The Joint Commission

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Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

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NEW: Rural Health Clinic Accreditation Program Launching Soon



On July 1, 2024, The Joint Commission will begin accepting applications for its **Rural Health Clinic** Accreditation Program. The program has been awarded its initial deeming authority from the US Centers for Medicare & Medicaid Services (CMS) for four years—from June 1, 2024, through June 1, 2028.

Rural health clinics are defined as follows in the "Glossary" (GL) chapter of the *Comprehensive Accreditation Manual for Rural Health Clinics (CAMRHC)*), which will publish on E-dition® in August:

> **rural health clinic** A clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR 491.2.

This program helps organizations in underserved, rural communities improve the quality of primary care and personal health services. Notification of the awarded deeming authority published in the *Federal Register* on May 1, 2024.

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

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

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Health care organizations must meet all state and federal requirements to be eligible for rural health clinic accreditation, 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. The following eligibility requirements will be available in "The Accreditation Process" (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) US Centers for Medicare & Medicaid Services (CMS) locations to meet the following eligibility criteria:
  - Located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR parts 405 and 491.
  - A rural health clinic that is certified for participation in Medicare in accordance with subpart S of 42 CFR part 405. The Secretary will notify the state Medicaid agency 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 The Joint Commission's mission development team for information on obtaining accreditation.

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APPROVED: Revised Requirements for Hospices Align with CMS Final Rule

Effective July 1, 2024, The Joint Commission revised two elements of performance (EPs) and added two new terms to the Glossary to align with the US Centers for Medicare & Medicaid Services' (CMS) final rule for **hospices** published in the *Federal Register* on November 16, 2023.

Human Resources (HR) Standard HR.01.01.01, EP 11, was revised to include *marriage and family therapist (MFT)* and *mental health counselor (MHC)* to the note listing terms defined in the glossary. In addition, Provision of Care, Treatment, and Services (PC) Standard PC.02.01.05, EP 6, was revised to add MFTs and MHCs to the list of individuals who establish an interdisciplinary group. The definitions for the following two terms have been added to the Glossary:

marriage and family therapist (MFT) An individual who meets all the following criteria:

- Possesses a master's or doctoral degree which qualifies for licensure or certification as an MFT under state law of the state in which such individual furnishes marriage and family therapist services
- After obtaining such a degree, has performed at least two years or 3,000 hours of post master's degree clinical supervised experience in marriage and family therapy in an appropriate setting, such as a hospital, skilled nursing facility, private practice, or clinic
- Is licensed or certified as a marriage and family therapist by the state in which the services are performed

mental health counselor (MHC) An individual who meets all the following criteria:

- Possesses a master's or doctoral degree which qualifies for licensure or certification as an MHC, clinical professional counselor, or professional counselor under state law of the state in which such individual furnishes MHC services
- After obtaining such a degree, has performed at least two years or 3,000 hours of post master's degree clinical supervised experience in mental health counseling in an appropriate setting, such as a hospital, skilled nursing facility, private practice, or clinic
- Is licensed or certified as an MHC, clinical professional counselor, or professional counselor by the state in which the services are performed

The revised requirements are 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 Home Care (CAMHC)*. For those customers who purchase it, the 2025 hard-copy *CAMHC* will include these revisions.

For more information, please contact the Department of Standards and Survey Methods.

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UPDATE: Use of Secure Text Messaging for Patient Information and Orders



Effective immediately, The Joint Commission updated its position about texting to communicate patient information and orders. **Joint Commission–accredited health care organizations** that implement a secure texting platform (STP) may text patient information and orders to members of the care team. Although computerized provider order entry (CPOE) remains the preferred method of order entry, organizations are permitted to text orders via an STP that transfers the information into the electronic health record (EHR).

Organizations that choose to text patient information and orders are required to do the following:

- Implement an STP that meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule, the Health Information Technology for Economic and Clinical Health (HITECH) Act Amendment 2021, and US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) addressing medical records. The STP must be secure, encrypted, and ensure the integrity of author identification to minimize patient privacy and confidentiality risks.
- Implement policies and procedures to routinely assess the security and integrity of the STP.
- Confirm that texted orders transmitted via the STP are dated, timed, authenticated, and promptly captured in the EHR.
- Ensure that the information transmitted into the EHR is accurately written, promptly completed, properly filed and retained, and accessible.

