAC–certified organizations.

Official Publication of Joint Commission Requirements

Performance Measures for New Heart Attack Certifications

Applicable to Acute Heart Attack Ready Certification

- ECG Within 10 Minutes of Arrival
- Arrival to Thrombolytics Within 30 Minutes
- Arrival to Transfer to PCI Center Within 45 Minutes (Door In–Door Out: Referring Hospital)
- EMS FMC to PCI ≤ 90 Minutes (when applicable)*

Applicable to Primary Heart Attack Center Certification

- ECG Within 10 Minutes of Arrival at This Receiving Center
- Primary PCI ≤ 90 Minutes
- EMS FMC to PCI ≤ 90 Minutes
- Arrival at First Facility to Primary PCI ≤ 120 Minutes

ECG, electrocardiogram; PCI, percutaneous coronary intervention; EMS, emergency medical services; FMC, first medical contact.

* When applicable if the Acute Heart Attack Ready (AHAR)–certified hospital provides any PCI coverage for primary PCI.

About the New Certifications

As reported in the February 2019 issue of *Perspectives*, The Joint Commission and the AHA developed these programs to address ST-elevation myocardial infarction (STEMI) heart attack patient care. Both the AHAR (that is, an AHA's Mission: Lifeline® [ML] STEMI–Referring Hospital) and PHAC (that is, an ML STEMI–Receiving Center) certification programs focus on symptom onset, emergency medical services, and the emergency department, as well as catheterization laboratories and inpatient settings.

The Joint Commission and AHA recommend AHAR certification for those hospitals without 24-hour-a-day, 7-day-a-week on-site primary percutaneous coronary intervention (PCI) coverage. An AHAR–certified hospital may transfer STEMI patients to a PHAC for PCI and inpatient care. In addition, The Joint Commission and AHA expect PHACs to have the staff and resources necessary for 24-hour-a-day, 7-day-a-week coverage for PCI.

Questions about these measures may be sent to the AHA.

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New Requirement for Office-Based Surgery Practices Providing Fluoroscopy Services

Effective January 1, 2020, The Joint Commission will require **office-based surgery** (OBS) practices that provide fluoroscopy services to comply with Environment of Care (EC) Standard EC.02.02.01, Element of Performance (EP) 17 (*see* the underlined text in the following box). Compliance with this requirement aligns with current radiological practice standards for OBS practices that provide fluoroscopy services. Currently, the requirement is applicable to ambulatory health care organizations, critical access hospitals, and hospitals.

The new requirement has been posted on the Prepublication Standards page of The Joint Commission website and will be published in the fall 2019 E-dition® update to the *Comprehensive Accreditation Manual for Office-Based Surgery* (*CAMOBS*).

For more information, contact Joyce Webb, project director, Division of Healthcare Quality Evaluation. P

Official Publication of Joint Commission Requirements

New Requirement for Office-Based Surgery Practices That Provide Fluoroscopy Services

APPLICABLE TO OFFICE-BASED SURGERY PRACTICES

Effective January 1, 2020

Environment of Care (EC)

Standard EC.02.02.01: The practice manages risks related to hazardous materials and waste.

Element of Performance for EC.02.02.01

17. **For practices that provide computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or fluoroscopy services:** The results of dosimetry monitoring are reviewed at least quarterly by the radiation safety officer, diagnostic medical physicist, or health physicist to assess whether staff radiation exposure levels are "as low as reasonably achievable" (ALARA) and below regulatory limits.

    Note 1: *For the definition of ALARA, please refer to US Nuclear Regulatory Commission federal regulation 10 CFR 20.1003.*

    Note 2: *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*

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Performance Measure Requirements Clarified for Primary Stroke Centers

Starting January 1, 2019, organizations seeking **Primary Stroke Center** (PSC) certification (an advanced disease-specific care certification program) were required to report on 2 new performance measures. The addition of these 2 measures brought the total number of stroke performance measures required to achieve and maintain PSC certification to 10.

An article in the July 2018 issue of *Perspectives* announced and detailed the criteria for the new measurements. At this time, The Joint Commission is further clarifying its expectations.

STK-OP-1: Door to Transfer to Another Hospital

The stroke outpatient (STK-OP) measure monitors "door in–door out" times for stroke patients transferred from the emergency department (ED) of a PSC to a higher-level acute stroke center. It applies **only** to PSCs. Thrombectomy-capable stroke centers (TSCs) and comprehensive strokes centers (CSCs) accepting these patients are ***not*** required to collect data for this measure; in addition, TSCs and CSCs are ***not*** required to report data for patients transferred from their facilities. (Acute stroke ready hospitals [ASRHs] have their own complement measure: ASR-OP-2.)

