The Joint Commission

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Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

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NEW: Responsible Use of Health Data Certification Program

The Joint Commission has developed a new voluntary **Responsible Use of Health Data** (RUHD) **Certification** program **effective January 1, 2024**, for **hospitals**. Protecting patient privacy is a foundational element of a strong data use policy. This new certification will provide guidance and recognize health care organizations that are navigating the sensitivities needed to safely use data for purposes beyond clinical care—also known as secondary use of data.

Based on principles from the Health Evolution Forum's "The Trust Framework for Accelerating Responsible Use of De-Identified Data in Algorithm and Product Development," the certification program provides an objective verification of these principles. These principles promote the responsible use of health care data by providing a framework for health care organizations to have policies and procedures in place regarding transparency, limitations of use, and patient engagement. The standards cover the de-identification process, data controls, limitations on use, algorithm validation, patient transparency, and oversight structure.

RUHD certification is available to all Joint Commission–accredited hospitals and non-Joint Commission–accredited hospitals that comply with applicable federal laws, including US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation.

For questions regarding RUHD certification requirements, please contact the Department of Standards and Survey Methods. For information on obtaining RUHD certification, contact Business Development.

Disclaimer

RUHD certification provides an assessment on a health care organization's commitment to protecting secondary use of de-identified health data through focused policies and procedures. A health care organization is fully responsible for its own expert analysis and confirmation that it is properly following laws, rules, and regulations related to development of any referenced policies and procedures around data use and transfer.

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The Joint Commission Recognizes Organizations for Contributing to 2023 Performance Measure Initiatives and Projects



In 2023 many accredited health care organizations assisted The Joint Commission in further strengthening performance measurement and quality improvement. This article shares information on these activities and thanks these organizations for their support and participation.

Joint Commission Accelerate PI™ (Performance Improvement) Webinar Series

The Joint Commission webinar series provides an opportunity for organizations to learn about important aspects of performance improvement. The tools, resources, and examples are intended to assist organizations with quality improvement initiatives that lead to consistent, high-quality patient care. The first webinar focused on stratification of key patient safety and quality measures to examine health care disparities and assist organizations on the journey to health care equity, regardless of where they are on the path. The second webinar shared resources and real-life examples of identifying and engaging physician leaders in quality improvement efforts.

2023 Accelerate PI Webinar Contributors

- **Using Data to Identify Disparities Across Patient Groups**
  - **Missouri Hospital Association** – Jefferson City, Missouri
  - **University Health** – Kansas City, Missouri
- **Physicians Engagement in Quality Improvement**
  - **Wisconsin Hospital Association** – Fitchburg, Wisconsin

Additional information (for example, recordings, presentation slides) about Accelerate PI and other quality measurement webinars/video webinars can be found on The Joint Commission's Quality Measurement Webinars & Videos page.

Joint Commission Patient Safety and Hospital Harm eCQMs Pilot Testing in Collaboration with the AIR

The Joint Commission, in collaboration with the American Institutes for Research (AIR), engaged organizations to pilot test patient safety and hospital harm electronic clinical quality measures (eCQMs). These organizations assisted in developing important measure-related initiatives, including data collection, feasibility, reliability, and/or validity measure testing. The Joint Commission thanks these organizations for their valuable participation.

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2023 Patient Safety and Hospital Harm eCQMs Pilot Testing Contributors

- **Northwell Health** – New Hyde Park, New York
- **Loma Linda University Health** – Loma Linda, California
- **Hackensack Meridian Mountainside Medical Center** – Montclair, New Jersey
- **Maria Parham Health** – Henderson, North Carolina
- **Hospital Menonita Guayama** – Guayama, Puerto Rico
- **East Alabama Medical Center** – Opelika, Alabama

Joint Commission Early Access of CY 2023 DDSP eCQM Module and Chart-Abstracted Measure (CAM) Module

The Joint Commission recognizes the following organizations, which participated in the early access and testing of the calendar year (CY) 2023 Direct Data Submission Platform (DDSP) prior to its launch. These organizations provided valuable feedback, which assisted with the successful launch of DDSP updates.

