The Joint Commission

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The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES



2 **New Rural Health Clinic Accreditation Program**

The Joint Commission recently announced its new Rural Health Clinic Accreditation Program, which has received initial deeming authority from the Centers for Medicare & Medicaid Services.

5 **Providing Culturally Sensitive Care for Displaced Persons**

This article highlights the health care experiences of displaced persons, including refugees and migrants, and outlines strategies for providing these individuals with respectful, culturally competent health care.

11 **Spotlight on Success: Mount Sinai Reduces Time for ED to ICU Transfers**

This article details a nurse-led quality improvement project at Mount Sinai Queens aimed at streamlining the process for transporting critical patients from the emergency department to the intensive care unit.

14 **Infographic: The Impact of Hospitalist Co-Management Programs in Neurosurgery Departments**

This infographic depicts findings from a study featured in the May 2024 issue of *The Joint Commission Journal on Quality and Patient Safety*, which describes the implementation of a hospitalist co-management program in a neurosurgery department and considers its influence on the incidence of complications, mortality, and length of stay.

16 **Top News: A Digest of Accreditation and Health Care News**

19 **Other Learning Opportunities from The Joint Commission and Joint Commission Resources**

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New Rural Health Clinic Accreditation Program

According to the Centers for Disease Control and Prevention (CDC), 15% of Americans live in rural counties. These individuals face higher risks of death than those who live in urban areas due to factors such as limited access to specialized medical care and emergency services, as well as exposure to specific environmental hazards. To help organizations in underserved rural communities improve the quality of primary care and personal health services, The Joint Commission recently announced that its new Rural Health Clinic Accreditation Program has received initial deeming authority from the Centers for Medicare & Medicaid Services (CMS) for four years—from June 1, 2024, through June 1, 2028.

The Joint Commission rural health clinic standards are based on CMS's Conditions for Certification (CfCs) and include input from industry stakeholders with clinical expertise and specific knowledge of the unique demographics and population needs for providing care, treatment, and services in rural settings. Although the rural health clinic standards primarily incorporate CMS's CfCs, there are additional Joint Commission–specific requirements that address critical patient safety and quality topics such as infection prevention and control, medication management, and the environment of care. Rural health clinic standards include but are not limited to the following key operational areas:

- Emergency management
- Health information management
- Infection prevention and control

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- Medication management
- Patient assessment and care
- Patient rights
- Patient safety
- Performance improvement
- Staff competency

> **The new Rural Health Clinic Accreditation Program closely aligns with The Joint Commission's strategic priority area on health care equity for all. All patients deserve access to safe and quality care regardless of their location.**
>
> **— Jonathan B. Perlin, President and Chief Executive Officer, The Joint Commission Enterprise**

The new program provides a framework to help standardize processes for staff, reduce variation and risk, and establish consistent care for patients, which all contribute to improved quality outcomes.

"With deeming authority from CMS, The Joint Commission will be able to work with rural health clinics across the country to help them establish a quality and safety framework for the more than 60 million Americans living in rural areas," says Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, Joint Commission Enterprise President and Chief Executive Officer. "The new Rural Health Clinic Accreditation Program closely aligns with The Joint Commission's strategic priority area on health care equity for all. All patients deserve access to safe and quality care regardless of their location."

To be eligible for rural health clinic accreditation, health care organizations must meet all state and federal requirements, including employing a nurse practitioner or physician assistant and having a nurse practitioner, physician assistant, or certified nurse midwife working not less than 50% of the time during operating hours. Additional eligibility requirements are outlined in "The Accreditation Process" (ACC) Chapter of the *Comprehensive Accreditation Manual for Rural Health Clinics* (*CAMRHC*).

The following eligibility requirements will be available in the ACC chapter of *CAMRHC*:

- The organization is in the United States or its territories or, if outside the United States, is owned or operated by the US government or under a charter of the US Congress.
- The organization is licensed pursuant to applicable state and local law.
- Determined by Survey Operations Group (SOG) CMS locations to meet the following eligibility criteria:
  - Located in a rural area designated as a shortage area, is not a rehabilitation agency or facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR parts 405 and 491.
  - Certified for participation in Medicare in accordance with subpart S of 42 CFR part 405. The Secretary will notify the state Medicaid agency

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whenever they have certified or denied certification under Medicare for a prospective rural health clinic in that state. A clinic certified under Medicare will be deemed to meet the standards for certification under Medicaid.

- Located in an area defined by the US Census Bureau as non-urbanized
- Located in an area currently designated by the Health Resources and Services Administration (HRSA) within the last four years as one of the following:
    - Primary Care Geographic Health Professional Shortage Area
    - Primary Care Population-Group Health Professional Shortage Area
    - Medically Underserved Area
    - Governor-Designated and Secretary-Certified Shortage Area

- The organization assesses and improves the quality of its care, treatment, and/or services. This process includes a review by clinicians, when appropriate.
- The organization identifies the health care services it provides, indicating which care, treatment, and/or services it provides directly, under contract, or through some other arrangement.
- The organization provides services addressed by Joint Commission standards.
- The organization has served 10 patients with at least 2 active patients at the time of survey.