This measure is stratified. When manually submitting STK-OP-1 data to The Joint Commission via the Certification Measure Information Process (CMIP) on an organization's secure *Joint Commission Connect*™ extranet site, data should be entered as the total number of cases for the reporting month and the median time in minutes (that is, the continuous variable value). The measurement value is calculated as follows:

Door to Transfer to Another Hospital	**=**	**ED Departure Date and Departure Time**	**–**	**Outpatient Encounter Date and Arrival Time**

When the total number of cases is zero for a stratum, no rate will be reported that month, and the continuous variable value field should be left blank.

CSTK-01: NIHSS Score Performed for Ischemic Stroke Patients

The comprehensive stroke (CSTK) measure captures the proportion of ischemic stroke patients for whom a National Institutes of Health Stroke Scale (NIHSS) score is performed prior to any acute recanalization therapy in patients undergoing recanalization therapy and documented in the medical record or documented within 12 hours of hospital arrival for patients who do not undergo recanalization therapy.

The CSTK-01 denominator population includes all ischemic stroke patients, including CSTK subpopulations 1 and 2 as defined in the Initial Patient Population algorithm of the *Specifications Manual for Joint Commission National Quality Measures*[*].

* Note that the 2018B1 version is active through June 30, 2019; for discharges from July 1 through December 31, 2019, reference the 2019A version.

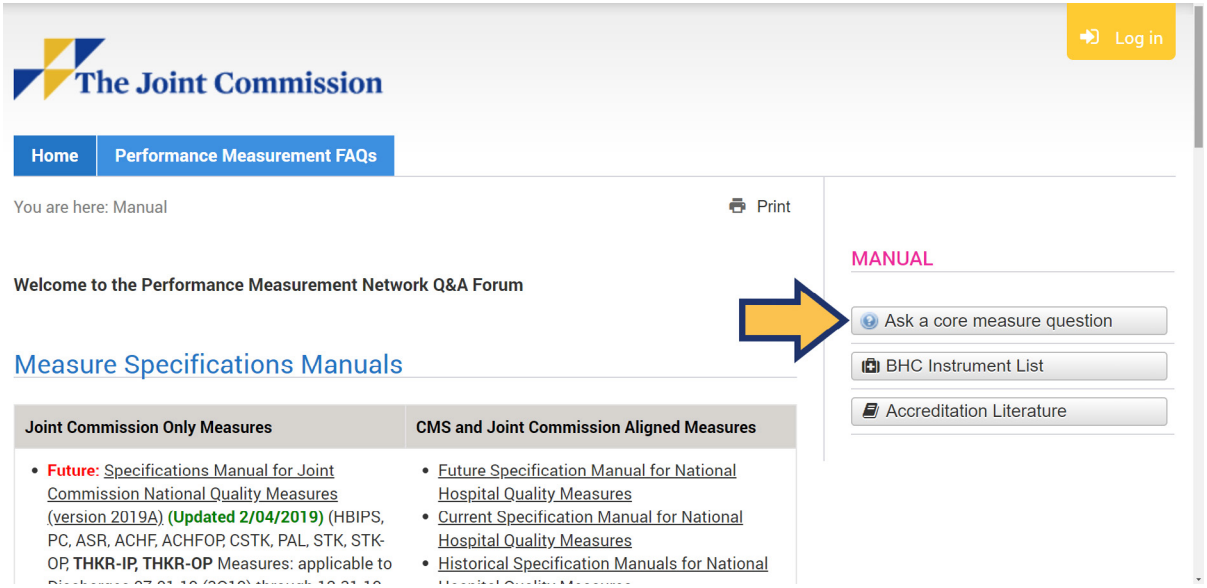
Organizations that use a vendor for CSTK measure data transmission should confirm with their vendor that data for CSTK-01 are included in the transmission. (*See* the following table for what should be included in the numerator and denominator populations for CSTK-01.) When the organization has verified that the vendor supports the CSTK-01 measure, it should notify hcooryx@jointcommission.org to enable the vendor transmission. Otherwise, the organization must manually enter the data for the measure in CMIP.

