

## Comparison of Changes CMS Made to the Medicare Hospital Conditions in its October 24, 2011 Notice of Proposed Rule-Making (NPRM) and TJC’s List of Issues

<u>Issues Raised with CMS by The Joint Commission</u>	<u>Status/Notes</u>
<b><u>Issues That CMS Indicated Will Require Rule-Making Changes</u></b>	
<p><i>Director of Outpatient Services.</i> As more care is being delivered on an outpatient basis, many hospitals appoint more than one person to direct outpatient care, allowing for individuals with the appropriate expertise or experience to direct the care, especially when multiple outpatient sites or types of services (e.g., pediatrics) exist. However, the Medicare hospital CoPs only allow one person to direct outpatient services. Therefore, to meet the CoP, hospitals have to hire another person to oversee the multiple directors. This increases costs, causes administrative problems, and lines of authority issues.</p>	<p>The Joint Commission is supportive of CMS’ proposed revisions for the director of outpatient services. The revisions provide hospitals more flexibility and highlight the need for multiple areas of expertise within the outpatient setting.</p> <p><i>CMS’ proposed revisions would allow hospitals to assign one or more individuals to be responsible for outpatient services, which will provide greater flexibility in determining the management structure of outpatient services. These services could be tailored to the scope and complexity of the services offered by an individual hospital.</i></p>
<p><i>Nursing Care Plans.</i> Most hospitals have moved to an integrated model for developing a plan of care. Therefore, care plans frequently represent many different health care disciplines, such as nursing, respiratory care, occupational therapy, pharmacy, etc. Yet, CMS requires hospitals to have a separate (independent) nursing care plan for each patient.</p>	<p>The Joint Commission is supportive of CMS’ proposed revision. The nursing care plan approach is outdated; more comprehensive and collaborative plans are utilized today.</p> <p><i>CMS proposed to revise its Nursing Services CoP to allow those hospitals that use an interdisciplinary plan of care in providing patient care, the care plan for nursing services could be developed and kept current as part of the hospital’s overall interdisciplinary care plan.</i></p>
<p><i>History and Physical Exams.</i> The CoPs require that a “history and physical” (H&amp;P) be updated within 24 hours of the patient’s <u>admission or registration</u> and before a surgical procedure. If a patient visits his doctor the day before (or the morning of) the surgery and receives an H&amp;P exam, an update to the</p>	<p>The Joint Commission will respond to CMS’ request for comments on this issue. The field is still confused about the requirements for H and P Exam within 24 hours of admission or registration.</p>

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<p>H&amp;P must be performed again after admission or registration to the hospital, but prior to surgery. Such a rigid interpretation that an H&amp;P that is conducted on the day before (or the morning of) the surgery does not meet the CoP creates unnecessary duplication and burden.</p>	<p><i>CMS <b>did not amend</b> its regulation regarding this issue, but clarified that the H&amp;P must document an examination for any changes in the patient's condition since the time that the patient's H&amp;P was performed that might be significant for the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&amp;P was completed, he/she may indicate in the patient's medical record that the H&amp;P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&amp;P was completed. CMS does not specify the extent of the examination that must be conducted; rather, it defers to the clinical judgment of hospital staff to determine the extent of the necessary H&amp;P update. CMS noted in the NPRM that it is specifically seeking comment on this issue.</i></p>
<p><i>Verbal Orders.</i> In general, CMS is opposed to verbal orders and will cite a hospital out of compliance for any order that goes beyond the 48 hour authentication period. Again, such a rigid interpretation of the requirements creates an unnecessary burden for community hospitals that do not have the benefit of medical residents, who are often responsible for authenticating verbal orders in academic medical centers.</p>	<p><i>The Joint Commission is supportive of CMS' revisions for verbal orders. It relieves burdens on healthcare facilities and addresses the January 2012 expiration of the "Sunset provision" that temporarily allowed authentication of verbal orders by other practitioners.</i></p> <p><i>CMS proposed to revise the Medical Records CoP to eliminate the requirement for authentication of verbal orders within 48 hours if no State law specifying a timeframe exists. CMS noted that very few States have authentication timeframe requirements. Thus, it does not believe that the few States that may have such requirements would impact the potential savings it estimated in the rule. CMS proposed making permanent the temporary provision (5-year Sunset provision due to expire early 2012) that allows for orders to be authenticated by another</i></p>

