Inside the Joint Commission

Independent news and guidance to ensure rigorous compliance and accreditation excellence

April 16, 2018 | Volume 23, Issue 8

IN THIS ISSUE

Infection control

Case study: Hospitalwide huddles curb catheter infections at Saint Anthony

Consider incorporating a review of patients with catheters as part of a daily, hospitalwide safety huddle that includes at least one senior leader from your C-suite. With such a daily focus on patient safety, within two years, Saint Anthony Hospital in Chicago cut its hospital-acquired infection (HAI) rate by 90% and saved itself $498,000.

For its efforts, Saint Anthony won the Illinois Health and Hospital Association's (IHA) "Innovation Challenge: Partners in Progress Award" in February.

*(see **HAIs**, p. 5)*

Pain management

Start with gap analysis, show your work to meet new TJC pain expectations

Do a gap analysis to see how well you are meeting The Joint Commission's (TJC) revised pain management standards and put together a multidisciplinary team now to start plugging the gaps you find.

Hammer home that leadership must be involved, says Jennifer Cowel, RN, MHSA, a former TJC director of service operations who is now president of Patton Healthcare Consulting in Naperville, Ill.

*(see **Pain management**, p. 7)*

Pain management

Craft policy that goes beyond the law to help patients and prescribers

Institute a policy on opioid prescribing to relieve your providers of some decision-making pressure in an age of addiction awareness — and, if you do it right, your providers should still be able to give patients the pain relief they need.

Concerns over the rise in prescription rates and associated reports on opioid abuse are at a peak. More than three dozen bills addressing various concerns about the opioid epidemic are before committees in the Senate and House. The Centers for Disease Control and Prevention (CDC) issued restrictive new guidelines for chronic-pain prescribing in March 2016, and the President's Commission on Combating Drug Addiction and the Opioid Crisis was established a year later.

States, however, have been ahead of the feds, with many instituting tough prescribing and dispensing restrictions; for example, effective Jan. 1, 2018, North Carolina's STOP Act restricts acute-pain opioid prescription amounts to five days and post-operative opioid prescriptions to seven days.

In some cases, payers have reacted with their own restrictions. "Some insurance carriers are beginning to decline coverage for any opioids prescribed beyond the protocol recommended by the CDC," says Nancy Irwin, Psy.D., primary therapist at Seasons Recovery Centers in Malibu, Calif.

Go beyond the law

It is, of course, important to keep up with the law, which can vary significantly from state to state. For example, in New York all prescriptions, including those for controlled substances, must be electronically written except in emergencies, while in other states a paper prescription is required.

"We have to write out the scrips — can't call it in at all," says Barbara Bergin, MD, an orthopedic surgeon with Texas Orthopedics, Sports and Rehabilitation Associates in Austin. "We can call in Tylenol #3 — which people who are habituated don't like because it's not strong enough for them. But anything stronger has to be written out on a prescription, which the patient has to hand deliver to the pharmacy."

And in some states like New York, it's on the provider to keep tabs on their patients' opioid prescription history via prescription drug monitoring programs (PDMP), says Kate Fuss, a surgical physician assistant most recently with hospitals in the Greenwich, Conn., area.

In addition, revised pain management standards by The Joint Commission, effective Jan. 1, has a new Leadership standard, **LD.04.03.13**, that includes an element of performance requiring hospital leadership to provide clinicians and pharmacists access to their state's PDMP, whether it is mandatory or not. (*More on pain revisions, see p. 1*).

Beyond whatever your state or local authority having jurisdiction requires, your policy on opioids is, to a great extent, your hospital's call, and experts suggest that you nail that down to protect both provider and patient.

Subscriber Information ▸ Have questions on a story? Call or email us.

Inside the Joint Commission is published 24 times each year by DecisionHealth, LLC. Copyright 2018.