In addition, a rural health clinic must provide routine diagnostic and laboratory services, provide basic laboratory services on-site, have arrangements with one or more hospitals to provide medically necessary services, have drugs and biologicals available to treat emergencies, and not be primarily engaged in providing mental health or rehabilitation services.

Rural health clinics currently surveyed under the Ambulatory Care, Critical Access Hospital, or Hospital Accreditation Programs will be contacted by a Joint Commission account executive to discuss options and answer questions.

The requirements for the new program can be requested from the Prepublication Standards page of The Joint Commission's website and will publish online in the summer 2024 interim E-dition® release of *CAMRHC*.

Contact the Department of Standards and Survey Methods for more information about the rural health clinic requirements or contact a representative from The Joint Commission for information on obtaining rural health clinic accreditation.

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Providing Culturally Sensitive Care for Displaced Persons

Improving health care equity is a mandate not just for The Joint Commission but for health care organizations (HCOs) around the globe. Every patient has value and therefore should be treated with dignity and respect, regardless of differences or group affiliation. To achieve health care equity, this idea should be taken a step further, to customizing care to the individual based on their features of diversity—but without stereotyping or making assumptions about the patient based on race or ethnicity or on any simplified image or idea. The first step toward providing equitable care is to develop cultural sensitivity or the ability to deliver culturally relevant care for diverse populations. This includes refugee, immigrant, and migrant (RIM) communities (*see* "Did You Know?" on page 6 for legal definitions), which often experience unique barriers to health care. This article will take a closer look at the health care experiences of this population and outline strategies for providing these individuals with respectful, culturally competent care.

Barriers to Health Care

The US Congressional Budget Office estimates that as of 2021, about 45 million people living in the United States were born in other countries. This figure includes refugees, asylum seekers, people with work visas, naturalized citizens, lawful permanent residents, and immigrants regardless of legal status. Of the 45 million, about three quarters are in the United States legally; the remaining one quarter lack legal status. To better understand the health and health care experiences of this diverse population, the Kaiser Family Foundation (KFF) and the *Los Angeles Times* conducted a survey of adult immigrants (defined as individuals age 18 and older who live in the United States but were born outside the United States or its territories) in 2023. The resulting report provides crucial insight into the health and health care experiences of displaced individuals (*see* infographic on page 8 for key findings).

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Although the majority of those surveyed by KFF (79%) reported being in excellent or good health, this measure was highly associated with income, with 31% of lower-income immigrants reporting fair or poor health. The Office of Refugee Resettlement (ORR), which is part of the US Department of Health and Human Services, notes that the health of refugees may be affected by a number of factors, including the quality of care individuals received in their countries of origin. Many refugees are displaced by war, natural disasters, or economic or environmental crises and must then undertake lengthy journeys with uncertain access to food, clean water, and sanitary conditions before resettlement. This leaves them susceptible to food- and waterborne illnesses as well as to communicable diseases. Some individuals may also be facing pregnancy or delivery complications or may have experienced assault along their journeys. According to the World Health Organization (WHO), maternal care is often the first point of contact with the health care system for refugees and migrants. In addition, many displaced persons have mental health needs related to the stress and trauma of the resettlement experience.

Did You Know?

According to the Centers for Disease Control and Prevention, an *immigrant* is someone admitted to the United States (or any other country) as a lawful permanent resident. The term *refugee* is used to describe persons who are unwilling or unable to return to their country of origin or country of last residence because of persecution or fear of persecution based on their race, religion, nationality, political stance, or membership in a particular group. In contrast, *migrant* is an umbrella term used to describe persons who choose to leave their home countries—regardless of legal immigration status—often to seek work, better living conditions, or educational opportunities, whether permanently or temporarily. Unlike refugees, migrants can safely return home if they choose to do so.

These groups are defined under different legal frameworks; in the United States, the Refugee Act of 1979 is the foundation for legal status for refugees, whereas the Immigration and Nationality Act is the legal framework for immigrants and migrants. Despite having different legal statuses, these groups share common challenges and barriers to care in the United States.

In the midst of this mental and physical upheaval, a significant initial barrier to care is understanding the US health care system, including the basics of where to go for what type of care. Language barriers present another challenge, particularly with the amount of paperwork required to get care. A related barrier is lack of health insurance. According to KFF, roughly 50% of undocumented immigrants and 18% of immigrants with legal status report being uninsured. To complicate matters further, many displaced persons work in lower-paid jobs that are less likely to offer employer-sponsored health plans, and persons without legal status are ineligible for federal programs such as Medicaid that could help bridge this gap; they are likewise not eligible for plans offered under the Affordable Care Act Marketplace. Even persons who have legal status may face a five-year waiting period before being eligible for Medicaid or the Children's Health Insurance Program (CHIP). Restrictions vary by state, creating a patchwork of disparate coverage options. An additional concern is that many undocumented individuals do not seek assistance through social support programs because of fear that applying for assistance will affect their immigration status.

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Overcoming Barriers to Provide Culturally Sensitive Care

The ORR funds programs and services that assist refugees in accessing health care. These include options for medical screenings, health coverage, and mental health, as well as specialized services for survivors of trauma. The ORR partners with state and local health departments and resettlement organizations to provide these services. In addition, the Centers for Disease Control and Prevention (CDC) offers health education and communication resources for RIM communities.