Previously, health care organizations were permitted to use secure text messaging to communicate patient information among members of the health care team; however, texting patient orders had been prohibited because of concerns related to the capability of texting platforms to protect information privacy and security and to incorporate texted information into the EHR.

On February 8, 2024, CMS released a quality, safety, and oversight (QSO) memorandum—QSO-24-05-Hosptial/[Critical Access Hospital] CAH—acknowledging the significant advancements in the current STPs. As a result, CMS revised its policy to state that texting patient information and orders is permissible if accomplished through a HIPAA–compliant STP and if in compliance with the CoPs at 42 CFR Part 482.24 and 41 CFR Part 485.638.

In response to the revised policy, The Joint Commission recently released Frequently Asked Questions (FAQs) related to using secure text messaging for patient information and orders. The following are links to FAQs by program:

- Ambulatory care
- Assisted living community
- Behavioral health care and human services

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- Critical access hospital
- Home care
- Hospital
- Laboratory
- Nursing care center
- Office-based surgery

For additional information or questions about texting patient orders, contact the Joint Commission Standards Interpretation Group.

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The Joint Commission Announces Officer Appointments

The Joint Commission enterprise welcomes the following four leaders to its executive team:

1. Elizabeth (Liz) Mort, MD, MPH, has been named Vice President and Chief Medical Officer.
2. Kathryn Petrovic, MSN, RN, has been named Vice President for Accreditation and Certification Product Development.
3. Andrew Rosen, MBA, has been named Vice President, Joint Commission International.
4. Lisa Steininger, CPA, MBA, CAE, has been named Executive Vice President and Chief Financial Officer.

"As The Joint Commission continues to embark on its journey of transformation, I am pleased to welcome these four dynamic leaders," says Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, Joint Commission Enterprise President and Chief Executive Officer. "Each brings expertise that will play a critical role in moving our organization forward—accelerating capabilities across the enterprise to help us enable and empower health care organizations globally to continuously improve patient safety and quality of care. I look forward to working closely with Liz, Kathryn, Andrew, and Lisa in support of our mission that all patients receive safe, high-quality, equitable, and compassionate health care."

Dr. Elizabeth (Liz) Mort, Vice President and Chief Medical Officer



Mort is a primary care general internist and nationally recognized expert in quality and patient safety. In her new role, Mort will oversee a physician leadership forum dedicated to health care safety issues and identifying significant emerging trends. In addition, she will promote all aspects of health care quality improvement as the primary voice of patient safety to external stakeholders. Serving as the key liaison between The Joint Commission and the health care safety community, she will help design services to further enhance quality and safety.

Most recently, Mort was Senior Vice President, Quality and Safety, and Chief Quality Officer at Massachusetts General Hospital and Massachusetts General Physicians Organization, Boston. She has broad experience in advancing systems of care to improve health outcomes across the continuum of care with expertise in health care leadership, quality and safety, and health care equity.

Mort earned her Doctor of Medicine from Harvard Medical School, Boston, and her Master of Public Health from the University of Michigan, Ann Arbor, Michigan. She completed her internship and residency at Massachusetts General Hospital.

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Kathryn Petrovic, Vice President for Accreditation and Certification Product Development



With more than 20 years of leadership experience in health care, Petrovic most recently served as Director of the Department of Standards and Survey Methods and as a Field Director in the Department of Surveyor Management and Development at The Joint Commission. Prior to The Joint Commission, she served as a nurse leader at several health care organizations.

In her new role, Petrovic will oversee the development and revision of standards for all domestic and international accreditation and certification programs. In addition, she is responsible for establishing survey processes used to assess compliance with the standards.

Petrovic earned her Master of Nursing Administration from the University of St. Francis, Joliet, Illinois.

Andrew Rosen, Vice President, Joint Commission International



Rosen is a strategic leader who built a globally influential health care innovation, strategy, and management advisory business. In his new role, Rosen will lead strategic development, execution, and mission development for Joint Commission International.