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	<p><i>practitioner who is responsible for the care of the patient and who, in accordance with hospital policy State law, is authorized to write orders.</i></p> <p><b><i>CMS proposed</i></b> adding new provisions to allow hospitals to use pre-printed and electronic standing orders, order sets, and protocols for patient orders if the hospital ensures that these orders: have been reviewed and approved by the medical staff and nursing and pharmacy leadership; are consistent with nationally recognized guidelines; are reviewed periodically and regularly by medical staff and nursing and pharmacy leadership; and are dated, timed, and authenticated by a practitioner who is responsible for the care of the patient and who is authorized to write orders by hospital policy in accordance with State law. In addition, it proposed to allow for drugs and biologicals to be prepared and administered on the orders of other practitioners if they are acting in accordance with State law and scope of practice and the hospital has granted them the privileges to do so.</p>
<p><i>Advance Practice Registered Nurse (APRN).</i> CMS requirements in several areas exclude APRNs from performing functions and duties within the scope of their license. The Joint Commission recommends that all CoPs be reviewed for this exclusion and rectified. This exclusion may delay treatment, cause unnecessary burden to the practitioner (co-signatures), and impede a state’s practice acts.</p>	<p><b>The Joint Commission is generally supportive of the changes below and believes they align with requirements under MS.01.01.01. Staff is still analyzing the implications on other Joint Commission requirements.</b></p> <p><b><i>CMS proposed</i></b> add language to clarify that a hospital may grant privileges to both physicians and non-physicians to practice within their State scope of practice, regardless of whether they are also appointed to the hospital’s medical staff. That is, technical membership in a hospital’s medical staff would not be a prerequisite for a hospital’s governing body to grant practice privileges to practitioners.</p>

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	<i>Hospitals wishing to bring on additional practitioners without also making them members of the medical staff would follow the same requirements specified in current regulation. That is, the medical staff would examine the credentials of each candidate and make recommendations to the governing body. Medical staff conducting the evaluations would operate under their own hospitals' policies and procedures. Moreover, the medical staff would continue to be limited by State law, and thus would not be permitted to grant a practitioner candidate any privileges beyond those allowed in the State where the hospital is located, where he or she would ultimately practice.</i>
<i>Institutional Plan and Budget.</i> The Joint Commission's institutional plan and budget requirements are more current and simplified than comparable CMS requirements. The Joint Commission requires that staff input is obtained when developing the budget; the budget must reflect the hospital's goals and objectives; the governing body must approve an annual operating budget and, when needed, a long-term capital expenditure plan; and leaders of the organization must monitor the implementation of the budget and the long-term capital expenditure plan. The Medicare Hospital CoPs require very detailed information about capital expenditures. This level of detail is outdated and not necessary to maintain high quality and safe care. CMS should simplify the budget requirements in the CoPs to eliminate unnecessary detail (such as the specifics related to acquisition of land and equipment).	<b>Not addressed in the 10/24/2011 NPRM.</b>  The Joint Commission is considering commenting on this issue, but CMS may be constrained by statutory language.
<i>Leaders vs. Governing Body vs. Medical Staff.</i> <sup>1</sup> The Joint Commission uses the term "leaders" to mean the governing body, the medical staff, the CEO and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. Throughout the	<b>Not addressed in the 10/24/2011 NPRM.</b>  The Joint Commission is considering linking this issue to the overall framework of the CoPs, which is focused on