2023 Early Access and Testing of DDSP eCQM and CAM Module Contributors

- **Northwest Community Hospital** – Arlington Heights, Illinois
- **University of Alabama at Birmingham** – Birmingham, Alabama
- **North Alabama Medical Center** – Florence, Alabama
- **RCHP Florence, LLC** – Muscle Shoals, Alabama
- **RHN Scott Memorial Health** – Scottsburg, Indiana
- **Spring View Hospital** – Lebanon, Kentucky
- **DLP Person Memorial Hospital, LLC** – Roxboro, North Carolina
- **DLP Rutherford Regional Health System, LLC** – Rutherfordton, North Carolina
- **DLP Wilson Medical Center, LLC** – Wilson, North Carolina
- **Southern Tennessee Medical Center, LLC** – Winchester, Tennessee
- **Essent PRMC, LP** – Paris, Texas
- **Danville Regional Medical Center, LLC** – Danville, Virginia
- **Clinch Valley Medical Center** – Richards, Virginia
- **Fauquier Medical Center, LLC** – Warrenton, Virginia
- **Wythe County Community Hospital, LLC** – Wytheville, Virginia
- **RCCH Trios Health, LLC** – Kennewick, Washington
- **Newark Beth Israel Medical Center** – Newark, New Jersey
- **Cookeville Regional Medical Center** – Cookeville, Tennessee
- **Ronald Reagan UCLA Medical Center** – Los Angeles, California
- **Henry County Medical Center** – Paris, Tennessee
- **Willamette Valley Medical Center** – McMinnville, Oregon
- **Pinelake Regional Hospital** – Mayfield, Kentucky
- **Westpark Springs, LLC** – Richmond, Texas
- **Raleigh General Hospital, LLC** – Beckley, West Virginia
- **Kempsville Center for Behavioral Health** – Norfolk, Virginia
- **UHS of Wyoming, Inc.** – Casper, Wyoming
- **River Park Hospital** – Huntington, West Virginia P

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APPROVED: CMS Renews Joint Commission's Deeming Authority for Home Infusion Therapy

In the December 14, 2023, *Federal Register*, the US Centers for Medicare & Medicaid Services (CMS) announced that it renewed The Joint Commission's deeming authority for **home infusion therapy** effective December 15, 2023, through December 15, 2029.

Home infusion therapy suppliers that want to obtain Medicare reimbursement for the nursing component of that service must be accredited by an accrediting organization that has been awarded deeming authority for home infusion therapy by CMS. There is no state survey option for home infusion therapy suppliers, so accreditation on its own is the only means of satisfying the reimbursement requirement. If organizations are not accredited by an approved accrediting organization, they will not qualify for or receive reimbursement from CMS for the nursing component of the home infusion therapy service.

Home infusion therapy involves professional services (including nursing services) provided in accordance with a physician-established plan of care that describes the type, amount, and duration of infusion therapy services to be furnished. A qualified home infusion therapy supplier provides infusion therapy to patients needing it for acute or chronic conditions. The home infusion therapy supplier also offers patient training and education and remote monitoring services 24 hours a day, 7 days a week.

Organizations that are not currently accredited, but interested in obtaining Medicare reimbursement for the nursing component of the home infusion therapy service must participate in an unannounced home care survey and achieve a decision of "Accredited" prior to submitting requests for reimbursement.

For more information, please contact Brenda Lamberti.

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The Joint Commission Announces New Officers

Recently, The Joint Commission enterprise announced the following two appointments to its executive leadership team:

1. Leslie Krohn, MS, has been named Executive Vice President and Chief Brand and Communications Officer.
2. Jason Miles has been named Vice President and US Commercial Officer.

Krohn's appointment was effective December 11, 2023, and Miles's appointment was effective December 4, 2023.