As Executive Director – International for The Advisory Board Company, he created the international hospital research leader role and rebuilt a dormant international business to a global brand with more than 600 member organizations in more than 50 countries. Previously, Rosen was Executive Vice President for Levin Associates, and earlier he served as Vice President of Strategy for Gartner, Inc.

Rosen earned his Master of Business Administration from the Australian Graduate School of Management at the University of New South Wales, Sydney, Australia, and Duke University, Durham, North Carolina.

Lisa Steininger, Executive Vice President and Chief Financial Officer



Steininger is a senior executive with deep financial and operational skills through successive leadership roles. In her new role, Steininger will lead the enterprise's financial strategy and its execution. She is responsible for overseeing financial reporting, accounts payable and receivable, budgeting and financial planning, investment management, pricing, payroll, and more.

Previously Steininger was at the American Society of Anesthesiologists, where she served as the Financial and Revenue Officer. She also held senior roles in finance, operations, business intelligence, and analytics at Navigant Consulting, Aon Hewitt, AT&T, and CDK Global.

Steininger earned her Master of Business Administration from the University of Chicago Booth School of Business. She is a certified public accountant and certified association executive.

The August 2023 and February 2024 issues of *Perspectives* announced other Joint Commission officer appointments. For more information about the executive leadership team, visit the Joint Commission Officers page on The Joint Commission's website. P

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Consistent Interpretation

Joint Commission Surveyors' Observations Related to the Integrity of Sprinkler Piping

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 ensuring that sprinkler piping is not compromised by adding unauthorized loads.

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

Life Safety (LS) Standard LS.02.01.35: The hospital provides and maintains systems for extinguishing fires.	
EP 4: Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)	
Compliance Rate	In 2023, the noncompliance percentage for this EP was **53.46%**—that is, **741** of **1,386** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	The primary function of sprinkler piping is to suppress fire, thereby safeguarding lives and property. This critical sprinkler system component always must be ready to perform its function. National Fire Protection Association's (NFPA) *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems* (NFPA 25–2011), Section 5.2.2.2, states that sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. Sprinkler systems are meticulously engineered to deliver water promptly when activated in response to a fire. In addition, sprinkler piping is carefully selected based on material specifications and hydraulic calculations, including the pipe support and hanger hardware. Sprinkler piping is never intended to be a substitute for a cable tray, cable hangers, hanging and supporting heating, ventilating, and air-conditioning (HVAC) ducts, electrical conduits, and/or plumbing. Using sprinkler piping to support such items leads to unintended stress on and misalignment of the pipe, thus resulting in damage and/or failure of pipe hangers, and/or broken and cracked pipes. The added load imposed by any of these infrastructure system elements reduces the overall integrity of the sprinkler system and dramatically increases the risk of failure during a fire. Because much of the sprinkler system piping is often above ceilings, it may not be readily apparent if an additional load has been imposed by incorrectly installed cabling, electrical, mechanical, and plumbing. Control measures implemented by the organization to monitor and inspect the sprinkler piping during renovations and building modifications will help to prevent additional loads on the piping that will compromise this critical safety feature.

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Surveyor Observations	Guidance/Interpretation
• One or more cables were wrapped around, draped over, or supported by the sprinkler pipe. • One or more cables were draped over or supported by the sprinkler pipe. • Conduit or tubing was resting on and/or supported by the sprinkler pipe. • HVAC ducts were resting on and/or supported by the sprinkler pipe. • Suspended ceiling systems were resting on and/or supported by the sprinkler pipe.	• Sprinkler piping cannot be used to support anything. This includes any items touching the piping. • Estimate the weight on sprinkler pipe to determine risk placement on the *SAFER* Matrix; use the number of cables as a guide only.

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The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **May 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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Editorials

303 Taming the Wild West of Procedural Safety: Assessing Interprofessional Teams in Non-Operating Room Anesthesia

R. Vazquez; A.F. Arriaga; M.P.T. Pimentel

The non-operating room anesthesia environment is recognized as a vulnerable patient care area, with a disproportionate number of adverse events compared to the operating room. In this editorial in response to an article by Schroeck and colleagues in this issue of the *Journal*, Vazquez and colleagues discuss the importance of matching skill sets and optimizing communication among members of ad hoc care teams in the non-operating room anesthesia setting.

