The Joint Commission

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Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

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NEW: Off-Site Review Option for Select DSC Certification Programs

Option Also Available for Palliative Care Recertification

The Joint Commission will begin conducting off-site (virtual) reviews for the following programs reviewed under the ***Comprehensive Certification Manual for Disease-Specific Care***, as well as programs certified under the ***Palliative Care Certification Manual***, with recertification due dates on or after **January 1, 2025**:

- Core disease-specific care programs (*see* the following table for a list of core programs)
- Advanced disease-specific care programs, including the following:
  - Acute Heart Attack Ready
  - Acute Stroke Ready Hospital
- Palliative care program

Organizations seeking initial certification for one or more of the listed programs will have their review conducted on-site. This new off-site review option will be the default model for **every other recertification cycle**. Disease-specific care programs that qualify for this off-site recertification review can request an on-site review by contacting their account executive during application processing. However, core disease-specific care programs that are reviewed with one or more advanced programs must request an on-site review so the core program(s) and advanced program(s) can be reviewed consecutively.

The chart on the next page indicates the available review model for all Joint Commission certification programs.

For questions regarding the off-site review option, please contact your account executive.

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Certification Program	Review Model
● Advanced Disease-Specific Care Programs ❍ Acute Heart Attack Ready ❍ Acute Stroke Ready Hospital ● Core Disease-Specific Care Programs* ❍ Cardiovascular ❍ Gastrointestinal ❍ General Medical ❍ Hematology/Oncology ❍ Neurological ❍ Orthopedic ❍ Pediatric ❍ Physical Medicine/Rehabilitation ❍ Pulmonary ❍ Wound Care ● Health Care Equity ● Palliative Care	Off-site review every other recertification cycle **after** the initial certification
● Advanced Certification in Perinatal Care ● Advanced Disease-Specific Care Programs ❍ Advanced Certification for Spine Surgery ❍ Advanced Certification in Heart Failure ❍ Chronic Kidney Disease ❍ Comprehensive Heart Attack Center ❍ Chronic Obstructive Pulmonary Disease ❍ Comprehensive Stroke Center ❍ Inpatient Diabetes Care ❍ Lung Volume Reduction Surgery ❍ Primary Heart Attack Center ❍ Primary Stroke Center ❍ Thrombectomy-Capable Stroke Center ❍ Total Hip and Total Knee Replacement ❍ Ventricular Assist Device ● Comprehensive Cardiac Center ● Integrated Care ● Medication Compounding ● Patient Blood Management	On-site review **every** recertification cycle, including initial certification
● Maternal Levels of Care Verification	On-site review **every** reverification cycle, including initial verification
● Health Care Staffing Services ● Responsible Use of Health Data ● Sustainable Healthcare	Off-site recertification review **only**, including initial certification review

* For clinical descriptions, *see* Table 1. Core Disease States, Conditions, and Procedures Certified Under Disease-Specific Care Standards, in "The Joint Commission Certification Process" (CERT) chapter of the *Comprehensive Certification Manual for Disease-Specific Care*.

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APPROVED: New and Revised Laboratory Requirements Maintain CMS Alignment

Effective January 1, 2025, The Joint Commission has new and revised requirements for **laboratories** in response to revisions to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations.

On July 11, 2022, the US Centers for Medicare & Medicaid Services (CMS) issued a final rule to update regulations for proficiency testing (PT) analytes and acceptable performance requirements. Amendments to 42 CFR 493.20 and 42 CFR 493.25 were effective August 10, 2022, and addressed in an October 2022 *Perspectives* article. These new and revised requirements address amendments to 42 CFR 493.2 and 42 CFR 493.801 through 493.959 that were effective July 11, 2024. The updates reflect current practice and address the more accurate and precise technology that is being used. The Joint Commission revised Quality System Assessment for Nonwaived Testing (QSA) Standards QSA.01.01.01, Element of Performance (EP) 5, and QSA.01.04.01, EP 1, and developed new Standard QSA.01.01.01, EP 9, to address the updated regulations. The revisions include the following:

- Requiring laboratories to report PT results for microbiology organism identification to the highest level that they report results on patient specimens
- Increasing satisfactory performance for unexpected antibody detection from 80% to 100%
- Clarifying which tests are included in the ban on improper PT referral

In addition to the updated requirements, a new Appendix E will be added to the *Comprehensive Accreditation Manual for Laboratories (CAMLAB)* to capture additional information related to the regulations. The new appendix will include the following regulatory information:

- Comprehensive analytes list as referenced in subpart I, including the 29 new analytes added with this final rule
- Criteria for acceptable performance limits for PT

The new and revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2024 E-dition® update to the *CAMLAB*. For those customers who purchase it, the hard-copy and PDF versions of the 2025 *CAMLAB* will include these new and revised requirements.