Some US states have undertaken efforts to systemically eliminate barriers to accessing care. For example, some states have eliminated the five-year waiting period for Medicaid and/or CHIP eligibility for specific groups of people or have extended eligibility to persons without legal status by using state-funded programs. KFF notes, for example, that 12 states plus Washington, DC, offer comprehensive coverage to children of all immigration statuses, while 6 states plus Washington, DC, fund coverage for low-income adults regardless of immigration status. Such programs have many benefits, including reducing rates of uninsured persons, increasing their access to care, and improving health outcomes.

At the HCO level, the first step toward providing equitable care is to develop cultural sensitivity or the ability to deliver culturally relevant care. This begins with efforts to develop the following critical global leadership competencies[1]:

- **Cultural curiosity**: A genuine desire to learn and understand the background and experiences of cultures different from one's own without judgment
- **Cross-cultural competency**: The development of comfort with engaging with people from any culture the provider may encounter, as well as an awareness of the provider's own implicit and explicit biases
- **Cultural agility**: The ability to adapt quickly to unexpected circumstances
- **Cultural humility**: A commitment to lifelong learning, ongoing self-evaluation, and self-critique, and an openness to new information
- **Divergent thinking and creativity**: A willingness to collaborate with others, particularly people from differing cultural backgrounds
- **Knowledge and integration of cross-national/cultural issues:** A commitment to ongoing education about the state of the world and the concerns others may face within it.

To accomplish their health care equity goals, HCOs must have the trust of the communities and patients they serve. Understanding the cultural differences that make up their patient population is an essential tool for building that trust. Disparities in access, treatment, and outcomes cannot be adequately addressed if community members do not feel that their health care providers are culturally sensitive to their needs.

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BY THE NUMBERS

A 2023 survey conducted by the Kaiser Family Foundation and the *Los Angeles Times* sought to better understand the health and health care experiences of individuals age 18 and older who live in the United States but were born outside the United States or its territories. A quarter of survey respondents reported that they had been treated unfairly in a health care setting since coming to the United States. In addition, survey respondents revealed the following:

BARRIERS AT POINT OF CARE

Lack of insurance or inability to pay led to unfair treatment: **16%**

Difficulties due to language barrier or accent: **15%**

Discrimination due to race, ethnicity, or skin color: **13%**

BARRIERS TO CULTURALLY COMPETENT CARE

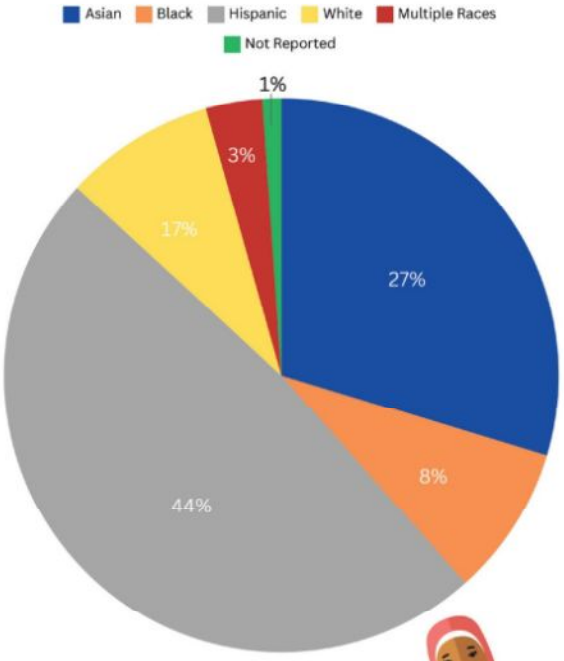
Provider not taking time to listen/ignoring concerns: **17%**

Provider not explaining things well: **15%**

No interpretation services offered: **18%**

Disrespectful staff members: **12%**

Race and Ethnicity of Immigrants*



Country of Birth

Mexico: **24%**
India: **6%**
Philippines: **5%**
China: **5%**
El Salvador: **3%**
Vietnam: **3%**
Cuba: **3%**
Dominican Republic: **3%**
Guatemala: **2%**
Korea: **2%**
Other: **44%**



***NOTE:** Persons of Hispanic origin may be of any race but were categorized as Hispanic for this analysis; other groups are non-Hispanic.
Source: Pillai D, et al. Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants. Accessed May 23, 2024. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants/

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The Joint Commission's Commitment to Health Care Equity



The Joint Commission is committed to strengthening the connection between equity and quality in health care. To that end, the enterprise introduced specific health care equity standards in 2022. These standards were subsequently elevated to National Patient Safety Goal® (NPSG) Standard NPSG.16.01.01, the requirements of which are outlined in "Related Standards" below. NPSG.16.01.01 applies to the following Joint Commission–accredited organizations:

- All critical access hospitals and hospitals
- Ambulatory care organizations providing primary care within the "Medical Centers" service in the ambulatory care program (the requirements are not applicable to organizations providing episodic care, dental services, or surgical services)
- Behavioral health care and human services organizations providing "Addictions Services," "Eating Disorders Treatment," "Intellectual Disabilities/Developmental Delays," "Mental Health Services," and "Primary Physical Health Care" services

There are also longstanding requirements related to health care equity in the "Rights and Responsibilities of the Individual" chapter (*see* "Related Standards" on page 10).