CSTK-01 Numerator Population	CSTK-01 Denominator Population
• Ischemic stroke patients for whom an NIHSS score is performed prior to undergoing any acute recanalization therapy (that is, IV t-PA, IA t-PA, or MER) and documented in the medical record **or** • Ischemic stroke patients, who do not undergo recanalization therapy, for whom an NIHSS score is performed and documented in the medical record within 12 hours of hospital arrival	• All ischemic stroke patients, which includes the patients who receive the following: ❍ Patients who receive IV thrombolytic therapy (t-PA) **and** ❍ Patients who receive IA t-PA **and** ❍ Patients who receive MER therapy (CSTK subpopulation 2) **and** ❍ Patients who do not undergo a reperfusion procedure (CSTK subpopulation 1)

CSTK, comprehensive stroke; NIHSS, National Institutes of Health Stroke Scale; IV, intravenous; t-PA, tissue plasminogen activator; IA t-PA, intra-arterial tissue plasminogen activator; MER, mechanical endovascular reperfusion.

TSCs and CSCs collecting and using data from CSTK-01 for internal quality improvement can and should continue to collect data for this measure.

Questions about these performance measures may be directed to the Performance Measurement Network Q&A Forum on The Joint Commission website.



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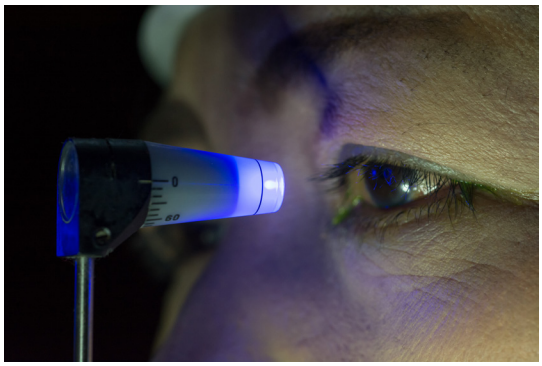
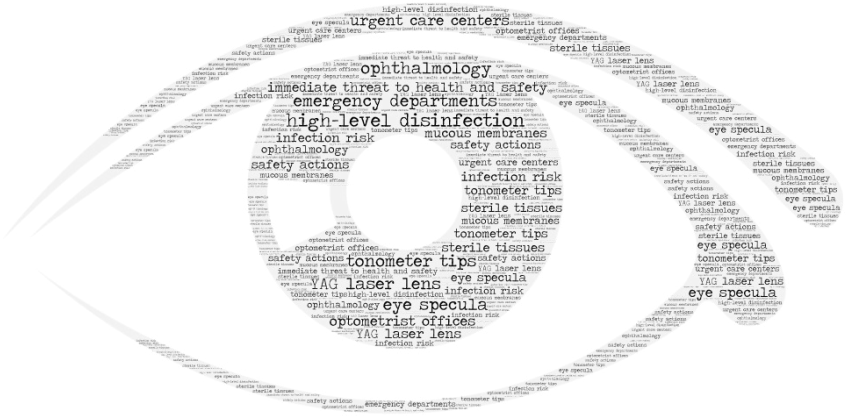
New *Quick Safety* Focuses on High-Level Disinfection of Ophthalmology Devices



Health care organizations that use tonometers and other devices that touch the eye must be aware of the infection risk to patients and know how to appropriately clean and disinfect such devices. Joint Commission survey data have identified either lack of awareness or misinterpretation of manufacturer instructions related to high-level disinfection of ophthalmology devices. These factors, combined with a lack of staff training and leadership oversight, have resulted in The Joint Commission declaring multiple instances of an immediate threat to health and safety. The Joint Commission recently released *Quick Safety* Issue 49: Disinfection of tonometers and other ophthalmology devices to address this situation.

The *Quick Safety* issue provides suggestions for health care organizations to ensure that safe protocols are in place to protect patients from infection. Suggested safety actions include the following:

- Review cleaning and disinfection instructions to ensure that items that touch the surface of the eye are—at minimum—high-level disinfected and those that touch non-intact surfaces of the eye are sterilized.
- Confirm that disinfectants listed as compatible, other than bleach, are US Food and Drug Administration (FDA)–approved high-level disinfectants.
- Have available and follow manufacturer instructions when using a device for ophthalmology examinations and/or procedures, as well as when cleaning and disinfecting such devices.
- Have a qualified individual available to review product labels and instructions for use who is knowledgeable about the different types of disinfectants. P