For more information, please contact The Joint Commission's Standards and Survey Methods.

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APPROVED: Home Care Survey Process Revised to Align with Updated CMS Guidance

Effective immediately, The Joint Commission made changes to its Home Care Accreditation survey process for **deemed home health agencies**. These changes were incorporated into the August 2024 update of the *Home Care Accreditation Survey Activity Guide* that is available now on the Joint Commission–accredited home care organizations' *Joint Commission Connect*® extranet site. These changes align with the US Centers for Medicare & Medicaid Services (CMS) revisions outlined in memo QSO-24-07-HHA, Revisions to Home Health Agencies (HHA) – Appendix B of the State Operations Manual, published on March 15, 2024.

Organizations will see changes in survey process, including extended interview times with patients, caregivers, family members, and home health staff. In addition, several CMS–required documents have been added to the list of requested documents that must be available during survey.

For more information, please contact The Joint Commission's Standards and Survey Methods.

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APPROVED: "Emergency Management" (EM) Chapter Fully Revised for Laboratories

Effective January 1, 2025, a fully revised "Emergency Management" (EM) chapter, including new and revised EM standards, has been approved for all Joint Commission–accredited **laboratories**. The Joint Commission thoroughly analyzed and rewrote the EM chapter, which resulted in the following:

- Reorganized requirements
- Renumbered standards
- Reduced number of elements of performance (EPs) by more than 28% for laboratories

Please note that these requirements are not applicable if the laboratory is part of a Joint Commission–accredited organization (such as a hospital, critical access hospital, or ambulatory care organization). However, the laboratory must demonstrate how it collaborates with the organization's EM leader(s) about any laboratory-specific needs related to the organization's EM program.

The goal of the EM chapter rewrite is to help health care organizations to develop more comprehensive EM programs and to better prepare for the health, safety, and security needs of their facilities, staff, patient populations, and communities during emergencies or disasters (such as a natural disaster, cybersecurity attack, high-consequence infectious disease, or special pathogen). The new and revised EM requirements clarify and emphasize the following:

- Assessing, applying, and incorporating the hazard vulnerability analysis throughout the entire EM chapter
- Ensuring that organization leaders are involved in and overseeing all aspects of the EM program
- Educating and training staff, with specific guidance for initial and ongoing EM training

The project's program-specific *R³ Report* provides rationales for the requirements as well as references to the research articles and reports used to develop them. In addition to an extensive literature review, the new and revised requirements were developed based on feedback resulting from the pandemic, public field review, expert guidance from a standards review panel, and an internal Joint Commission EM workgroup.

The new and revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2024 E-dition® update to the *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing (CAMLAB)*. For those customers who purchase it, the hard-copy and PDF versions of the 2025 *CAMLAB* will include these new and revised requirements.

For more information, please contact The Joint Commission's Standards and Survey Methods.

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Application Period Open: 2024 John M. Eisenberg Patient Safety and Quality Awards

The Joint Commission and the National Quality Forum (NQF) invite organizations to submit their quality and patient safety improvement initiatives to be considered for the 2024 John M. Eisenberg Patient Safety and Quality Awards. Applications will be accepted via the online platform until October 29, 2024.

For 23 years, this prestigious awards program has recognized major achievements by individuals and organizations that use innovative approaches to improve patient safety and health care quality. The awards honor the late John M. Eisenberg, MD, MBA, former administrator of the Agency for Healthcare Research and Quality (AHRQ), and an impassioned advocate for health care quality improvement.

Applications are accepted for awards in the following three categories:

1. **Individual Achievement**—This award recognizes individuals who have demonstrated exceptional leadership and scholarship in patient safety and health care quality through a substantive lifetime body of work.
2. **National Level Innovation in Patient Safety and Quality**—This award recognizes projects or initiatives that focus beyond local areas to across the country to achieve national impact.
3. **Local Level Innovation in Patient Safety and Quality**—This award recognizes projects or initiatives that focus on a local community, organization, or regional level (for example, statewide).