Have questions on a story? Call toll-free: **1-855-CALL-DH1**

President:
Elizabeth Petersen,
1-800-727-5257, x3432
EPetersen@blr.com

Content Manager
Jay Kumar, 978-624-4560
jkumar@blr.com

Vice President:
Tonya Nevin, x6036
tnevin@decisionhealth.com

Editor:
A.J. Plunkett, x6001
aplunkett@h3.group

Join our DecisionHealth — Medical Practice & Hospital community!
www.facebook.com/DecisionHealthMP
www.twitter.com/DH_MedPractice
www.linkedin.com/groups/4048762

DecisionHealth Pledge of Independence: DecisionHealth's *Inside the Joint Commission* works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers, and we'll be there for you and your peers for decades to come.

Some prescribers have worked out their own ways of dealing with a patient whose PDMP record shows a recent opioid prescription. "Typically, I will prescribe them a third to a half of the original prescription I was going to write for [patients], as they do need appropriate pain coverage post-operatively," says Fuss. "Typically, there is not much push back." When she gets "pill-counting" behavior — that is, when patients specifically comment on how many pills they have and how many they think they need — "the encounter becomes slightly more complex," she says. If she's getting nowhere with the patient, she defers to a pain management specialist, either the patient's own or one to whom she refers.

Make it a policy

But one benefit of having a set policy that providers are expected to follow is "physicians can defer to the institution, which will have their back on their decisions," says Celine Thum, M.D., director of emergency ultrasound and attending physician at a Level I trauma center in New York City.

The drawback is that "sometimes the patient really does need the medication," Thum says. Some flexibility can vitiate that side effect; just as some hospitals allow certain antibiotics to be prescribed only by its infectious disease specialists, so too a provider could allow only certain prescribers in certain circumstances to write beyond the limits of the policy.

Some providers write contracts with patients that may involve periodic drug screens, violation of which will cause the provider to stop prescribing the drug, says Fuss. Others refer the patient to a pain management specialist if they feel uncomfortable prescribing opioids.

Some try to provide alternative treatments. While opioids are an important part of the program at the Laser Spine Institute in Tampa, Fla., its chief medical director and co-founder, Michael Perry, M.D., says "we try to do everything we can to restrict the amount and dosage of narcotics by doing things others may not be doing" with a "multi-modal" approach.

That includes non-opioid pain treatments including "something called an IceMan that circulates cold water on their back" and drug cocktails such as Tylenol, Lyrica and Celebrex, "which studies show significantly reduces post-operative pain." Perry says the institute keeps up with advances in pain management via peer-review journals and "if something is new and we think it might be an advantage, we assess it in every aspect," he says.

Tips for opioid policy

- **Write smaller amounts,** even if the law doesn't require it, says Bergin. State laws are a ceiling, not a floor. A study published in CDC's Morbidity and Mortality Weekly Report (MMWR) found that patients' chances of becoming addicted to opioids increased as their prescription amounts increased — and that patients given a 10-day course had a one-in-five chance of getting hooked. If you write shorter-term prescriptions, patients "use them more sparingly so they won't have to come back. That's probably the biggest effect: It makes people who are drug-innocent more careful about how they're using narcotics," she says.
- **Brief the patient on the law.** "Educating patients in advance of any legislative changes regarding their opiate prescriptions with ample notice can help the patient get psychologically geared up to switch to a non-addictive, non-narcotic medication," says Irwin.
- **Tell them to use less even if they have it.** Toleration varies among patients; some will need every dose the prescription calls for, while others will need less. However, "if the label said 'one to two every six hours,' a narcotic-innocent patient might take the maximum dose because it said so on the prescription," says Bergin. "Now we're telling them: Take it less than the prescription says as soon as possible, and get off of them as soon as you can." — *Roy Edroso (redroso@decisionhealth.com)*

Resource

- CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016: *http://jamanetwork.com/journals/jama/fullarticle/2503508*

HIPAA

'Siri, this a HIPAA violation?' Beware risks of virtual voice assistants

Voice-activated virtual assistants, such as Amazon's Echo and Google Home, are convenient and helpful. They're rising in popularity in the medical field, but they can create legal headaches when used by doctors and other clinicians.