305 Optimizing Hospitalist Co-Management for Improved Patient, Workforce, and Organizational Outcomes

R. Metter; A. Johnson; M. Burden

Hospitalist co-management of surgical patients has become more popular, but the literature has not yielded a clear consensus on whether the benefits outweigh the negatives. In this editorial in response to an article by Márchan-López and colleagues in this issue of the *Journal*, Metter, and colleagues discuss the reasons for the discrepancies in research findings.

Teamwork and Communication

308 Team Relations and Role Perceptions During Anesthesia Crisis Management in Magnetic-Resonance Imaging Settings: A Mixed Methods Exploration

H. Schroeck; M.A. Whitty; B. Hatton; P. Martinez-Camblor; L. Wen; A.H. Taenzer

Patient care in non-operating room anesthesia (NORA), including magnetic resonance imaging (MRI) suites, is accomplished by interprofessional ad hoc teams who do not regularly work together otherwise. Schroeck and colleagues used the Relational Coordination Index (RCI), a survey about role perceptions, and semistructured interviews to identify and describe overlapping and mismatched perceptions between the two groups.

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318 Impact of a Hospitalist Co-Management Program on Medical Complications and Length of Stay in Neurosurgical Patients

Á. Marchán-López; J. Lora-Tamayo; C. de la Calle; L.J. Roldán; L.M.M. Gómez; I.S. de la Fuente; M.C. Fernández; A. Lagares; C. Lumbreras; A.G. Reyne

Medical complications among neurosurgical patients can jeopardize their clinical results, and medical co-management has been suggested to mitigate the negative outcomes. Marchán-López and colleagues used a quasi-experimental study design that compared a historical control period (July–December 2017) to a prospective intervention arm to determine the impact of a hospitalist co-management program in a neurosurgery department on the incidence of complications, mortality, and length of stay.

326 Preoperative Communication Between Anesthesia, Surgery, and Primary Care Providers for Older Surgical Patients

D. Ron; C.M. Gunn; J.E. Havidich; M.M. Ballachino; T.E. Burdick; S.G. Deiner

Inadequate perioperative communication between physicians compromises patient safety and leads to inefficiency, increased complications, surgery delays, and same-day cancellations. Ron and colleagues administered surveys and semistructured interviews to elucidate the perioperative interdisciplinary communication needs, barriers, and preferences of older patients and their anesthesia, surgery, and primary care providers.

338 Development and Evaluation of I-PASS-to-PICU: A Standard Electronic Template to Improve Referral Communication for Interfacility Transfers to the Pediatric ICU

N.R. Parikh; L.S. Francisco; S.C. Balikai; M.A. Luangrath; H.R. Elmore; J. Erdahl; A. Badheka; M. Chegondi; C.P. Landrigan; P. Pennathur; H.S. Reisinger; C.L. Cifra

Miscommunication during interfacility handoffs to a higher level of care can harm critically ill children. Parikh and colleagues developed and evaluated an electronic health record (EHR)–supported clinical note template by adapting elements from I-PASS to support information exchange between referring clinicians and receiving pediatric ICU physicians to improve communication for interfacility pediatric ICU transfers.

348 Refining a Framework to Enhance Communication in the Emergency Department During the Diagnostic Process: An eDelphi Approach

M. Manojlovich; A.P. Bettencourt; C.W. Mangus; S.J. Parker; S.E. Skurla; H.M. Walters; P. Mahajan

Suboptimal communication between the patient and the interdisciplinary care team increases the risk of diagnostic error, and the role of communication remains underrepresented in diagnostic decision-making conceptual models. Manojlovich and colleagues used eDelphi methodology to examine the entire diagnostic process in the emergency department, identify where communication breakdowns could occur, and develop a final framework that positions communication more prominently.