Eligible organizations will have undertaken successful quality improvement initiatives that make the environment of care safer or that advocate on the patient's behalf. Such initiatives could address new technologies, protocols and procedures, education, organizational culture, legislation, patient advocacy, systems theory, or another area. Health care organizations submitting applications must provide data showing a baseline for the start of the project or initiative and evidence of sustained improvement for no fewer than 12 months.

Additional information on the John M. Eisenberg Patient Safety and Quality Awards, including application previews for the National/Local Initiatives and Individual Achievement categories (respectively), a tipsheet to assist with application submission, and the link to the online application, is available on The Joint Commission's website. P

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The Joint Commission Enterprise Recognizes World Patient Safety Day

In an early September 2024 statement, The Joint Commission and Joint Commission International (JCI) recognized the annual World Patient Safety Day observance sponsored by the World Health Organization (WHO). By participating in this observance on September 17, 2024, The Joint Commission enterprise recommitted to its purpose to ensure that people always experience the safest, highest-quality, health care across all settings globally.



Dressed in orange to support World Patient Safety Day, Joint Commission staff gathered at their Oakbrook Terrace, Illinois, headquarters.

This year WHO's focused topic is improving diagnosis for patient safety. Data indicate that 16% of patient harm stems from delayed, wrong, and/or missed diagnoses—or simply failing to communicate a diagnosis. There are many contributing factors to this topic, including but not limited to biases, staff shortages, and errors in judgment.

To contribute to improved patient outcomes worldwide, The Joint Commission and Joint Commission International will unite with stakeholders through the HELP Agenda to ensure that the more than 23,000 health care organizations and programs across more than 70 countries will provide patients with the safest care. The HELP Agenda will address safety challenges that affect health care organizations, including the following diagnostic safety topics:

- **Health Care Equity**—The Joint Commission stands for health care equity. Patients with worse social determinants of health may have less access to health care systems that can provide the correct diagnosis. The Joint Commission's health care equity standards—including National Patient Safety Goal 16 and the Health Care Equity certification program—introduced in the United States in 2023, challenge providers to address these disparities in care (*see* the January 2023 issue of *Perspectives*).
- **Environmental Sustainability**—The Joint Commission encourages health care organizations to pursue sustainability. According to WHO, 3.6 billion people worldwide already live in areas that are highly susceptible to climate change. Health care organizations serving these areas must become resilient to these effects to continue caring for and diagnos-

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ing patients. In January 2024 The Joint Commission launched the Sustainable Healthcare Certification for health care organizations in the United States (*see* the October 2023 issue of *Perspectives*), and in early September JCI and the Geneva Sustainability Centre (GSC) announced the JCI-GSC Health Care Sustainability Certification to advance sustainable health care throughout the world. Both programs provide structure and validation to decarbonization and resiliency efforts.

- **Learning**—The Joint Commission values the responsible use of health data as they accelerate the use of artificial intelligence (AI) and algorithms that enhance safety and quality. To guide health care organizations in their use of patient data for AI in 2021, WHO published its first global report on AI in health and outlined six principles to guide its use—for diagnosis and beyond.
- **Performance Integration and Improvement**—The Joint Commission advocates for consistent measures and reduced complexity, so the emphasis is on better care, not competing measures. For example, a health care organization's performance against timely and accurate diagnosis measures can be monitored and improved.

For more information about The Joint Commission's commitment to improving diagnosis for patient safety, visit its World Patient Safety Day page.



The Joint Commission's Central Office was lit orange in mid-September to shows its support for World Patient Safety Day.

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Consistent Interpretation

Joint Commission Surveyors' Observations Related to the Importance of Having a Continuity of Operations Plan

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 the importance of having a written continuity of operations plan, including describing prioritized hazards.

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

Emergency Management (EM) Standard EM.13.01.01: The hospital has a continuity of operations plan. **Note:** *The hospital considers its prioritized hazards identified as part of its hazard vulnerability analysis when developing a continuity of operations plan.*	
EP 1: Ⓓ The hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. **Note:** *The COOP provides guidance on how the hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.*	
Compliance Rate	In 2023, the noncompliance percentage for this EP was **1.30%**—that is, **18** of **1,385** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	A continuity of operations plan (COOP) is vital for an organization to reduce the negative effects from operational disruptions (such as power failures or cyberattacks) and natural disasters that fully halt an organization's ability to provide medical care and treatment. In such instances, the lack of a COOP may lead to compromised patient care and safety, as well as financial losses and damage to an organization's reputation because it was not able to provide continuous care during crises. Many health care organizations are required to have a COOP to comply with various regulations. In addition to the potential consequences previously stated, organizations may face legal action for not have a COOP. A COOP provides structure so an organization can better coordinate staff and resources during an emergency so that it can still provide safe patient care.