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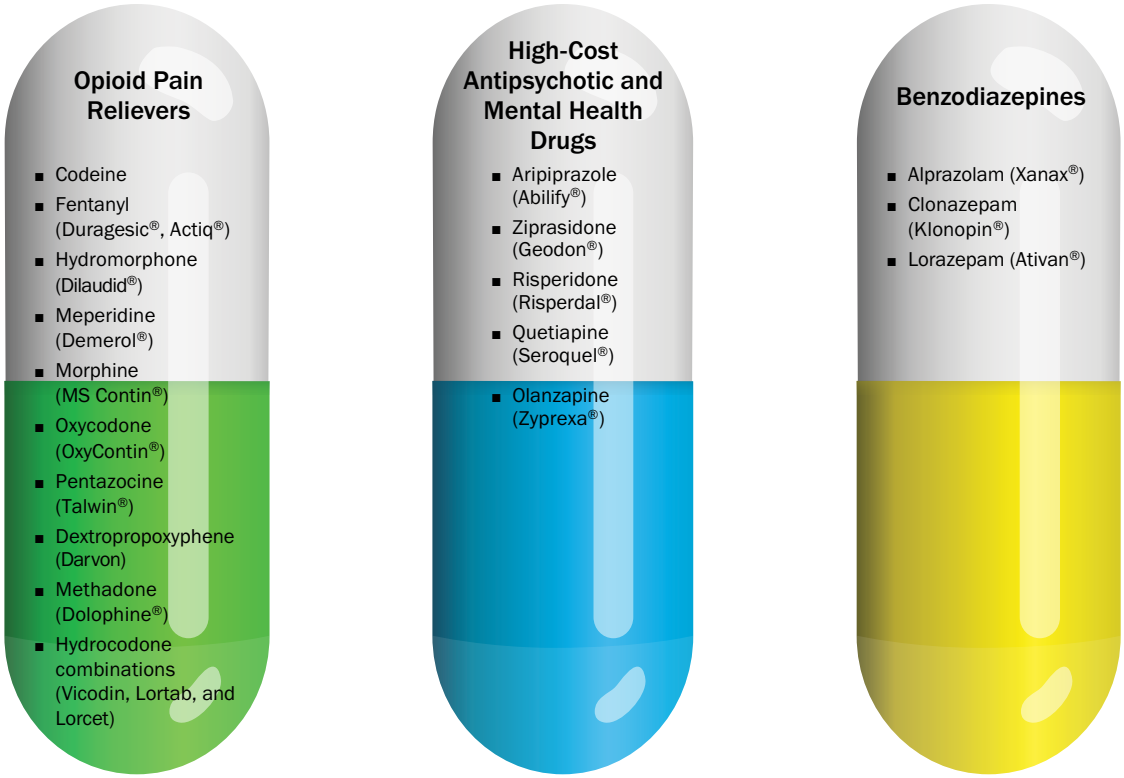
Recent *Quick Safety* Addresses Drug Diversion

Recently, The Joint Commission released *Quick Safety* Issue 48: Drug diversion and impaired health care workers. Drug diversion is a potential threat to patient safety in every health care organization. As challenges from controlled prescription drug usage continue to make headlines, health care organizations work to ensure patient safety, which may be compromised by impaired health care workers.

Drug diversion is a growing problem that spans all levels of an organization from chiefs to frontline staff across all clinical disciplines. The diversion of controlled substances can be difficult to detect in organizations. This *Quick Safety* issue outlines common patterns and trends that may indicate diversion, as well as actions to consider. The following graphic shows commonly diverted drugs by their common classifications. P

Commonly Diverted Drugs*



* Names in parentheses are the commonly known brand name of the drug.
Source: US Department of Health & Human Services, US Centers for Medicare & Medicaid Services, "Drug Diversion in the Medicaid Program: State Strategies for Reducing Prescription Drug Diversion in Medicaid," January 2012.