357 Involving the Patient and Family in the Transfer of Information at Shift Change in a Pediatric Emergency Department

A. Mora Capín; A. Jové Blanco; E. Oujo Álamo; A. Muñoz Cutillas; V. Barrea Brito; P. Vázquez López

The transfer of information at the change of shift is a critical point for patient experience. Mora Capín and colleagues implemented a multidisciplinary bedside handoff in a pediatric emergency department and evaluated caregivers' perceptions before and after implementation of three dimensions of patient experience: information received and communication with professionals, participation, and continuity of care.

Innovation Report

363 Improving Outcomes in Patients Sent to the Emergency Department from Outpatient Providers: A Receiver-Driven Handoff Process Improvement

K. DeVore; K. Schneider; E. Laures; A. Harmon; P. Van Heukelom

Transitions of care from the outpatient setting to the emergency department are susceptible to miscommunication resulting in adverse events. DeVore and colleagues developed and implemented a standardized receiver-driven handoff process consisting of screening to determine whether a patient was referred to the emergency department, review of the electronic health record, and use of electronic health record documentation, followed by a questionnaire to evaluate success.

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Improvement Brief

371 Implementation of an Interdisciplinary Transfer Huddle Intervention for Prolonged Wait Times During Inter-ICU Transfer

S. Hyder; R. Tang; R. Huang; A. Ludwig; K. Scott; N. Nadig

Extended wait times during ICU transfers from a regional to a tertiary-level hospital can negatively affect survival, length of stay, and cost. Hyder and colleagues developed and implemented an interdisciplinary transfer huddle intervention with the goal of reducing wait times by providing a consistent channel of communication between key stakeholders.

Interview

377 Handoffs and Care Transitions: Interviews with Chris Landrigan and Theresa Murray

D.W. Baker

Dr. David W. Baker, Editor-in-Chief of the *Journal*, interviewed Chris Landrigan, MD, MPH, Chief of General Pediatrics at Boston Children's Hospital, Director of the Sleep and Patient Safety Program at Brigham and Women's Hospital, and Professor of Pediatrics and Medicine at Harvard Medical School, and Theresa Murray, MSN, RN, CPPS, LSSBB, Director of Clinical Program Management at the I-PASS Patient Safety Institute and a Quality and Safety Specialist at Dartmouth Health, on ways health care organizations can improve handoffs and why they should make it a priority.

Article Collection

385 *The Joint Commission Journal on Quality and Patient Safety* 50th Anniversary Article Collection: Handoffs and Care Transitions

In May, the *Journal* is highlighting our past publications on handoffs and care transitions.

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 June article collection will focus on clinician well-being and burnout.

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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

- Requirements for a new **Rural Health Clinic** Accreditation Program (*see* page 2 in this issue for the full article)
- Revised requirements and added two new glossary terms for **hospices** (*see* page 4 in this issue for the full article)
- Updated requirements related to texting patient orders for **Joint Commission–accredited health care organizations** that implement a secure texting platform (see page 5 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- No standards currently in field review

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

- Revised restraint and physical hold requirements for **behavioral health care and human services** organizations
- New and revised Emergency Management (EM) requirements for **nursing care centers**
- New and revised Infection Prevention and Control (IC) requirements for **assisted living communities**, **home care** organizations, and **nursing care centers**
- New and revised Emergency Management (EM) requirements for **laboratories**
- New workplace violence prevention requirements for **home care** organizations
- Safe staffing requirements for **critical access hospitals** and **hospitals**
- Revised core requirements for all **disease-specific care** programs
- 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**

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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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Emergency Management Leader™—a brand-new digital newsletter from JCR—provides practical strategies to help health care organizations comply with The Joint Commission's Emergency Management (EM) requirements. This newsletter features case studies explaining how health care organizations handle **real** emergencies; practical tips from Joint Commission subject matter experts and industry leaders to help maintain and support compliance; and useful tools such as tabletop exercises, drill scenarios, checklists, sample policies and plans, and after-action reports.

Intended for emergency management leaders, managers, and coordinators in all health care settings, *Emergency Management Leader*™ covers a wide range of topics, including mass casualty incident response, communication during disasters, infectious disease preparedness, EM training, EM program evaluation, and more.

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