<sup>1</sup> This issue is also addressed in the section on *Issues That CMS Indicated Some Flexibility with Resolving.*

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<p>CoPs, there are requirements that the governing body or medical staff is responsible for certain services, development of policies and procedures, approval of policies and procedures, and other tasks (some examples are 482.12(e), 482.12(f)(2) and (f)(3), 482.21(b)(3), 482.52(b)(3), 482.53(a)(2)). The Joint Commission has taken the approach to require leadership responsibility for these functions. However, it is CMS’ expectation that accreditation organizations match the exact language of the CoPs. Rather than requiring The Joint Commission to match the exact language of the CoPs, CMS should be more flexible when determining the comparability of requirements. If leaders include governing body members and medical staff members, the intent of the CoP should be considered met.</p> <p>Additionally, CMS requirements dictate a “top down” organizational structure. However, current philosophy is to encourage a “bottom up” organizational structure that allows front line staff, mid-level management, and leaders an opportunity to resolve issues in a collaborative manner—leading to solutions that are sustainable over time.</p>	<p>departments versus systems of care. Staff continues to believe that CMS should shift to using the term leaders, which would encompass the concepts of both governing bodies and medical staff.</p>
<p><i>Self Administration of Medications.</i> CMS requires that all drugs and biologicals be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations. The CoPs do not allow for self-administration of medication and need to be updated to address this issue. Instead of updating the CoPs to account for the acceptable practice of self-administration of certain medications, CMS updated its interpretative guidelines. However, both The Joint Commission and CMS believe the CoPs should also be updated to allow for self-administration.</p>	<p>The Joint Commission is supportive of CMS’ proposed revision because it is inclusive of more medication delivery methods and supports patient and family-centered care initiatives.</p> <p><i>CMS proposed changes would allow hospitals the flexibility to develop and implement policies and procedures for a patient and his or her caregivers/support persons to administer specific medications (non-controlled drugs and biologicals). CMS noted that this proposal would be consistent with the current practice of giving patients access at the bedside to urgently needed medications, such as nitroglycerine tablets and inhalers, and selected non-prescription medications, such as lotions and rewetting eye drops. These proposed changes would</i></p>

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	<p><i>apply to the self-administration of both hospital-issued medications and the patient's own medications brought into the hospital. Hospitals that choose to develop and implement a program that allows for patients and caregivers/support persons to administer certain medications would be expected to address the program in their hospital policies and procedures. CMS would expect a collaborative effort by the hospital's medical staff, nursing department, and pharmacy department to develop these policies and procedures. A hospital would need to: assure that a practitioner had issued an order, consistent with hospital policy, permitting self-administration of medications; assess patient and caregiver/support person capacity to self-administer specific medications; provide patient and caregiver/support person instruction regarding the safe and accurate administration of the specified drugs and biologicals (for specific hospital-issued medications and, if determined to be needed, for a patient's own medications brought in from home); ensure the security of medications for each patient; identify a patient's own medications and visually evaluate those medications for integrity; and document the administration of each medication in the patient's medical record.</i></p>
<p><i>Infection Control Log.</i> The Joint Commission and CMS require individuals responsible for a hospital's infection control program to develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases. CMS is more prescriptive, however, and requires a specific infection control log. CMS may want to reconsider the requirement for a log and allow hospitals more flexibility in determining how to collect infection control information. A log might not be the best method.</p>	<p><b>The Joint Commission is highly supportive of CMS' proposed revisions. The new requirement would eliminate the current prescriptive method of infection control monitoring and evaluation, and allow for greater flexibility within facilities.</b></p> <p><b><i>CMS proposed to eliminate the current requirement at §482.42(a)(2), proposing instead to allow hospitals flexibility in their approach to the tracking and</i></b></p>