"We are excited to welcome these two innovative leaders to help The Joint Commission enterprise advance its mission to elevate patient safety, quality improvement, and equitable care," says Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, President and Chief Executive Officer, The Joint Commission. "The wealth of expertise and skills they both bring will increase awareness of The Joint Commission enterprise as a leader in health care as we expand our ability to serve the health care industry and address its key concerns."

Leslie Krohn, Executive Vice President and Chief Brand and Communications Officer



Krohn is a communications leader with experience in strategic internal and external communications, branding, reputation management, and thought leadership through traditional, digital, and social media channels. In her new role, Krohn will help The Joint Commission enterprise advance its patient safety and quality improvement initiatives. She will set direction for and manage message creation and alignment, corporate and executive communications, issues and crisis management, and more. In addition, she will oversee digital communications, including the enterprise's websites and multimedia channels.

Previously, Krohn was Chief Communications Officer at Argonne National Laboratory, where she elevated the organization's profile and reputation regionally, nationally, and internationally. During her tenure with Argonne, Krohn received two Argonne Board of Governors Awards in 2020 for her leadership in diversity and inclusion, and safety during the COVID-19 pandemic.

In addition, she held leadership positions in communications and marketing at Nielsen, Tyson Foods (formerly Sara Lee Corporation), and GE Healthcare Financial Services. She earned a master's degree in integrated marketing communications at Northwestern University's Medill School of Journalism and a bachelor's degree in American studies from the University of Notre Dame.

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Jason Miles, Vice President and US Commercial Officer



Miles is a dedicated health care executive with experience bringing valued offerings to organizations seeking improvements to their operations and outcomes. In his new role, Miles will shape The Joint Commission's US business development strategy. In addition, he will oversee US marketing and state and payor relations.

Previously, Miles was with Woodson Equity following leadership roles at Abbott Diagnostics, IBM Watson Health, and Merge Healthcare. In these roles, he oversaw sales, customer relationships, marketing, finance, and strategic partnerships. Miles is a 10X President's Club winner and received multiple recognition awards at Abbott, IBM Watson Health, and Merge Healthcare. He received his bachelor's degree from Michigan State University with a business emphasis.

The August 2023 issue of *Perspectives* announced other Joint Commission officer appointments. For more information about the executive team, visit the Joint Commission Officers page on The Joint Commission's website.

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Consistent Interpretation

Joint Commission Surveyors' Observations Related to Kitchen Fire-Suppression Systems

The **Consistent Interpretation** column helps organizations to comply with specific Joint Commission requirements. Each installment of the column draws from a database of surveyors' de-identified observations (left column) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on interpreting the observations (right column).

The requirements in this column are not necessarily those with high rates of noncompliance. Rather, they have the potential to negatively affect care or create risk if 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 apply to hospitals; however, the guidance may be extrapolated to apply to other accreditation programs with similar services and populations served.

This month, **Consistent Interpretation** focuses on several requirements related to fire-suppression systems in areas with commercial-grade grease-producing appliances.

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

Life Safety (LS) Standard LS.02.01.35: The hospital provides and maintains systems for extinguishing fires.	
EP 10: The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed either in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 18/19.3.5.12; 9.7.4.1; NFPA 10-2010: 6.2.1.1; 6.1.3.3.1; 6.1.3.4; 6.1.3.8)	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **18.72%**—that is, **283** of **1,512** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	Fire extinguishers are intended for staff use when a fire is small and somewhat contained. In addition, they must be readily available for use if a fire ignites. To ensure quick access, fire extinguishers should be spaced not less than 75 feet from any point in the building. Regarding this 75-foot distance, this requirement states, "travel distance from any point." This could include being within 75 feet of staff access. In such a case, spacing a fire extinguisher every 75 feet down a corridor would not be adequate. This standard also addresses properly installing fire extinguishers on a wall or storing in a cabinet, as is allowed under certain provisions. If mounted on the wall, fire extinguishers must be secured on a hanger designed for the extinguisher. This will prevent the extinguisher from being bumped off the hanger. In addition, the fire extinguisher should not hang fewer than 4 inches from the floor. For those fire extinguishers that weigh 40 pounds or less, the top should not exceed 60 inches (5 feet) from the floor. If stored in a cabinet, there must be an appropriate sign or placard to identify where the fire extinguisher is. For example, a tented sign may be mounted above the cabinet.