According to a recent survey, almost a fourth of physician offices use virtual assistants at work for functions such as drug dosing questions, calendar appointments, supply ordering and diagnostic information searches.

This number is likely to rise as these products become more common. For instance, Apple, which launched Siri in its iPhones several years ago, has now released a tabletop Siri HomePod.

There are also voice assistants integrated into electronic health records (EHR) systems. In December 2017, eClinicalWorks added a voice-activated assistant, called Eva, to its EHR software. With Eva, physicians can use voice commands to have the EHR pull up lab reports and other patient records. Several other EHR vendors have similar voice-activated assistants under development.

Ease of use means increased risk

These assistants are easy to use and enable physicians to have more face time with patients. However, the devices can create compliance risks. These include:

- **Privacy violations.** Since these are voice-powered devices, the physician's query and the device's response can be easily overheard by others, says attorney Michael Kline, with Fox Rothschild in Princeton, N.J. If a physician provides too much patient-specific information so as to make the patient identifiable, speaks more loudly than necessary, or positions the device so that it's not in a private area, it could be a violation of HIPAA or state privacy rights.
- **Data security.** Virtual voice assistants store users' queries and some manufacturers may access the data for other purposes, such as marketing research, or to share with third parties. In addition, different voice assistants have different levels and types of security for the stored information, warns attorney Elizabeth Litten, also with Fox Rothschild. For instance, the iPhone's Siri keeps recordings and transcripts but ties them to random numbers, making the users more anonymous. Amazon's Alexa is less secure; it stores full transcripts that can be viewed by anyone who can access the account. "You've created data. Be aware this is another place where the data is stored," says Litten.
- **Security of the device.** Virtual voice assistants are part of the "Internet of Things," interconnecting devices like smart TVs, wireless insulin pumps and baby monitors. Unfortunately, they are easily exploited by cybercriminals, who can hack into them; eavesdrop and collect information for blackmail or defamation; disable or reprogram the devices; or download malware that can then affect other connected electronic systems. The FBI has issued warnings about the risks of the Internet of Things for years. Virtual voice assistants have additional vulnerabilities because they're voice activated and can be turned on by more than one voice. So an unauthorized person could access the scheduling calendar or EHR and delete or change information and their actions could be blamed on the authorized user, warns Kline.
- **Unreliable or incorrect content.** Just because a virtual voice assistant is programmed to search the internet does not mean that the information it locates and spits back is reliable and trustworthy. "You don't know how good the information is and whether it's validated," warns Litten. For example, a recent report found the Siri HomePod correctly answered just 52% of 782 standardized questions; Microsoft's Cortana answered 57% correctly. Google Home fared better but still only answered 81% of the questions accurately. These errors are particularly concerning when asking for and relying on clinical information.
- **Medical record problems.** Virtual voice assistants that input automatically into the medical record may do so in a way that you don't want or makes the information hard to find. Others don't transcribe voice files. That means that the clinician needs to take notes on the information received from the device and then enter them into the record. If the clinician fails to do so, then the medical record is faulty or incomplete, warns Kline.
- **Malpractice concerns.** Relying on information provided by a voice assistant and failing to keep complete medical records are malpractice risks. And since the tools store past queries, they can be discoverable in malpractice litigation.
- **'Wake up' errors.** The devices sometimes inadvertently turn on when they hear a word similar to their "turn on" word. For example, Alexa can turn on when hearing a word that sounds like Alexa. So it can be recording you when you don't know it's on.