In addition, The Joint Commission launched a Health Care Equity Certification program in July 2023 for all Joint Commission–accredited hospitals and critical access hospitals and non-Joint Commission–accredited hospitals and critical access hospitals that comply with applicable federal laws, including Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. To assist HCOs with their health care equity journey, The Joint Commission offers the following complimentary online resources:

- Health Care Equity Accreditation Resource Center
- Health Care Equity Certification Resource Center

Although health care equity is often viewed through a social justice lens, it is first and foremost a quality of care issue. This means that to accomplish sustainable achievement, organizations need to approach health care equity the same way they approach other crucial patient safety priorities—by understanding the root causes and implementing targeted interventions. TS

Reference

1. Davis MIW. Global leadership. *Journal of Business Diversity*. 2018 Nov;18(3):20–25.

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Related Standards

Standard and EP	Summary	Applicability
NPSG.16.01.01, EP 1	Identify an individual to lead activities to improve health care equity.	AHC (select settings, as noted above), BHC (select settings, as noted above), CAH, HAP
NPSG.16.01.01, EP 2	Assess the patient's health-related social needs.	Same as EP 1
NPSG.16.01.01, EP 3	Analyze quality and safety data to identify disparities.	Same as EP 1
NPSG.16.01.01, EP 4	Develop an action plan to improve health care equity.	Same as EP 1
NPSG.16.01.01, EP 5	Take action when the organization does not meet the goals in its action plan.	Same as EP 1
NPSG.16.01.01, EP 6	Inform key stakeholders about progress to improve health care equity.	Same as EP 1
RI.01.01.01, EP 6	Respect the patient's cultural and personal values, beliefs, and preferences.	AHC, ALC, BHC, CAH, HAP, NCC, OBS, OME
RI.01.01.01, EP 9	Accommodate the patient's right to religious and spiritual services.	ALC, BHC (in 24-hour settings), CAH, HAP, NCC, OME
RI.01.01.01, EP 29	Prohibit discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.	AHC, BHC, CAH, HAP
RI.01.01.03, EP 1	Provide information in a manner tailored to the patient's age, language, and ability to understand.	AHC, ALC, BHC, CAH, HAP, NCC, OME
RI.01.01.03, EP 2	Provide interpreting and translation services.	AHC, BHC, CAH, HAP, NCC, OME
RI.01.01.03, EP 3	Provide information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.	AHC, ALC, BHC, CAH, HAP, NCC, OBS, OME

Key: *AHC, ambulatory care; ALC, assisted living community; BHC, behavioral health care and human services; CAH, critical access hospital; EP, element of performance; HAP, hospital; NCC, nursing care center; NPSG, National Patient Safety Goals; OBS, office-based surgery; OME, home care; RI, Rights and Responsibilities of the Individual.*

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Spotlight on Success

MOUNT SINAI REDUCES TIME FOR ED TO ICU TRANSFERS



Photo courtesy of Mount Sinai Health System.

Emergency department (ED) boarding (continuing to care for patients in the ED after the decision to admit due to lack of inpatient bed availability) is a long-standing yet increasingly common quality and safety issue.[1] The Joint Commission addresses boarding in Leadership (LD) Standard LD.04.03.11, Element of Performance (EP) 6, which requires Joint Commission–accredited hospitals and critical access hospitals to set goals to mitigate and manage the boarding of patients who come through the ED (*see* "Related Joint Commission Standard" on page 12).

When Mount Sinai Queens, a 165-bed hospital with 70,000 annual ED visits, started to restructure staffing guidelines in its ICU, nurses and nurse leaders saw an opportunity for a quality improvement (QI) project to reduce median ED boarding times to improve patient experience and patient safety.

"Patients staying in the ED are more uncomfortable and distressed," says Geneline Barayuga, MSN, RN, Nurse Manager, Critical Care Services, Mount Sinai Queens. "The ED gets noisy and chaotic, and this increases patient and family member anxiety and leads to a negative overall experience and impacts [patient] recovery."

Jonathan Nover, MBA, RN, Senior Vice President of Nursing, Emergency Services, at Mount Sinai Queens, adds, "What keeps every ED nurse or manager up at night is probably boarders. And every study, every editorial, or every anecdotal piece of information shows there are negative outcomes and poor patient experiences associated with longer ED boarding times."

This article details how ED and ICU charge nurses at Mount Sinai Queens collaborated to change the process for transporting critical patients from the ED to the ICU and how this led to improvements in the timeliness of ICU admissions.

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Related Joint Commission Standard

LD.04.03.11 The hospital manages the flow of patients throughout the hospital.

EP 6 This hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department.

Implementing the QI Project

The idea for the QI project came about when Mount Sinai Queens restructured staffing guidelines in the ICU so that the charge nurse would not have a patient assignment. Leadership realized this was an opportunity to reconfigure the ICU charge nurse role while also reducing the time to transfer a critically ill patient from the ED to the ICU. "We were creating a robust job description for the ICU charge nurse," says Nover, "and we thought the ICU charge nurse was the best person to transfer these patients."