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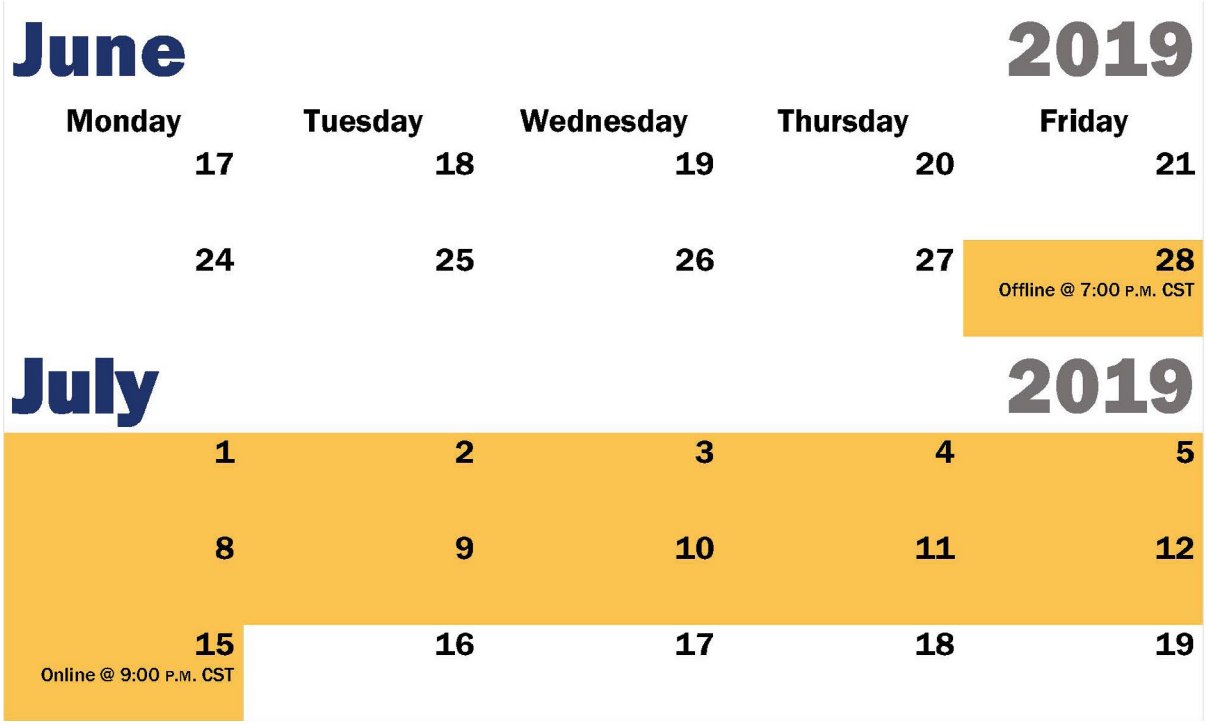
Focused Standards Assessment (FSA) Tool Temporarily Offline for July 2019 Standards Update

Starting June 28, 2019, at 7:00 P.M. central standard time (CST), the Focused Standards Assessment (FSA) tool in the Intracycle Monitoring (ICM) Profile on the *Joint Commission Connect*® extranet site will be offline for the July 2019 standards update. The tool will come back online July 15, 2019, at 9:00 P.M. CST.

Questions may be directed to your organization's designated Account Executive at 630-792-3007. P



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Consistent Interpretation

Joint Commission Surveyors' Observations of Power Strips in Patient Care Areas

The monthly **Consistent Interpretation** column is designed to support organizations in their efforts to comply with specific Joint Commission requirements. Each installment of the column draws from a database containing surveyors' de-identified observations (in the column to the left) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on how to interpret the observations (in the column to the right).

The requirements highlighted in this column are not necessarily those with high rates of noncompliance. Rather, they are EPs that have the potential to negatively impact the delivery of high-quality care or create risk from a safety perspective if found out of compliance. That is, they may appear in the upper right corner of a *Survey Analysis for Evaluating Risk*® (*SAFER*™) Matrix if cited on survey. Featured EPs are applicable to the hospital program; however, the guidance in this column may be extrapolated to apply to other accreditation programs that offer similar services and populations served.

This month, **Consistent Interpretation** highlights Environment of Care (EC) Standard EC.02.05.01, EP 23, which outlines the requirements of using power strips (also known as relocatable power taps [RPTs]) in patient care areas.

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

Standard EC.02.05.01: The hospital manages risks associated with its utility systems.	
EP 23: Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 400-8; 590.3(D); Tentative Interim Amendment (TIA) 12-5)	
Compliance Rate	In 2018 the noncompliance percentage for this EP was **21.14%**—that is, **309** of **1,462** hospitals surveyed were out of compliance with this requirement.
Noncompliance Implications	Overloaded power strips may cause a critical device plugged into it to fail during use. In addition, exceeding the current rating can cause an electrical fire.

Surveyor Observations	**Guidance/Interpretation**
• Power strips were used in a patient care area that do not meet UL 1363A. • The power strip used in the operating room was mounted to the wall.	• Power strips providing power to patient care–related electrical equipment must be special-purpose relocatable power taps (SPRPTs) listed as UL 1363A or UL 60601-1. • Power strips must be permanently mounted to the equipment or an assembly and are not permitted to be mounted to the wall. *See* CMS S&C 14-46 for further guidance.