"The convenience the technology creates can [cause one to] easily slip," warns Kline. — *Marla Durben Hirsch (ijc_editors@decisionhealth.com)*

Resources

- Accuracy of virtual voice assistants: *http://loupventures.com/we-ran-homepod-through-the-smart-speaker-gauntlet/*
- Use of voice assistant devices by physicians: *https://decisionresourcesgroup.com/report/419581-digital-paging-dr-siri-taking-the-pulse-u-s-2017/*

HFAP

Longtime accrediting organization to keep its name, continue to expand

The Healthcare Facilities Accreditation Program — also commonly known as HFAP — will be keeping its name. The longtime accrediting organization had originally planned to take the name of the Accreditation Association for Hospitals/Health Systems (AAHHS), which acquired them in 2015 from the American Osteopathic Association (AOA.)

AAHHS is a non-profit organization focused on quality and safety in healthcare and has been acting in a management capacity for existing HFAP accreditation programs since the merger. According to HFAP media representative Mary Velan, to avoid the alphabet soup of switching from AOA/HFAP to AAHHS/HFAP, they plan to simplify by going forward as HFAP.

"We had considered a name change but HFAP has over 70 years of history behind its accreditation programs and we want our current and future customers to know that the practical, educational approach that is what HFAP delivers remains unchanged," she said.

Even though the name change is off, HFAP members shouldn't worry said Velan. The change in plan won't affect any of the services provided by HFAP or its survey process.

"HFAP continues with its mission of advancing high-quality patient care and safety through objective application of recognized standards," Velan said in an email.

She also added the accreditor is expanding their specialty care certification programs, including stroke, lithotripsy, wound care, joint arthroplasty, and compounding pharmaceuticals. HFAP is also working on renewing its CMS deeming authority prior to 2019 expiration dates.

HFAP was established in 1945 to review osteopathic hospitals and was one of only two accrediting organizations deemed to review hospitals for eligibility to participate in Medicare when it was created in 1965. The other deemed accreditor was The Joint Commission. HFAP accredits both acute care and critical access hospitals, as well as other types of healthcare organizations. — *Brian T. Ward (bward@hcpro.com)*

Resource

- Briefings on Accreditation and Quality, October 2015: *http://www.hcpro.com/QPS-322674-16/AAAHC-moves-into-hospital-accreditation-market-with-HFAP-acquisition.html*

HAIs

(continued from p. 1)

While most hospitals conduct regular safety huddles, Saint Anthony conducts their interdisciplinary safety huddle (DISH) every day and includes representatives from all departments, including security, nursing, emergency services, infection control and other areas hospitalwide. The DISH is held every morning, but kept to a 15-minute daily briefing.

Alfredo Mena Lora, MD, is the medical director of infection control (IC) at Saint Anthony. DISH is just one aspect of their HAI reduction program, he says, but it's an important part of it.

"We know that huddles have been proven to improve outcomes and reduce certain variables, whether it's in surgery or catheter placement," he says. "But a hospital-wide huddle [on catheter use] is what I think is novel."

At DISH, nurse managers report on which patients have indwelling catheters (urinary or central venous). Then it's decided which patients still need their catheters. For those who don't, the hospital expects the catheter to be removed within 24 hours. The longer a patient has a catheter, the more likely he or she is to develop an infection.

Performance improvement quantified

For an improvement program, DISH is pretty simple and cheap to set up. Saint Anthony started doing DISH meetings in late 2014. While it took a few months to get rolling, Lora says the hospital saw results almost immediately.

After one year of DISH meetings, Lora became curious. He felt the meeting was making a difference—after all, he saw the catheters being removed. But he wanted to prove it.

"Everything we do, every small quality improvement initiative, as the IC person here I always try to study it to see if there are empirical ways to assess the before and after," he says. "I knew the meeting was being effective; my objective was to look at the before and after."

They tracked their progress by tracking their device usage rate (DUR). While the definition of HAIs have changed over time, DUR has remained a constant variable for measuring the effects of medical intervention.

"When we reviewed this retrospective, we saw a downtrend after we were assessing the needs of catheters on a daily basis and forcing their removal," he says. "I do think it promotes quick removal and is pretty cost-efficient and easy to do."