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Surveyor Observations	Guidance/Interpretation
• A fire extinguisher was mounted higher than 60 inches (5 feet) from the floor to the top of the extinguisher. • A mostly recessed fire extinguisher cabinet was not visible and did not have a sign to indicate the fire extinguisher's location that was visible when looking down the corridor. • The key to access the fire extinguisher cabinet was not available and staff could not access the key. • A labeled fire extinguisher cabinet did not contain a fire extinguisher. • The travel distance between fire extinguishers was greater than 75 feet.	• A fire extinguisher in a cabinet mounted higher than 60 inches (5 feet) from its top to the floor complies with this requirement if the organization has a letter from its fire marshal stating it is acceptable. • Cite here, at Standard LS.02.01.35, EP 10, if the fire extinguisher is mounted higher than 60 inches (5 feet) with a clamp.

EP 11: Class K–type portable fire extinguishers are located within 30 feet of grease-producing ranges, griddles, broilers, or cooking appliances that use vegetable or animal oils or fats, such as deep fat fryers. A placard is conspicuously placed near the extinguisher stating that the fire protection system should be activated prior to using the fire extinguisher. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.10.2; NFPA 10-2010: 5.5.5; 6.6.2) R

Compliance Rate	In 2022, the noncompliance percentage for this EP was **4.70%**—that is, **71** of **1,512** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	In most areas of an organization, portable fire extinguishers are used as soon as required to put out a fire. However, in a kitchen with commercial cooking equipment, this requirement states that a sign must be posted explaining the slightly different sequence when using and operating a Class K–type portable fire extinguisher. Prior to using a K–type fire extinguisher, the primary fire-suppression system should be activated. In addition, The Joint Commission requires training for all staff members expected to use this type of fire extinguisher. The Class K–type fire extinguisher is designed specifically for combustible cooking media, such as animal or vegetable oils and fats. These wet-chemical extinguishers are intended to form a thick "skin" (saponify) over the grease fire to contain the fire until it is extinguished. Class K–type fire extinguishers must be located within 30 feet of grease-producing ranges, griddles, broilers, or cooking appliances that use animal or vegetable oils or fats, such as deep fat fryers. A placard must be conspicuously placed near the fire extinguisher stating that the fire-protection system should be activated *prior* to using it. Refer to National Fire Protection Association (NFPA) 10-2010: Figures A.5.5.5.3(a) and (b) for recommended Class K fire extinguisher placard wording. In addition to posting the placard, staff training is key to ensure that the proper sequence of events is followed. The fire-suppression system should be activated first so that the fire alarm is activated, first responders are notified, and the gas supply (fuel) is turned off. *See also* LS.02.01.35, EP 13. Following the proper steps significantly reduces the chance that a fire escalates and reduces the time before first responders can assist in containing the fire.

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Surveyor Observations	Guidance/Interpretation
• The required Class K fire extinguisher sign was not placed with the extinguisher. • There was no Class K fire extinguisher for the grill in the cafeteria outside the kitchen.	• The required placard must be in the same location as the fire extinguisher. • Class K fire extinguishers must be within 30 feet of grease-producing appliances. NFPA 10 does not mandate that a Class K fire extinguisher is necessary for each location where grease-producing appliances are used. • A fire-suppression system and Class K fire extinguisher are required only for commercial cooking equipment; do not cite here, at LS.02.01.35, EP 11, for residential-style appliances. • Cite at Environment of Care (EC) Standard EC.02.03.01, EP 1,* if a Class K fire extinguisher and/or sign are not present in a business occupancy where grease-producing appliances are used.