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	<i>surveillance of infections. The modern surveillance systems already in use include infection detection, data collection and analysis, monitoring, and evaluation of preventive interventions.</i>
<p><i>Restraint and Seclusion Timeframes.</i> In 2006, CMS revised the restraint and seclusion requirements to address the use of restraints for the non-violent, non-self destructive patients. These revised requirements do not include minimum timeframes for renewal of orders and the monitoring of patients. The Joint Commission agrees that the need to renew orders and monitor patients may vary. However, the failure to provide a minimum requirement has allowed prolonged timeframes in organizational policies, sometimes for up to 72 hours. Patients restrained for non-violent, non-self-destructive behavior include vulnerable populations, such as geriatric patients with dementia, brain injury patients, and pediatric patients. The Joint Commission recommends setting a minimum requirement, as was evident in its restraint and seclusion requirements.</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p><b>The Joint Commission is considering commenting on this issue. Extended restraint and seclusion pose a serious safety issue for non-violent, non-self-harming patients, and remains a problem due to lack of proper reevaluation for restraint authorization approval.</b></p> <p>This issue predates TJC’s hospital deeming application, but it has not been resolved.</p>
<p><i>Restraint Death Reporting.</i> The requirement for death reporting needs clarification. The data collected from reporting all deaths while restrained does not accurately reflect death or injury caused by the restraint itself. Some patients who are near death may be restrained for a number of reasons and should not be included in this reporting mechanism.</p>	<p><b>The Joint Commission generally supports this proposed revision, but plans to ask for clarification. We believe that the reporting is necessary, but only for those incidents that are directly caused by or contributed in part by the use of restraints.</b></p> <p><b><i>CMS proposed modifying the reporting requirements for hospitals when the circumstances of a patient’s death involve only the use of soft two-point wrist restraints and no use of seclusion. CMS proposed that hospitals would be required to notify CMS of the deaths described at (soft two-point wrist restraints and no use of seclusion) within seven days after the date of death through a log or other system. CMS proposed that the record would include, at a minimum, the patient’s name, date of birth, date of death, attending physician, primary diagnosis(es), and medical</i></b></p>

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	<p><i>record number. CMS proposed that hospitals make the log or other system accessible to CMS upon request at all times. CMS stated that it is unable to eliminate the reporting requirement for these deaths due to statutory provisions in the Children’s Health Act that require such deaths to be reported.</i></p>
<p><i>Life Safety Code Edition.</i> The Joint Commission’s ability to remain up-to-date with changes to the LSC is constrained under this new hospital deeming relationship. CMS is still using the 2000 edition of the code and to remain aligned with CMS, The Joint Commission will need to continue to use the 2000 edition. However, the 2009 edition of the LSC is available and the 2012 edition is almost ready.</p>	<p><b>The Joint Commission is considering commenting on this issue because CMS needs the flexibility to be able to make changes as LSC editions are updated, and to be able to utilize the most current edition when it is published.</b></p> <p><i>CMS noted that it expects the 2012 edition of the LSC to be released in Fall 2011. Based on the content of the 2012 edition, CMS will decide whether it or another more recent edition, is appropriate for incorporation into the regulations for hospitals and other affected providers and suppliers. Any regulatory changes would be addressed through separate notice-and-comment rulemaking. CMS is specifically seeking comment on this issue.</i></p>
<p><i>Direction of Services.</i> The Joint Commission has moved to a more contemporary system involving organizational and functional integration of services. As a result of this integrated approach, The Joint Commission’s leadership chapter has one standard (LD.04.01.05) that addresses the effective management of all programs, services, sites of care, and departments. The Joint Commission requires that one or more qualified professional(s) direct the operations and services provided in programs, at sites of care, and within departments. A qualified professional may be a licensed independent practitioner with clinical privileges. The hospital determines the responsibilities of the person directing the operations and services provided and then the person is held accountable for his/her responsibilities.</p>	<p><b>The Joint Commission is considering commenting on the overall framework and structure of the CoPs.</b></p> <p><i>CMS noted that based on stakeholder feedback, it considered revising the overall organizational structure of the CoPs to condense current requirements for departmental leadership responsibilities into a single, non-specific CoP that would allow hospitals to appoint hospital leaders based on hospital-established qualifications and needs specific to each hospital</i></p> <p><i>CMS is specifically seeking comment on this issue.</i></p>