There are always small challenges in trying a new improvement project, he says. But DISH is very sustainable and it helps correct any kind of challenges they have.

Right now, he's working on a way to better assess why certain catheters remain. For example, was there a

rise in the DUR because there were more sick patients? Because a new physician didn't know the catheter policies? Or something else?

"Because I'm the infection control physician here, I know why some catheters remain—because some patients are sick and so forth," he says. "As part of optimizing DISH, I'm looking for better ways to obtain that data moving forward and report it at DISH in a more efficient way."

Togetherness provides focus

While Lora's DISH study looked at catheter reduction, the huddles have more than one use.

"I think the success of the huddle is that it just morphed into including all the other disciplines," he says. "Because on certain days we'd need information from other groups or departments in the hospital. Eventually we just decided to include all of them, because it improves communication between all departments."

"For example, a week ago there was some minor construction that was going to happen," he continues. "I know about it because of that [DISH] meeting and I implemented immediately whatever I need to do from an IC standpoint. Similarly, if there's an issue in the OR, all the disciplines go there, so we all communicate."

The daily huddle gives everyone from nutrition to facilities management a chance to update each other on what they're doing. Everyone gets something out of this meeting, he says. And what they get is:

- Ability to ask questions and get quick responses
- Knowledge of everything going on in the hospital
- Accountability for finding solutions

"No matter what variable, this meeting does help," he says. "And that's part of the reason why we've been doing this for three years."

Changing behavior

Prior to DISH, Saint Anthony's catheter reduction program was similar to what most facilities have: an evidence-based approach, checklists, antibiotic discs, and other such measures. What made DISH successful, Lora says, is how it changed the behavior around reporting and removing catheters.

"We know that in infection control a lot of what we're trying to control is human behavior," he says. "We know that a patient that needed a central line for a lifesaving measure needs that central line. Maybe after day three or four they don't need it. But sometimes it's more comfortable for the nurses or people to forget that the catheter is there. So, I think that's one of the human factors that this meeting controls. There's more checks and balances to removing Foleys and central lines."

Editor's note

What's your story? Share your problems, solutions and successes

Hospital accreditation and safety doesn't happen in a vacuum. We want to learn more about how people and facilities go about keeping patients, staff and visitors safe in everyday life.

That's why we here at *Inside the Joint Commission* are calling on our readers to contact us about your successes, challenges, and experiences in infection control, patient safety, quality, accreditation and compliance.

What are we looking for?

We want stories about patient and staff safety challenges you and your facility have faced and solutions that succeeded — or even ones you're still facing and have questions about:

- Quality and patient safety projects your facility has undertaken
- Hurdles managed during renovations or facility changes
- Lessons learned while meeting a new regulatory requirement or standard

Who can submit?

Anyone working in or who has worked at an accredited healthcare facility — from a small hospital or off-campus clinic to a multi-state health network.

When?

We accept story ideas year-round.

How?

Submit your idea by emailing me, A.J. Plunkett, at *aplunkett@h3.group* with the subject line "Accreditation Case Study Idea" and you might be featured in an upcoming edition of *IJC!*

Something he's noticed in the data is a global drop in catheter use in all of Saint Anthony's units. The most dramatic changes came from non-intensive care units, especially the medical-surgical units. The only place where the decrease was statistically insignificant was in their ICU.

What this suggests is a lot of ICU patients have catheters but are justified in having them. However, he says without the daily meetings, it was more likely for patients to leave the ICU and have the catheter remain for a few extra days.

"Clinical practice is very busy, so I think sometimes we forget that we can remove these catheters or use an alternative line," he says. "And I think that's where we found the dramatic change."

The boss is watching

Lora says the most important reason why DISH has been so successful was "because our leadership saw the value in this and really helped move everybody to come to this meeting." Since day one, hospital leaders have attended, which gives people an incentive to not let problems linger.