EP 12: Grease-producing cooking devices such as deep fat fryers, ranges, griddles, or broilers have an exhaust hood, an exhaust duct system, and grease removal devices without mesh filters. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 6.1)

Compliance Rate	In 2022, the noncompliance percentage for this EP was **6.42%**—that is, **97** of **1,512** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	Grease can be trapped in mesh filters, and attempting to clean these filters that may still contain grease is a potential fuel source for a fire. To eliminate this fire hazard, mesh filters are prohibited in areas where grease may collect, including above deep fat fryers, ranges, griddles, and broilers. Using a form of baffle to collect grease-laden vapors from the exhaust and drain it into a container for cleaning and disposal is one alternative to mesh filters. The management of airborne grease includes a required exhaust hood and an exhaust duct system. The duct system is made of a heavier-gauge material (with liquid-tight welds) than conventional heating and cooling ductwork. The heavier material protects the occupants by containing the grease by-products and directing them to a safe location.

Surveyor Observations	Guidance/Interpretation
• The kitchen hood grease baffles were covered with a heavy accumulation of grease and were not on a cleaning schedule. • The grease baffles in the kitchen hood had excessive gaps (greater than 1/2 inch) between the baffles.	• NFPA 96-2011 requires that the suppression system covers the grease-producing equipment properly and baffles are placed securely.

EP 13: The automatic fire extinguishing system for grease-producing cooking devices does the following: deactivates the fuel source, activates the building fire alarm system, and controls the exhaust fans as designed. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.4; 10.6.1; 10.6.2; 8.2.3)

Compliance Rate	In 2022, the noncompliance percentage for this EP was **1.06%**—that is, **16** of **1,512** hospitals surveyed did not comply with this requirement.

* Standard **EC.02.03.01, EP 1**: The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. R

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Noncompliance Implications	When a fire ignites, automatic fire extinguishing systems for grease-producing cooking devices do the following three activities: 1. Remove the fuel source 2. Activate the building fire alarm system to alert occupants 3. Control air movement using the exhaust fans The fuel source must be removed when a fire ignites to prevent reignition and requires a manual reset. After the cooking oil has properly cooled, the manual reset should reduce the chance that it reignites. Depending on the system design, exhaust fans may either shut down or ramp up. To ensure that the system works efficiently, it must be properly maintained and tested. *See also* Standard EC.02.03.05, EP 13.*

Surveyor Observations	**Guidance/Interpretation**
● The kitchen hood automatic fire-extinguishing system for grease-producing cooking devices did not activate the building fire alarm system. ● The kitchen hood extinguishing system's pull station was mounted higher than 48 inches, which did not meet the NFPA 72-2010, 17.14.4, requirement for pull stations to be mounted not less than 42 inches and not higher than 48 inches from the floor.	● If this is an existing system approved by the authority having jurisdiction, do not cite an extinguishing system with a pull station higher than 48 inches.

Standard LS.02.01.50: The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.	
EP 1: Equipment using gas or gas piping complies with NFPA 54-2012, National Fuel Gas Code; electrical wiring and equipment complies with NFPA 70-2012, National Electric Code. Existing installations can continue in service provided there are no life-threatening hazards. (For full text, refer to NFPA 101-2012: 18/19.5.1.1; 9.1.1; 9.1.2)	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **3.84%**—that is, **58** of **1,512** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	NFPA 54-2012, 9.6.1.2 states that kitchen appliances must have a restraint or tether. This component is necessary to prevent accidentally pulling and breaking the flexible gas line connection—resulting in the release of natural gas into the kitchen. The tether may be removed after moving the appliance away from the wall to facilitate cleaning. The tether must be reattached when the appliance is moved back into position.

Surveyor Observations	**Guidance/Interpretation**
● The cooking equipment mounted on casters in the kitchen did not have the required restraining devices attached.	● Kitchen appliances are required to have restraints or tethering to prevent excessive force from being applied to a gas connector, which can lead to a connector failure over time. This is specified in NFPA 54-2012, 9.6.1.2.

* Standard **EC.02.03.05, EP 13**: Ⓓ Every 6 months, the hospital inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented.

Note 1: *Discharge of the fire-extinguishing systems is not required.*

Note 2: *For additional guidance on performing inspections,* see *NFPA 96-2011: 11.2.*

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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 **January 2024** 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.

