




The Joint Commission, CMS and State Hospital Accreditation

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The Joint Commission

- ▶ Not-for-profit 501(c)3
- ▶ 1951
- ▶ “To continuously improve the safety and quality of care provided to the public...”
- ▶ 16,000 organizations
- ▶ Ambulatory care, **behavioral health**, home care, hospice, **hospitals** and critical access hospitals, laboratories, long-term care, office-based surgery
- ▶ Certification

Accreditation

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- ▶ Set standards
 - Advisory committees
 - Field reviews
 - ▶ Onsite survey
 - Unannounced
 - Priority focus
 - Tracer methodology
 - ▶ Accreditation decision
 - ▶ Quality Check
 - ▶ Periodic performance review
 - ▶ Performance measures
 - ▶ Standards Improvement Project

Performance Measures

- ▶ ORYX for psychiatric hospitals
 - Choose non-core measures from vendor (e.g. NRI)
- ▶ Hospital-based Inpatient Psychiatric Services Measure set (HBIPS)
 - Implemented 10/01/08
 - *Can* meet ORYX requirement
- ▶ National Quality Forum endorsement
 - September 1, 2009
 - Would be *required* in 2010

HBIPS


1. Admission screening
2. Restraint use
3. Seclusion use
4. Multiple antipsychotic medications
5. Multiple antipsychotic medications with justification
6. Post-discharge care plan
7. Post-discharge plan transmitted to provider



Continuum of Care

- ▶ Case management
- ▶ Corrections
- ▶ Crisis stabilization (acute)
- ▶ Day programs
- ▶ Family preservation/wrap-around
- ▶ Forensics
- ▶ Foster care
- ▶ Therapeutic foster care
- ▶ In-home

Continuum of Care

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- ▶ Technology-based (e.g., online)
 - ▶ Outdoor
 - ▶ Outpatient
 - ▶ Residential/group home
 - ▶ Shelters/transitional living
 - ▶ Therapeutic schools (24 hour)
 - ▶ Supervised/supportive living
 - ▶ Vocational rehabilitation
 - ▶ Hospitals

Areas of Standards

- ▶ Provision of care
- ▶ Organizational infrastructure
- ▶ Organizational leadership, culture

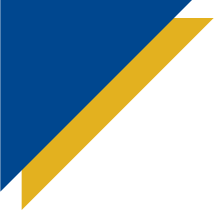
Provision of Care

- ▶ Rights of individual
- ▶ Care, treatment, service
- ▶ Medication management
- ▶ Infection prevention, control
- ▶ *Opioid treatment programs*
- ▶ *Foster care*
- ▶ ***Emergency management***



Infrastructure

- ▶ Human resources
- ▶ Information management
- ▶ Environment of care, life safety
- ▶ Record of care
- ▶ ***Waived laboratory testing***
- ▶ ***Medical staff***
- ▶ ***Nursing***



Leadership



Leadership

- Governance, administrators, clinicians
- Culture
- Quality and safety

Performance improvement

CMS and Hospitals

- ▶ Medicare Conditions of Participation
- ▶ 1965 – “deemed status” for hospitals by law
- ▶ Home health, laboratories, ASC, CAH, home medical equipment- “deemed status” by CMS approval
- ▶ 2008 – “deemed status” for hospitals by CMS approval
 - Hospitals deemed under law before 7/2010
 - Application submitted, accepted
 - No problem anticipated


CMS–Joint Commission Discussions

- ▶ Small additions, clarifications made
- ▶ Discuss
 - Telehealth
 - Equivalent process for APNs, PAs
 - Single director for radiology, etc.
 - One medical staff per provider number
- ▶ Special psychiatric conditions
 - “Record-keeping,” staffing
 - Plan to submit this year

Role of Hospital in Recovery

- ▶ Suicidal
- ▶ Dangerous to others
- ▶ Remove from uncontrolled crises
- ▶ Exacerbation in severe and persistent illness
- ▶ Comorbidities
 - Substance abuse
 - Medical conditions


Risks in Hospital

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- ▶ Suicide
 - ▶ Medication use
 - ▶ Infections
 - ▶ Transitions
 - Admission
 - Internal
 - Discharge
 - ▶ Failure to diagnose, treat