UL, Underwriters Laboratories; CMS, US Centers for Medicare & Medicaid Services.

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The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of Perspectives presents the **May 2019** Table of Contents for *The Joint Commission Journal on Quality and Patient Safety* (*JQPS*). The Joint Commission works closely with *JQPS* (published by Elsevier) to make it a key component in helping health care organizations improve patient safety and quality of care.

To purchase a subscription or site license to *JQPS*, please visit *The Joint Commission Journal on Quality and Patient Safety* website.

EDITORIAL

Quality Measures

Performance Improvement

Medication Safety

Safety Culture

RESEARCH LETTER

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COMMENTARY

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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

- Effective Friday, May 24, 2019, The Joint Commission is suspending for an undetermined period of time the APR.03.01.01 requirement related to Intracycle Monitoring. **This process update applies to accredited programs only.** This does not impact the certification intracycle evaluation, which is still required. Please contact your organization's designated Account Executive if you have any questions.
- Selected performance measures for two advanced **disease-specific care** certification programs—Acute Heart Attack Ready and Primary Heart Attack Center (*see* page 2 in this issue for the full article)
- Added new requirement related to dosimetry monitoring for **office-based surgery** practices that provide fluoroscopy services (*see* page 4 in this issue for the full article)

POST FIELD REVIEW DEVELOPMENT

- Developing proposed new antimicrobial stewardship requirement for the **ambulatory health care** and **office-based surgery** practice programs
- Developing proposed perinatal care standards for the **critical access hospital** and **hospital** programs

CURRENTLY IN FIELD REVIEW

- Proposed standards revisions for **ambulatory health care**, **critical access hospital**, and **hospital** programs that elect The Joint Commission Primary Care Medical Home option (field review ends June 10, 2019)
- Proposed **behavioral health care** requirements related to substance use disorders (tentative start date for field review is June 24, 2019)

Note: *Please visit the Standards Field Reviews pages on The Joint Commission website for more information. Field reviews usually span six weeks; dates are subject to change.*

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Evaluating current child welfare standards in the **behavioral health care** program
- Developing proposed requirements to address Conditions for Coverage for **ambulatory health care** organizations that provide treatment for end-stage renal disease
- Identifying proposed deletions in the **laboratory** program to reduce redundancies between the hospital and laboratory survey processes
- Evaluating current National Patient Safety Goal (NPSG) Standard NPSG.02.03.01 on follow-up of all test results (**program applicability to be determined**)
- Developing proposed new and revised requirements to incorporate updated American Heart Association/American Stroke Association Acute Ischemic Stroke Guidelines in all **disease-specific care** advanced stroke programs
- Researching issues related to dental and vision care for the **behavioral health care** program

The Joint Commission Perspectives®

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In Sight

- Researching issues related to management of biosafety threats (**program applicability to be determined**)
- Evaluating current **advanced total hip and total knee replacement** certification standards for relevance and scientific merit
- Researching quality and safety gaps in the **nursing care center** program

Joint Commission Resources

2019 WEBINARS

National Patient Safety Goals®
12:00pm-1:00pm CST
Wednesday, March 20, 2019
Wednesday, June 12, 2019
Wednesday, September 11, 2019
Wednesday, December 04, 2019

CMS Readiness Webinar Series
12:00pm-1:00pm CST
Wednesday, January 23, 2019
Wednesday, February 20, 2019
Wednesday, March 27, 2019
Wednesday, April 24, 2019
Wednesday, May 22, 2019
Wednesday, June 19, 2019
Wednesday, July 24, 2019
Wednesday, August 21, 2019
Wednesday, September 25, 2019
Wednesday, October 23, 2019
Wednesday, November 20, 2019
Wednesday, December 18, 2019

Environment of Care and Exploring the Life Safety Webinar Series
12:00pm-1:00pm CST
Wednesday, March 13, 2019
Wednesday, June 26, 2019
Wednesday, September 18, 2019
Wednesday, December 11, 2019

Infection Control Webinar Series
12:00pm-1:00pm CST
Thursday, March 14, 2019
Thursday, June 13, 2019
Thursday, September 19, 2019
Thursday, December 12, 2019

Medication Management Webinar Series
12:00pm-1:00pm CST
Thursday, March 21, 2019
Thursday, June 20, 2019
Thursday, September 26, 2019
Thursday, November 07, 2019

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