Tell your performance improvement story! Consider submitting an article to *The Joint Commission Journal on Quality and Patient Safety*. See website for author guidelines.

Note: As part of the 50th anniversary celebration of *The Joint Commission Journal on Quality and Patient Safety* in 2024, the January issue is a fully open access special issue about diversity, equity, and inclusion in health care. Click on the titles that follow to view each article in its entirety.

Editorial

1 Achieving Health Care Equity Requires a Systems Approach

D.W. Baker

The goal of achieving equal access, quality, safety, and outcomes for all is complex and daunting. In this editorial reflecting on the new research published in the *Journal*'s special issue on health care equity, Baker discusses the clear need for systems approaches to address these challenges.

Adverse Events

6 Investigating Racial and Ethnic Disparities in Maternal Care at the System Level Using Patient Safety Incident Reports

M.C. Alfred; D. Wilson; E. DeForest; S. Lawton; A. Gore; J.T. Howard; C. Morton; L. Hebbar; C. Goodier

Maternal mortality in the United States is high, and women and birthing people of color experience higher rates of mortality and severe maternal morbidity. More than half of maternal deaths and cases of severe maternal morbidity are considered preventable. Alfred and colleagues reviewed and statistically analyzed incidents reported in the labor and delivery and antepartum and postpartum units of a large academic hospital in 2019 and 2020 for differences across racial/ethnic groups.

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Process Improvement

16 Documentation of Disability Status and Accommodation Needs in the Electronic Health Record: A Qualitative Study of Health Care Organizations' Current Practices

M.A. Morris; C. Sarmiento; K. Eberle

Individuals with disabilities face significant disparities in health outcomes and health care access. Systematic documentation of patients' disabilities and accommodation needs is a crucial first step to identifying and addressing potential care disparities in health care organizations. In this study, Morris and colleagues conducted qualitative interviews with health care organizations with active or past initiatives to implement systematic collection of disability status in the electronic health record.

24 Leveraging Technology and Workflow Optimization for Health-Related Social Needs Screening: An Improvement Project at a Large Health System

N. Angah; B. Meedzan; N. Pruzinsky; A. O'Connell; L. Hart; D. Cobbs-Lomax; P. Vanderwoude

Social conditions that shape daily life have a significant impact on health outcomes, but screening for nonmedical data–referred to as health-related social needs (HRSN)–remains suboptimal. To improve HRSN screening rates, Angah and colleagues developed and tested a standard screening questionnaire and systems to collect HRSN for hospitalized patients and those in ambulatory care practices across a large health system.

34 Addressing Veteran Health-Related Social Needs: How Joint Commission Standards Accelerated Integration and Expansion of Tools and Services in the Veterans Health Administration

J.M. List; L.E. Russell; L.R.M. Hausmann; K. Groves; B. Kligler; J. Koget; E. Moy; C. Clancy

The Joint Commission recently named reduction of health care disparities and improvement of health care equity as quality and safety priorities. The Veterans Health Administration (VHA) sought to leverage these new accreditation standards to further integrate and expand existing tools and initiatives to reduce health care disparities and address health-related social needs (HRSN). In this conceptual article, List and colleagues share how strategies to address veteran HRSN and health care disparities within VHA are being integrated to support the new Joint Commission standards.

Review Articles

41 Disparities in Patient Safety Voluntary Event Reporting: A Scoping Review

K. Hoops; E. Pittman; D.C. Stockwell

Voluntary event reporting systems underestimate the incidence of safety events, and the information they capture may be inadequate to characterize disparities in reported safety events. Hoops and colleagues performed a scoping review of the literature related to voluntary event reporting systems to better understand the state of the evidence as it relates to differences in safety events and safety event reporting by age, gender, and race.

49 Embedding Equity into the Hospital Incident Command System: A Narrative Review

R. Moyal-Smith; D.J. Barnett; E.S. Toner; J.A. Marsteller; C.T. Yuan

Health systems plan for and respond to disasters using the Hospital Incident Command System (HICS), an organizational structure that centralizes communication and decision-making. The HICS does not have an equity role or considerations built into its standard structure or implementation. Moyal-Smith and colleagues conducted this narrative review to identify and summarize approaches to embedding equity into the HICS.