National Patient Safety Goals

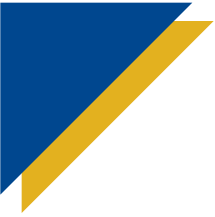
- ▶ Suicide (NPSG 15)
- ▶ Medication use (NPSGs 1, 2, 3, 8)
- ▶ Infections (NPSG 7)
- ▶ Transitions (NPSG 2)
- ▶ Rapid response (NPSGs 2, 16)

Challenges

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- ▶ Coverage
 - ▶ Cost
 - ▶ Quality
 - Underuse
 - Overuse
 - Misuse

Relationships

- ▶ ↓ Underuse → ↑ Costs
- ▶ ↓ Overuse → ↓ Costs
- ▶ ↓ Misuse → ↓ Costs
- ▶ ↓ Costs → enables ↑ coverage




Principles

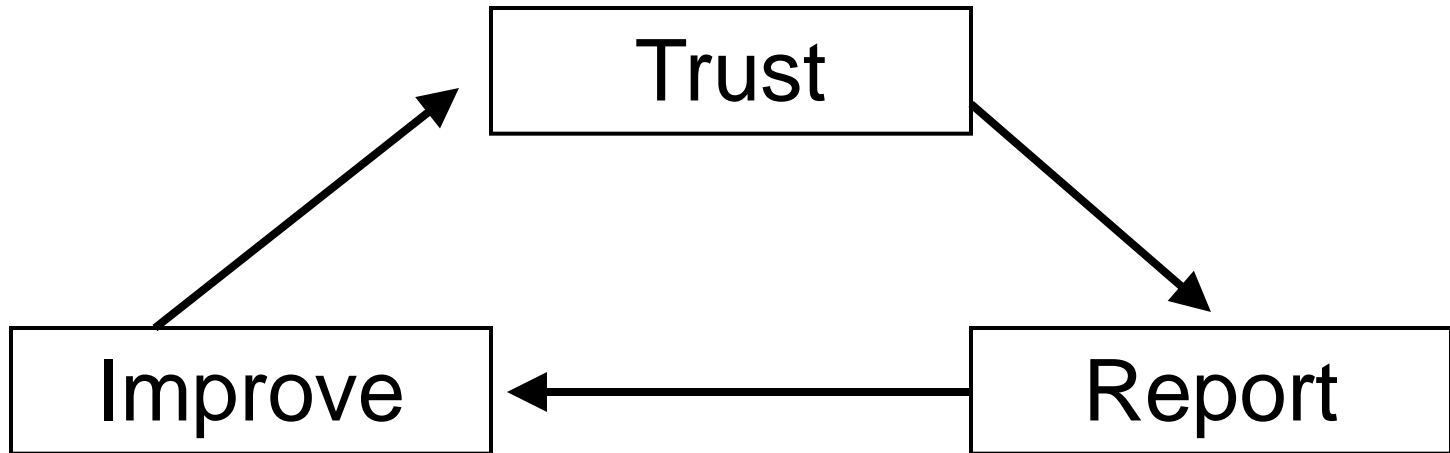
- ▶ Health care is complex→risky
- ▶ To err is human
- ▶ Safety and quality is not in humans being more competent and committed
- ▶ Safety and quality is in design of systems humans work within
- ▶ Need culture of safety



Culture of Safety

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- ▶ Culture of trust
 - ▶ Just culture
 - ▶ Mindfulness

Culture of Trust



Just Culture

- ▶ Human error (slips, mistakes, lapses) – console, redesign processes
- ▶ Misjudgment – counsel, redesign processes
- ▶ Intentional – discipline



Mindfulness

- ▶ High risk
 - Complex
 - Tightly-coupled
 - Time pressure
 - Variable input
 - Human intervention
- ▶ Unanticipated, unintended consequences
- ▶ Requires vigilance
- ▶ Requires teamwork



Joint Commission Foci

- ▶ High reliability organizations
 - Culture of safety
 - Reliability of systems, processes
- ▶ System and process improvement
 - Robust process improvement (e.g., Lean, Six Sigma methods)
 - E=QxAxA
- ▶ “Peer review”
- ▶ Overuse

More Information

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Comments, Questions?