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<p>The Medicare hospital CoPs still have separate service requirements, which were adopted from The Joint Commission in the 1980s. Throughout the CoPs there are requirements that the services are directed by specific types of individuals with specific qualifications. The CoPs are not consonant with organizational structures desired today to provide cost efficient, safe and high quality care. Organizational structure requirements should allow for flexibility as available resources, leadership philosophy, and the interdependent nature of services and there coordination becomes increasingly necessary to arrive at more integrated and cross accountable care.</p>	
<p><i>Integration of Medical Staff and Governing Bodies.</i> It is CMS’s position that every Medicare-participating hospital must be independently in compliance with the Medicare hospital CoPs. Hospitals must be able to demonstrate this independent compliance during an onsite survey, especially as it relates to how the governing body and medical staff function. Yet, multi-hospital systems (those with several CCNs) have integrated their medical staff and governing body functions to oversee care in a more efficient and effective manner. These hospital systems will need to go through a burdensome, duplicative, and counter-productive set of processes to ensure that meeting minutes and other administrative functions demonstrate independent compliance with the CoPs.</p> <p>In its response to the joint American Hospital Association and Joint Commission letter, CMS noted that its position on the integration of medical staff and governing bodies is an essential element of accountability. The Joint Commission’s position is more flexible, but it still expects medical staff and governing body accountability. The Joint Commission also believes that CMS’ position on this issue runs counter to goals of delivery system reforms promoted by the Affordable Care Act. Accountable care organizations, patient-centered primary care homes and other delivery system models that integrate health care services and providers will be difficult to implement if they are prohibited from integrating medical staff and governing bodies</p>	<p><b>The Joint Commission is supportive of CMS’ revisions to this requirement; however, we are considering adding this to the comments on the overall framework of the CoP discussion to clarify the impression that CMS is looking for a CEO-like figure to lead the facility.</b></p> <p><i>CMS proposed revising the “Governing body” requirements to allow hospitals in a multi-hospital system (defined here as those having more than one CMS Certification Number (CCN)) to be governed by a single governing body. Specifically, CMS states that “There must be an effective governing body that is legally responsible for the conduct of the hospital.”</i></p> <p><i>CMS would retain the current provision that requires the persons legally responsible for the conduct of the hospital to carry out the functions specified in Part 482 of its regulations that pertain to the governing body if the hospital does not have an organized governing body.</i></p>

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<p>across organizational lines of accountability.</p> <p><i>Scoring of Life Safety Code Deficiencies.</i><sup>2</sup> CMS and The Joint Commission score LSC deficiencies differently. Violations that fall in the low and medium categories are sometimes not scored as a requirement for improvement by Joint Commission surveyors. Instead Joint Commission surveyors may offer education and guidance on how to correct the problem. CMS, however, includes all LSC violations in its report, thereby increasing the instances of the LSC being out of compliance. In addition, CMS spends significantly more time surveying the LSC and frequently uses local fire marshals, which are very familiar with a facility's physical plant, as surveyors.</p> <p>In its response, CMS expressed concern that Joint Commission surveyors do not always score violations that fall into a low category of leading to (or causing) harm to patients, hospital staff and visitors. The Joint Commission welcomes an opportunity to discuss this issue further with CMS and to provide examples of violations that we believe are not worthy of citation. We hope that CMS will see the benefit of using an educational approach to correct low category LSC issues, rather than the more punitive approach of scoring a deficiency for every minor infraction.</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>Staff does not believe the current NPRM is the correct venue to comment on this issue and will pursue outside of the NPRM.</p> <p>This issue has been around for several years and it appears to also be an issue for the other hospital accrediting bodies.</p>
<p><i>Immediate Jeopardy.</i> CMS frequently calls an immediate jeopardy based on a situation that occurred well before the CMS survey and was addressed or corrected against future like occurrences. CMS is made aware of these situations by a variety of mechanisms, including complaints, self-reports and news articles. In contrast, The Joint Commission only calls an Immediate Threat to Life when there is evidence on a survey that a situation is having (or may potentially have) a serious adverse effect on patient health or safety and that immediate action must be taken.</p> <p>In its response, CMS stated that only “serious violations that are not fully</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>Staff does not believe the current NPRM is the correct venue to comment on this issue and will continue to pursue outside the NPRM.</p> <p>This issue has been around for several years. CMS’ response to this issue is to require TJC to change its approach, rather than sitting down and developing an approach that accomplishes the goals without being so</p>