Innovation Report

59 Self-Reported Accommodation Needs for Patients with Disabilities in Primary Care

G.E. Buning; T.G. James; B. Richards; M.M. McKee

People with disabilities experience barriers to engaging with health care due to inaccessible social and physical environments at primary care clinics. Despite legal mandates, the identification and provision of necessary accommodations for this population at primary care clinics are poor. In this study, Buning and colleagues administered a questionnaire to assess patient-reported disability status and accommodation needs among patients at a primary care clinic.

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Improvement Brief

66 Multisite Quality Improvement Program Within the Project ECHO Diabetes Remote Network

C.J. Wang; E.M. Lewit; C.L. Clark; F.-S.W. Lee; D.M. Maahs; M.J. Haller; A. Addala; R.A. Lal; N. Cuttriss; L.G. Baer; L.E. Figg; C. Añez-Zabala; E.P. Sheehan; S.C. Westen; A.V. Bernier; W.T. Donahoo; A.F. Walker

The telementoring Project ECHO (Extension for Community Healthcare Outcomes) model has shown promising results in increasing provider knowledge and confidence and improving patient outcomes in many areas, including diabetes. Wang and colleagues recruited 13 clinics in underserved communities to evaluate whether ECHO could also be an effective tool for quality improvement of diabetes care in these communities.

Tool Tutorial

75 Equity and Performance Improvement: A Novel Toolkit That Makes Using an Equity Lens the Default

F.A. Ganz-Lord; P. Beechner; M. Wnorowksi; D. Asante; K. Johnson; J. Bianco; S. Gazivoda; S.K. Forest

Performance improvement methodologies do not currently include any structures that encourage analysis of how bias, inequity, or social determinants of health (SDOH) contribute to outcomes. In this article, Ganz-Lord and colleagues describe the development of a novel quality improvement (QI) toolkit that ingrains issues of diversity, equity, and inclusion and SDOH into a QI fellowship program to ensure inclusion of equity as an integral part of all QI projects and prevent the unintentional exacerbation of existing disparities within each QI project.

Research Letter

83 Improving Communication with Patients with Limited English Proficiency: Non-English Language Proficiency Assessment for Clinicians

L.N. Alarcon; A.M. Ewen; E. Acuña-Martinez; C.C. Cheston

Patients with limited English proficiency continue to face health care disparities, and underutilization of language assistance services to enhance communication, reliance on ad hoc interpretation, and getting by with providers' non-English language skills remain commonplace. In this study, Alarcon and colleagues aimed to adapt a non-validated version of a publicly available scale to streamline proficiency testing and build a more generalizable, evidence-based, and high-value approach to universal non-English language assessment.

Commentary

87 Bringing the Equity Lens to Patient Safety Event Reporting

T.K. Gandhi; L.B. Schulson; A.D. Thomas

Bias and inequity can occur in many areas of the safety event reporting process. In this commentary, Gandhi and colleagues identify issues with patient safety reporting that are strongly connected to inequity and bias and propose approaches health systems may take to mitigate them.

The *Journal is celebrating its* 50th anniversary in 2024! Select previously published *Journal* articles will be available via open access on the 50th Anniversary Open Access Article Collections page.

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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

- New Responsible Use of Health Data Certification program for **hospitals** (*see* page 2 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- Revised restraint and physical hold requirements for **behavioral health care and human services** organizations (field review expected to begin in late February)
- New and revised Infection Prevention and Control (IC) requirements for **assisted living communities**, **home care** organizations, and **nursing care centers** (field review ends February 21)

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

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Safe staffing requirements for **critical access hospitals** and **hospitals**
- New and revised Emergency Management (EM) requirements for **laboratories**
- Revised core requirements for **all disease-specific care programs**
- New workplace violence prevention requirements for **home care** organizations

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