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Surveyor Observations	Guidance/Interpretation
● There was no COOP. ● The COOP did not describe how the hospital will continue to perform its essential business functions.	● Confirm that the essential elements of the COOP describe the functions and services to continue during and after an emergency, including the following: ❍ Administrative and vital records ❍ Information technology ❍ Financial services ❍ Security systems ❍ Communications/telecommunications ❍ Essential and critical building operations

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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 **September 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.

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Celebrating 50 Years of Quality and Patient Safety

Editorials

617 A Half Century of Quality and Safety

J.B. Perlin

OPEN ACCESS

September 2024 marks the 50th anniversary of the first issue of *Quality Review Bulletin*, the publication that evolved into *The Joint Commission Journal on Quality and Patient Safety*. Dr. Jonathan Perlin, President and Chief Executive Officer of The Joint Commission, reflects on the *Journal*'s history, achievements, and importance in the field of health care quality and safety.

618 Communication After Medical Error: The Need to Measure the Patient Experience

A. Kachalia; C. Hemmelgarn; T.H. Gallagher

Effective communication with patients is crucial to mitigate the emotional distress that can result after an error. Responding to an article in this issue that assessed the connection between effective communication and emotional distress, Kachalia and colleagues discuss the urgency of improving communication with patients after medical errors and factors to consider in collecting patient experience data.

Adverse Events

620 Associations Between Organizational Communication and Patients' Experience of Prolonged Emotional Impact Following Medical Errors

L. Sokol-Hessner; T. Dechen; P. Folcarelli; P. McGaffigan; J.P. Stevens; E.J. Thomas; S. Bell

Medical errors can have long-lasting effects on patients' emotional health, but the factors related to the emotional impacts of errors are underexplored. Sokol-Hessner and colleagues analyzed results of a patient survey to describe the frequency of and factors associated with prolonged emotional impact after patient-reported errors, including the nature of organizational communication with the patient following the event.

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Process Improvement

630 Divergent Trends in Postoperative Length of Stay and Postdischarge Complications over Time

R.D. Li; R.H.-S. Joung; J.W. Chung; J. Holl; K.Y. Bilimoria; R.P. Merkow

Despite an intense focus on decreasing hospital length of stay (LOS), little effort has been made to characterize and improve quality of care in the postdischarge setting other than evaluating readmission. To help close this knowledge gap, Li and colleagues used data from a national surgical registry to evaluate changes in LOS and postdischarge complications over time and assess patient and procedural factors associated with postdischarge complications in five representative surgical specialties.

638 Patient Safety Indicators at an Academic Veterans Affairs Hospital: Addressing Dual Goals of Clinical Care and Validity

N. Allaudeen; E. Schalch; M. Neff; K. Poppler; A.A. Vashi

Patient Safety Indicators (PSIs) are a validated and widely used metric to evaluate hospital administrative data on preventing hospital-acquired complications. Many studies have addressed PSI validity, but few have aimed to reduce PSI through clinical care. After analyzing the frequency of performance gaps and cost-versus-impact of potential solutions, Allaudeen and colleagues implemented five interventions to address the three most common, highly weighted PSIs: pressure ulcers, postoperative venous thromboembolism, and postoperative sepsis.

645 Going (*Anti*)Viral: Improving HIV and HCV Screening and HPV Vaccination in Primary Care

A. McGaffey; G. Castelli; M.P. Friedlander; S. Proddutur; C. Simpkins; D.B. Middleton; K.O. Spencer; J.M. Taormina; A. Gerlach; M.P. Nowalk

Human immunodeficiency virus (HIV) and hepatitis C (HCV) screening and human papillomavirus (HPV) vaccine uptake remains suboptimal, with fewer than 50% of targeted adults receiving HIV and HCV screening and completed HPV vaccination of adolescents below the goal of 80%. In this article, McGaffey and colleagues report the results of a quality improvement project to improve HIV and HCV screening and HPV vaccination in three family medicine residency practices.