Historically, the ICU charge nurse at Mount Sinai Queens was assigned two ICU patients and therefore could not go to the ED to escort a patient to the ICU. Instead, an ICU provider (either the intensivist or an ICU–trained physician assistant) would transfer patients from the ED to the ICU along with an ED nurse. The changes to the ICU charge nurse role made it possible for the ICU charge nurse to transfer the patient to the ICU.

"ED nurses have always wanted this," says Francelia Thomas, BSN, RN, Nurse Manager, Emergency Department, Mount Sinai Queens. "We wanted to reduce ED boarding times, keep the ED nurse at the bedside so they could take care of their other patients, and decrease the time involved in handing off a patient transferring from the ED to the ICU." Thomas explains that transferring an ED patient to the ICU was time-intensive for ED nurses. Steps in the process included calling and giving the ICU nurse a verbal report and then handing off all their other patients to other ED nurses before coordinating the team needed to transport the patient to the ICU; accompanying the patient to the ICU; giving another report to the ICU nurse upon arrival, including reviewing continuous drips; and finally returning to the ED to chart the transfer and receive reports on their other ED patients. "At a minimum, the time to transfer a patient to the ICU took the ED nurse 30 minutes," says Thomas.



Barayuga notes that ICU nurses initially resisted this change. "I've been a critical care nurse for 36 years, and there's always resistance to any change," says Barayuga. "But what helped us was having staff engagement and leadership involved. The reason we were doing all of this was for patient safety. After a few weeks, the new process was the standard and a normal workflow for us. . . . And if the ICU charge nurse is responding to a

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rapid response call, the ICU nurse assigned to the patient will go down to the ED instead."

Nover adds that leadership is respectful of the nurses' time and their other responsibilities. "We're always trying to find ways to give time back to the charge nurse," says Nover. "The ICU team has been trying to reduce the rapid response team [RRT] call burden and only respond to RRT calls that are truly necessary." As a result, any RRT related to sepsis was redesigned so that the ICU charge nurse did not have to leave the ICU but could serve as clinical support via the phone for nursing staff taking care of the patient with the potential for sepsis. "There is a give and take," says Nover. "We have added responsibilities to the ICU charge nurse role, but leadership also helps reduce their burden with other activities as well."

Results

As a result of this QI project, Mount Sinai Queens reduced average ED boarding times from 64 minutes to 49 minutes; in some months, the team has even gotten the ED boarding time to under 40 minutes.

In addition, nurses and nurse leaders have appreciated the improved communication between the ED and the ICU. "Initially at the start of the shift, the ED and ICU charge nurses will chat in the electronic medical record," says Barayuga. "This communication is ongoing throughout the shift and . . . promote[s] safer patient transitions, optimize[s] clinical resources, and improve[s] outcomes."

Thomas adds, "The patient also sees a collaborative effort between the two teams, with the ICU nurse and provider coming to the ER [emergency room] to get the patient. The patient sees that there is a lot of communication, and the patient is not having to repeat themselves or introduce family members multiple times."

An unexpected benefit was knowledge transfer among the nurses. "In the ED, there was a new graduate nurse fellowship program, resulting in several newer ED nurses," says Nover. "So having the experienced ICU charge nurse come down to the ED allowed for feedback about continuous drips and tips on how to start arterial lines."

Furthermore, with the ICU charge nurse free of patient assignments, there was more time to reliably provide breaks not only to other ICU nurses but also to ED nurses. "These changes allowed us to ensure that all our ED nurses received more timely break time relief," says Thomas. "Instead of being upstairs in the ICU giving a report, the nurse is able to get a break."

Finally, this nurse-led QI project also help reduce staff burnout. "Timeliness of treatment and the patient's comfort is key," says Barayuga. "But staff burnout is important also. ED staff taking care of an ICU patient that needs to be in the ICU and also trying to take care of all the ED patients definitely leads to burnout." TS

Reference

1. American College of Emergency Physicians. Emergency Department Crowding: High Impact Solutions. May 2016. Accessed Jun 4, 2024. https://www.acep.org/siteassets/sites/acep/media/crowding/empc_crowding-ip_092016.pdf.

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The Impact of Hospitalist Co-Management Programs in Neurosurgery Departments

Medical complications are common among neurosurgical patients and can jeopardize their clinical results, leading to longer lengths of stay, higher costs, and higher readmission and mortality rates. Interventions, such as medical co-management, aimed at reducing medical complications, might improve outcomes, but the real-world impact of co-management is unknown.

A study featured in the May 2024 issue of *The Joint Commission Journal on Quality and Patient Safety (JQPS)* describes the implementation of a hospitalist co-management program in a neurosurgery department and considers its impact on the incidence of complications, mortality, and length of stay.

THE STUDY

The quasi-experimental study aimed to determine whether general neurosurgery inpatients benefit from a hospitalist-led medical co-management program in terms of mortality, complications, and use of resources.

The study compared a historical control period to a prospective intervention arm within a neurosurgical inpatient ward in Madrid.

Retrospectively compared to:

Co-managed patients:
From July to December 2019, 191 patients provided informed consent, were included in the study, and were prospectively followed.