<sup>2</sup> This issue is also discussed in the section on *Issues Associated with Validation Surveys*.

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<p>remedied” are subject to citation as an immediate jeopardy. Again, we welcome the opportunity to discuss this issue further with CMS because hospitals consistently report that they are being cited for an Immediate Jeopardy well after a situation occurs. The Joint Commission believes that CMS should take a close look at this issue before implementation of the ACA provision that prohibits a hospital from participating in the Value-Based Purchasing Program during the year an immediate jeopardy is cited.</p>	<p>punitive.</p>
<p><b><u>Issues That CMS Indicated Some Flexibility with Resolving<sup>3</sup></u></b></p>	
<p><i>Intravenous Medication and Blood Transfusions.</i> Administering intravenous medications and blood transfusion has been a nursing function for more than 20 years. The skills needed to perform these tasks are taught in schools of nursing and reinforced during a nurse’s orientation to a hospital. Yet, the CoPs specifically state that “If blood transfusion and intravenous medications are administered by personnel other than doctors of medicine or osteopathy, the personnel must have special training for this duty.”</p> <p>In its response, CMS noted that it will add this issue to its “schedule for interpretive guidance.” We are very appreciative of that strategy.</p>	<p><b>The Joint Commission is supportive of these revisions. It allows facilities to exercise flexibility in allowing practitioners other than physicians to perform services within their scope of practice without the burden of additional training.</b></p> <p><i>CMS proposed to revise the current Nursing services CoP to add a new provision that would allow for drugs and biologicals to be prepared and administered on the orders of practitioners other than a physician. CMS also proposed a further revisions, which would add a new provision allowing orders for drugs and biologicals to be documented and signed by practitioners other than those specified as a physician.</i></p> <p><i>CMS would allow for these two revisions only if such practitioners are acting in accordance with State law, including scope of practice laws, and only if the hospital has granted them privileges to do so.</i></p>

<sup>3</sup> CMS states that it will add this to the list of items that need to be changed in the interpretative guidelines. But, CMS has not given any sort of indication on when the guidelines will be changed.