Health Care Equity

655 Association of Homelessness with Before Medically Advised Discharge After Surgery

H.C. Decker; C.M. Silver; D. Graham-Squire; L. Pierce; H.K. Kanzaria; E.C. Wick

Before medically advised (BMA) discharge is associated with higher rates of readmission and death, but the association between BMA discharge after surgery and housing status is unknown. Decker and colleagues performed this retrospective study to evaluate if housing status is associated with BMA discharge after surgery and determine if there are differences in documented reasons for discharge based on housing status in patients who discharge BMA.

664 How Health Care Organizations are Implementing Disability Accommodations for Effective Communication: A Qualitative Study

J.Y. Oshita; C.D. MacLean; A.E. Couture; M.A. Morris

Despite federal mandates, clinicians infrequently provide accommodations enabling equal access to health care information for patients with communication disabilities. Oshita and colleagues interviewed disability coordinators at 15 US health care organizations to determine how they were delivering these accommodations in the context of clinical care, what communication accommodations they provided, and what disability populations they addressed.

Tool Tutorial

673 BONE Break: A Hot Debrief Tool to Reduce Second Victim Syndrome for Nurses

A. Hess; T. Flicek; A.T. Watral; M. Phillips; K. Derby; S. Ayres; J. Carney; A. Voll; R. Blocker

As many as 43% of clinicians have experienced second victim syndrome, and about half of these indicate it has had a moderately severe to severe impact on their lives. Hess and colleagues developed a structured hot debriefing tool specifically designed for use by a team of nurses in the same unit following an adverse event, with a focus on immediate peer-to-peer support and emotional first aid to mitigate potential symptoms of second victim syndrome.

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Improvement Brief

678 Impact of a Daily Huddle on Safety in Perioperative Services

H. Tuyishime; R. Claure; K. Balakrishnan; H. Chan; L. Lam; M. Randolph; J. Stroud; K. Traber; K. Tileston; K. Shea

Communication failures contribute to quality gaps and may lead to serious safety events (SSEs) in the operating room (OR). Noting an increased rate of SSEs in 2020, Tuyishime and colleagues implemented a daily morning OR safety huddle conducted before bringing patients into the OR to reduce quality gaps and improve communication.

Article Collection



684 *The Joint Commission Journal on Quality and Patient Safety* 50th Anniversary Article Collections: 50 Most Cited Articles in 50 Years

In September, the *Journal* is highlighting its 50 most cited articles of its 50 years in publication. This collection is available free during the month of September.

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. The October article collection will focus on quality improvement in non-hospital settings.

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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 off-site review option for **select disease-specific care** and **palliative care** certification programs (*see* page 2 in this issue for the full article)
- New and revised **laboratory** requirements align with US Centers for Medicare & Medicaid Services (CMS) regulations for proficiency testing (*see* page 4 in this issue for the full article)
- Revised survey process aligns with CMS guidance for **deemed home health** agencies (*see* page 5 in this issue for the full article)
- New and fully revised "Emergency Management" (EM) chapter for **laboratories** (*see* page 6 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- New and revised Emergency Management (EM) requirements for **behavioral health care and human services** organizations (field review ends October 4, 2024)

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

- New and revised Emergency Management (EM) requirements for **assisted living communities** and **office-based surgery practices**
- Safe staffing requirements for **critical access hospitals** and **hospitals**
- New and revised Infection Prevention and Control (IC) requirements for **ambulatory care** organizations, **behavioral health care and human services** organizations, **laboratories**, and **office-based surgery practices**
- New and revised workplace violence prevention requirements for **ambulatory care** organizations, **assisted living communities**, **behavioral health care and human services** organizations, **laboratories**, **nursing care centers**, and **office-based surgery practices**

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Executive Editor
Kathy DeMase

Senior Content Systems Specialist
Chris Zwirek

Associate Director, Editorial, Accreditation Content
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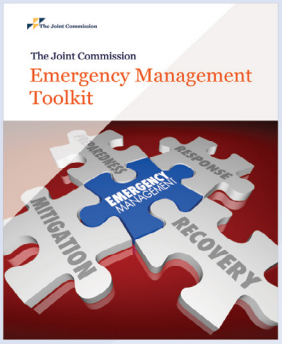
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