Historical cohort:
From July to December 2017, data from 227 patients with similar characteristics and from the same unit were collected retrospectively.

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The 2019 co-management program incorporated two hospitalists into the neurosurgery team. The hospitalists intervened in the diagnostic and therapeutic plan of patients, participated in clinical decisions, and coordinated patient navigation with neurosurgeons.

The incidence of moderate or severe complications such as in-hospital mortality and length of stay were compared, multivariate regression was used to adjust for confounders, and the average treatment effect was estimated using inverse probability of treatment weighting.

THE RESULTS

Complications

A **significant reduction in the incidence of relevant medical complications** was seen in the co-managed patients.



Patients presenting at least one moderate, severe, or lethal complication:



Mortality

No differences were found in in-hospital mortality rates.

The study found that hospitalist co-management was associated with a reduced incidence of complications and length of stay in neurosurgical patients, but there was no difference in in-hospital mortality.

To learn more about this study, visit:
https://www.jointcommissionjournal.com/article/S1553-7250(24)00006-0/fulltext

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50th ANNIVERSARY

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Top News

A DIGEST OF ACCREDITATION AND HEALTH CARE NEWS

The Joint Commission Launches Redesigned E-dition®



In response to user feedback, The Joint Commission Enterprise recently launched a fully redesigned E-dition®, the Web-based tool that provides health care organizations with access to all accreditation, certification, and verification requirements, including survey process content. The redesigned E-dition features improved navigation and usability, as well as a modernized look and feel. Although E-dition looks different, users still have access to all its current features and can adjust their service profile to tailor their experience. As applicable, users also still have access to an interactive crosswalk showing how Joint Commission elements of performance relate to US Centers for Medicare & Medicaid Services (CMS) requirements.

Current E-dition users can access a 30-minute E-dition Modernization Training session highlighting the new features and functions here.

2023 Sentinel Event Data Available

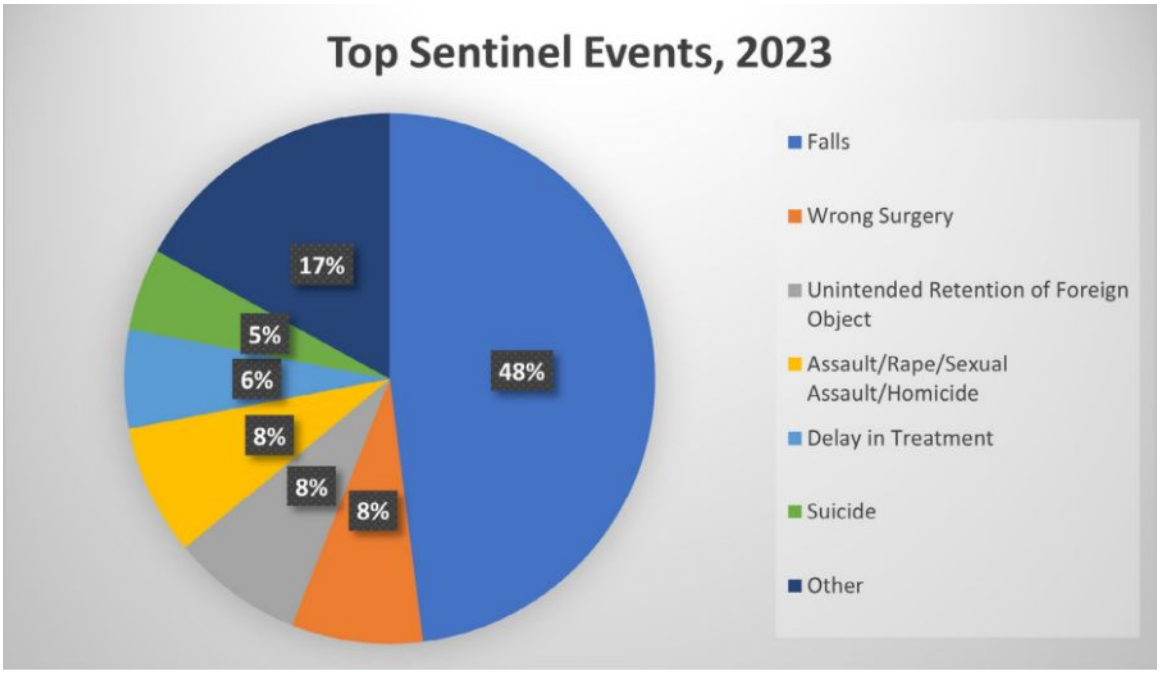
A *sentinel event* is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that results in death, permanent harm, or severe temporary harm. Sentinel events are debilitating to both patients and health care providers. The Joint Commission works closely with its organizations to address sentinel events and to prevent these types of events from occurring in the first place.

The Joint Commission's Sentinel Event Database includes de-identified data collected and analyzed from the review of sentinel events and subsequent comprehensive systematic analyses, such as root cause analyses, voluntarily submitted by health care organizations to The Joint Commission's Office of Quality and Patient Safety (OQPS). Upon receiving notice of a sentinel event, patient safety specialists within OQPS help the organization conduct a credible and thorough analysis to identify causative factors and implement relevant system solutions to prevent harm to patients. By partnering with OQPS, the organization receives an independent review of the event, insights from reviews of similar events, and suggestions for improvement strategies that have been successfully employed in other health care organizations.