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	<p><i>CMS proposed to eliminate the requirement that non-physicians must have special training in administering blood transfusions and intravenous medications. CMS believes that this training is standard practice, and thus does not need to be prescribed in these regulations. CMS proposed that those who administer blood transfusions and intravenous medications do so in accordance with State law and approved medical staff policies and procedures.</i></p>
<p><i>Therapeutic Diet Manual.</i> CMS requires each hospital to have a therapeutic diet manual. While we believe that other reference materials help to deliver safe, high quality health care, a manual is not mentioned in, or required by, the CoPs. The Joint Commission has taken a broader approach and requires that all necessary knowledge-based information is available 24/7.</p> <p>In its response, CMS indicated that no action was “necessary for The Joint Commission to adopt a broader requirement above the minimums specified by CMS.” However, during the hospital deeming application process, CMS required The Joint Commission to add the word manual to an element of performance (requirement). As a result, many hospitals that were using electronic therapeutic diets felt they had to purchase a manual to demonstrate compliance.</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>The Joint Commission is considering providing comment on this issue. We believe that facilities should be allowed the flexibility to utilize knowledge-based information as a means of staying current on nutritional guidelines, as opposed to utilizing hard-copy manuals that may not be as able to keep up with rapid changes in standards.</p> <p>This issue surfaced during TJC’s hospital deeming application and has not been resolved.</p>
<p><i>Interpretative Guidelines.</i> CMS updates the Medicare CoP Interpretative Guidelines (IGs) more frequently than it updates the regulatory CoP requirements. In general, these updates lack outside input, have become increasingly more prescriptive, and in many cases appear to overreach the intent of the regulatory requirement. During its application for deeming authority, CMS has required The Joint Commission (and other accrediting bodies) to change its requirements based on the interpretative guidelines, regardless of CoP wording.</p> <p>In its response, CMS noted that accrediting bodies are not expected to revise</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>The Joint Commission is considering providing comment on this issue because the NPRM is a platform to point out the accrediting bodies (and pertinent stakeholders) should be allowed an opportunity to provide comments on changes to the IGs.</p> <p>This issue has been around for several years, but we have no indication that CMS will share its draft guidelines with</p>

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<p>accreditation requirements based on <u>every</u> IG. The Joint Commission would like to take this opportunity to clarify that we did not mean to imply that during the deeming application process CMS required changes based on <u>every</u> IG. However, The Joint Commission has had to make changes based on the IGs. Holding accreditation organizations accountable for the wording of CMS' IGs does not take advantage of the state-of-art requirements that accreditation organizations are able to use in their surveys of health care providers. In addition, we again stress the importance of CMS sharing updates to the IGs with accrediting bodies before they are disseminated to the public, so that CMS can benefit from the experience and expertise these bodies have to offer.</p>	<p>accrediting bodies.</p>
<p><i>Survey Process Related to Policies and Procedures.</i> The Joint Commission's standards and survey process focus has shifted from reviewing policies and procedures to assessing performance. Individual tracers and other survey activities focus on performance of activities, observations, and discussions with staff. Policies and procedures are reviewed when there seems to be inconsistent practice or uncertainty of what a practice actually is or if a practice is being followed. As CMS evaluates its CoPs and survey processes, we ask that a similar shift in focus be considered. One example is the focus on policies and procedures at 482.52(b). CMS' survey process, described as tracer methodology, is focused heavily on document review. A more balanced approach as described above would yield a more robust survey and lead to a more credible survey process.</p> <p>In its response, CMS noted that it would be "pleased to consider" refinements to its State Operations Manual. CMS is encouraged to use the experience it gleans from attending The Joint Commission's Annual Invitation Training Conference, which brings together all surveyors and field staff for intensive educational training, to refine and improve its survey process. We would be pleased to work with CMS and appreciate CMS' open view on this issue.</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>Staff does not believe the current NPRM is the correct venue to comment on this issue and will continue to pursue outside of the NPRM.</p> <p>This issue has been around for several years.</p>

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<u><i>Issue That CMS Did Not Address</i></u>	
<p><i>Medical Record Delinquency.</i> CMS and The Joint Commission require that medical records be complete within 30 days. CMS will cite a hospital for having just 1 delinquent medical record. In contrast, The Joint Commission requires the assessment of delinquency rates over 4 quarters because it encourages organizations to conduct a continuous review for timely completeness. Citing a single record out of compliance does not provide a “big picture” look at how the organization is doing with their overall record completion and delinquency, and is punitive in nature.</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>Staff does not believe the current NPRM is the correct venue to comment on this issue and will pursue outside of the NPRM.</p> <p>This issue surfaced during TJC’s hospital deeming application and has not been resolved.</p>
<u><i>Issue Awaiting Resolution</i></u>	
<p><i>Telehealth.</i> The practice of providing services via telehealth was not contemplated when the Medicare hospital conditions of participation were last updated as a comprehensive package—now more than 25 years ago. Therefore, it is not surprising that the CoPs bar hospitals from using the credentialing and privileging determinations made by another hospital in all circumstances. In contrast, The Joint Commission worked with hospitals and safety experts to develop a process known as credentialing and privileging by proxy, which allows smaller hospitals (that frequently operate in underserved areas) to use the credentialing and privileging decisions made by the hospital (or ambulatory site) providing the telehealth services, assuming the latter meets credentialing and privileging accreditation standards.</p> <p>While CMS has proposed allowing the hospitals whose patients receive telehealth services to rely wholly on the <u>credentialing</u> done by the distant site hospital from which the services are provided. To address the <u>privileging</u> issue, CMS has proposed allowing the medical staff at the receiving hospital to rely on information provided by the medical staff at the distant hospital to</p>	<p><i>Already addressed in a final rule.</i></p>