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Between January 1, 2023, and December 31, 2023, The Joint Commission reviewed 1,411 sentinel events; the majority of these—96% (1,358)—were voluntarily self-reported to The Joint Commission by an accredited or certified entity. The remaining 53 sentinel events were reported either by anonymous sources, patients (or their families), or employees (current or former) of the organization.

The most prevalent event types identified in 2023 are shown in the figure below.



Reporting sentinel events to The Joint Commission is a voluntary process, and, as such, epidemiological inferences are not reliable. No conclusions should be drawn about the actual relative frequency of events or trends in events over time.

The *Sentinel Event Data 2023 Annual Review* can be downloaded here. In addition, the August issue of *The Source* will cover the top sentinel event—patient falls—in depth, including risk factors for patient falls and prevention strategies.

HHS Unveils Task Force on Maternal Mental Health

The United States has the highest maternal mortality rate among high-income countries; deaths related to mental health and substance use account for 22% of these deaths. (*See* the February issue of *The Source* for an in-depth discussion on strengthening supports for maternal mental health.) In response to this public health crisis, the US Department of Health and Human Services (HHS) recently announced a national strategy to address maternal mental health and substance use issues, with recommendations from the Task Force on Maternal Mental Health. It also released a Report to Congress aimed at guiding efforts to implement the national strategy.

"At HHS we are working every day to transform behavioral health. This critically includes providing support for maternal mental health," says HHS Deputy

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Secretary Andrea Palm. “This report, and the accompanying National Strategy, will further our efforts to improve access to care—including the integration of perinatal behavioral health care across our health and social systems.”

The five pillars of the national strategy focus on the following:

1. Building a national infrastructure that prioritizes perinatal mental health and well-being, with a focus on reducing health care disparities
2. Making care and services accessible, affordable, and equitable
3. Using data and research to improve outcomes and accountability
4. Promoting prevention and engaging, educating, and partnering with communities
5. Lifting up the voices of people with lived experience

A free Maternal Mental Health Hotline is available 24 hours a day, 7 days a week to provide mental health support before, during, and after pregnancy. The hotline can be reached at 1-833-TLC-MAMA (1-833-852-6262).

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Other Learning Opportunities

FROM THE JOINT COMMISSION AND JOINT COMMISSION RESOURCES

JCR Live Events

Hospital Accreditation Essentials with Tracers and Data Analysis (August 6–8, 2024). This three-day in-person seminar is designed to provide you with practical solutions and implementation tips. It sets the stage for a successful survey and for building a framework to deliver the highest level of patient safety and care. You will learn how to conduct tracers in your organization by participating in case study discussions and program-specific tracers.

Hospital Executive Briefing (September 10, 2024). Available either in person or via live webcast, the Hospital Executive Briefing will share data-driven observations, trends, themes, and advice based on aggregate survey data and Joint Commission leadership experience. Hear from Joint Commission officers and subject matter experts on critical topics.

Hospital CMS Update (September 11, 2024). Available either in person or via live webcast, this educational program is designed to provide health care professionals with key information necessary to navigate the challenging aspects of the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation for hospitals. CMS experts from Joint Commission Resources will offer tips and compliance strategies to help you and your organization fulfill CMS requirements. This program is geared toward individuals who already have a working knowledge of CMS compliance issues.

Hospital Accreditation Essentials (October 8–10, 2024). This live webcast is designed to provide practical solutions and implementation tips to help you set the stage for a successful survey and build a framework to deliver the highest level of patient safety and care.

Behavioral Health and Human Services Conference (October 24–25, 2024). At this annual event, you will take part in sessions on the hottest behavioral health care and human services topics and will gain a better understanding of upcoming changes at The Joint Commission that will be helpful to your organization maintaining compliance in 2025.

Primary Care Medical Home Certification Conference (November 6, 2024). Designed to provide health care professionals with strategies and insights to help their organizations successfully achieve Primary Care Medical Home (PCMH) certification, this program will provide the answers, tips, tools, and guidance necessary for your organization to obtain and/or maintain PCMH certification.

Ambulatory Care Conference (November 7–8, 2024). This two-day educational program will help your organization maintain or achieve ambulatory care accreditation with The Joint Commission. It promises to be a content-rich program that also recognizes the value of patient safety, quality, and process improvements in ambulatory care settings.

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Online Learning Opportunities

Joint Commission Resources offers several virtual workshops and training opportunities for today's health care leaders.

Green Belt Certification Training Program. Achieve your Green Belt certification through our new training program for individuals and small teams. Featuring expert faculty with significant experience in applying the systematic approach of Robust Process Improvement® (RPI®), the Green Belt Certification Training Program incorporates a blended approach of Lean, Six Sigma, and change management specifically within health care settings.

Facilitating Change: Leading Through Formal Change Management Methods. Change management is a critical competency for all health care leaders in today's environment. Health care leaders are faced daily with the need to lead, support, and drive change. This training is designed to equip leaders with the tools and methods to get buy-in, acceptance, and accountability in this ever-changing environment.