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<p>make a judgment about privileging the practitioners involved. We believe this proposed process is better than the current language of the Conditions of Participation, but think it still introduces unnecessary burden and does not allow for the most appropriate and effective oversight of telehealth providers. Nor does it address ambulatory sites.</p>	
<p><b><u>Additional Issues for Consideration</u></b></p>	
<p><i>30 Minute Rule.</i> CMS IGs found at A-0406 encourage State surveyors to assess whether “drugs have been administered within 30 minutes of the scheduled time for administration.” This guideline is known as the “30-minute rule.” In contrast, The Joint Commission requires surveyors to assess that medications are delivered in a timely and safe manner. Joint Commission surveyors recognize that some medication must be delivered on a rigid time schedule, but most can be administered in a more flexible manner.</p> <p>In a survey conducted by Institute for Safe Medication Practices,<sup>4</sup> most of the nurses responded that the “30-minute rule is unsafe, unrealistic, impractical and virtually impossible to follow.” Many nurses felt the rule “set them up to fail by compelling them to take shortcuts to administer medication within the required time and pressuring them to perform like “med-pusher” robots rather than well-trained healthcare professionals who engage in critical thinking.”</p>	<p><b>Not addressed in the 10/24/2011 NPRM</b></p> <p>This is not a regulatory issue, so staff believes it is likely to be addressed in changes to the CMS Interpretive Guidelines.</p> <p>This is an issue that has recently received a lot of attention. While TJC has heard that this issue will be addressed in the interpretative guidelines, we have not received any official correspondence to confirm this statement.</p>
<p><i>Definition of a Physician.</i> The Joint Commission made a number of changes to its definition of "physician" to comply with the CMS definition. The CMS definition includes a broader array of clinicians than the previous Joint Commission definition, which was limited to a doctor of medicine or osteopathy. Issues have been raised about the appropriateness for using the broader CMS definition in all instances where The Joint Commission</p>	<p>Staff believes that statutory law may prohibit CMS from being consistent throughout the CoPs in the definition of a physician, so that may be why it is not addressed in the NPRM.</p> <p><b><i>CMS proposes in the NPRM to expand the list to include</i></b></p>

<sup>4</sup>September 9, 2010, ISMP Medication Safety Alert.

<u>Issues Raised with CMS by The Joint Commission</u>	<u>Status/Notes</u>
<p>references "physician" and also there appears to be some inconsistencies in the CMS use of the broader definition. Further, the rationale for excluding certain licensed independent practitioners, such as podiatrists, from being the "physician" who heads the medical staff of a podiatric hospital has been questioned. The Joint Commission would like to explore with CMS the use of the term "physician" in its various citations throughout the CoPs.</p>	<p><i>doctors of podiatric medicine (DPMs). CMS believes this change would permit a podiatric physician to serve as the president, or its equivalent, of a hospital's medical staff in a significant number of states.</i></p>

**Note: The issues related to Validation Surveys were deleted because they are not relevant to the changes proposed in the Oct. 24<sup>th</sup> Notice of Proposed Rule-Making (NPRM).**