On-Demand Programs



2024 Breakfast Briefings Webinar Series. Educate your staff and maximize your budget by having your whole team participate in this opportunity while earning continuous education credit. Gather everyone together for a complete overview of the standards, chapter by chapter, including any changes or anticipated changes to the survey process. Available for the following programs:

- Ambulatory Care
- Behavioral Health Care and Human Services
- Hospital

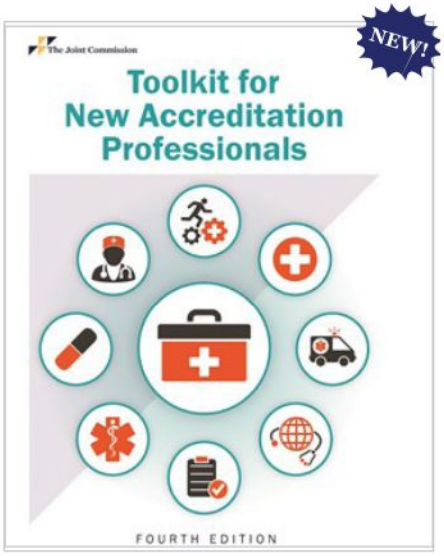
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DIGITAL LEARNING CENTER

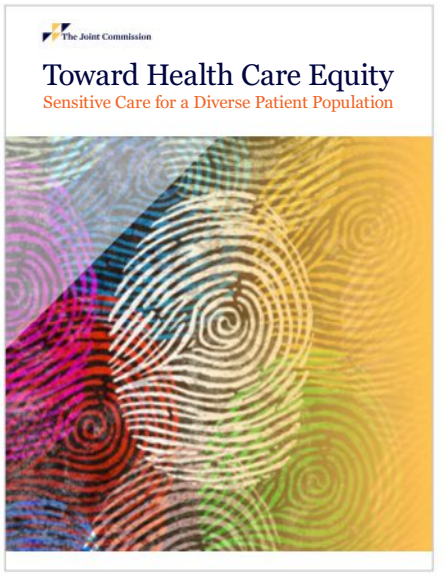
Be sure to check out JCR's Digital Learning Center (DLC) for top webinars, videos, all JCR e-books, select peer-reviewed articles from *The Joint Commission Journal on Quality and Patient Safety*, *PolicySource,*™ digital newsletters—including *The Source*—and other resources. This subscription-based virtual learning service provides self-paced education and allows staff to customize their learning experience. Content is developed, curated, and regularly updated by JCR subject matter experts.

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Must-Have JCR Books



Toolkit for New Accreditation Professionals, Fourth Edition, leads both new and seasoned accreditation professionals through The Joint Commission accreditation process. It introduces the key concepts that make up Joint Commission standards, with activities and downloadable tools to help you apply the concepts in your everyday responsibilities.



Toward Health Care Equity: Sensitive Care for a Diverse Patient Population aims to help health care providers learn more about the diverse populations they serve by providing basic knowledge and awareness about the myriad ways in which their patients are diverse. This guide also encourages health care providers to recognize and address their own and systemic health care biases and to reject assumptions or stereotypes about individuals or groups. With learning comes awareness and, hopefully, understanding, respect, sensitivity, and equitable care for every patient.



2024 PolicySource™ features dozens of downloadable sample policies and procedures required by Joint Commission standards, reviewed and approved by The Joint Commission. It is available as an e-book for the following settings: hospital/critical access hospital, behavioral health care and human services, home care, ambulatory care/office-based surgery, laboratory, and nursing care center/assisted living community.

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2024 Conferences and Seminars



Take a look at our upcoming education events

August 6-8 2024
Hospital Accreditation Essentials with Tracers and Data Analysis - In-person

August 20-21, 2024
Environment of Care Base Camp - In-person or Live webcast

August 22-23, 2024
Exploring the Life Safety Chapter- In-person or Live webcast

September 10, 2024
Hospital Executive Briefing- In-person or Live webcast

September 11, 2024
Hospital CMS Update In-person or Live webcast

October 8-10, 2024
Hospital Accreditation Essentials - Live webcast

October 24-25, 2024
Behavioral Health Care and Human Services Conference - In-person

November 6, 2024
Primary Care Medical Home Certification Conference - In-person

November 7-8, 2024
Ambulatory Care Conference - In-person

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2024 PolicySource™ E-books

Ensure that your policies and procedures comply with Joint Commission standards



The 2024 *PolicySource* e-books offer a collection of downloadable sample P&Ps that are organized by and correlated to Joint Commission standards to help you comply with accreditation requirements.

Currently available for Hospital/Critical Access Hospital; Behavioral Health Care and Human Services; Home Care; Ambulatory Care/Office-Based Surgery; Laboratory; and Nursing Care Center/Assisted Living Community.

Learn more at https://store.jcrinc.com/2024-policysource-pandps-for-compliance-with-joint-commission-requirements/

JCR is an expert resource for health care organizations, providing advisory services, educational services, software and publications to assist in improving quality and safety and to help in meeting the accreditation standards of The Joint Commission. JCR provides advisory services independently from The Joint Commission and in a fully confidential manner.

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