"If I as the infection control person say, 'Hey, we talked about removing this catheter yesterday; was there a problem?' chances are because we have the vice presidents there and senior leadership, most people will come with an answer the next day if the catheter does remain," he says. "Or try to remove it, which is our ultimate goal."

He says that DISH is usually attended by at least one senior administrative person, usually the vice president of nursing and the vice president of patient care services. Lora says this creates an air of accountability that's promoted results and maintained DISH over the years.

The accountability extends to Lora, as infection control leader. "I have an IC nurse that goes to these meetings, and it's somewhat redundant for me to go. But I started going and I saw the value immediately. These meetings don't last more than five to 15 minutes, plus or minus depending on how many people come up. But the value you get from this meeting is massive because you know everything that's going on in the hospital. I think the value of the meeting is that though we have leadership supporting and moving this, the value is obvious to everyone, which is why I think everyone enjoys going."
— Brian T. Ward (bward@hcpro.com)

Pain management

(continued from p. 1)

While TJC surveyors may not be hitting hospitals hard yet on the requirements that took effect Jan. 1, they could be soon, especially as federal regulators continue to crack down on the overprescription of opioids nationwide.

Looking for leadership

Generally what surveyors look for most in the first year of implementing new standards is the level of leadership involvement, notes Cowel.

"Did you get leadership involved, is it a priority, did you get a team together to start looking at this, and have you done a gap analysis?" she asks.

Schedule regular meetings with your pain management team to ensure you are taking steps to plug the holes identified in that gap analysis and be able to show surveyors how you plan to meet the new requirements.

"They want to know that you've looked at them and you've tried, and you're working on it," says Cowel.

The revised standards emphasize safe opioid prescribing and encourage the use of nonpharmacologic methods of managing pain. It also adds a Leadership standard requiring that hospital executives not only make pain management and assessment a priority, but provide resources for non-opioid education and programs. Failure to meet a Leadership standard is a condition-level finding, which could prove a threat to a hospital's accreditation and draw the attention of CMS surveyors.

CMS also requires pain assessment

While many of the TJC revisions are new, the requirements to manage pain and monitor opioid use are also found in CMS' State Operations Manual, Appendix A, which outlines interpretive guidelines for Medicare's state and regional surveyors implementing the Conditions of Participation.

Under **§482.13(b)(1)**, "the patient has the right to participate in the development and implementation of his or her plan of care," to include at a minimum "the right to: participate in the development and implementation of his/her inpatient treatment/care plan, outpatient treatment/care plan, participate in the development and implementation of his/her discharge plan, and participate in the development and implementation of his/her pain management plan."

One of the more difficult requirements is providing patients the option of nonpharmacologic methods of pain management. There are not a lot of proven hospital programs on managing pain without drugs, but the number is growing, says Cowel.

R3 report offers starting point

TJC issued an R3 Report on the new requirements in August that highlights several studies on nonpharmacologic methods of pain management under EP 2 of **LD.04.03.13**, the new standard requiring Leadership involvement.

Education of both staff and patients will be a key part of any successful program. Both are required under the new requirements. Cowel, also a former nurse surveyor for TJC, says hospitals must do more education prior to surgery, to help patients anticipate the pain ahead, "rather than finding out afterwards."

While nurses already provide a lot of patient education, increasing what patients and families know about pain and the array of potential solutions — including those that do not involve drugs — "all of these things together would allow our country to move on past this reliance on a pill to treat all pain, to a more realistic expectation of pain," she says. — *A.J. Plunkett (aplunkett@h3.group)*

Resource

- The Joint Commission's R3 report on pain management: *https://www.jointcommission.org/assets/1/18/R3_Report_Issue_11_Pain_Assessment_2_9_18_REV_FINAL.pdf*

Medication management

ASHP issues fact sheet for coping with injectable opioids shortages

Even as accreditation and compliance officers are under pressure to meet new requirements on pain management, other hospital departments are struggling to meet patient pain needs in light of a shortage of injectable opioids.

The American Society of Health-System Pharmacists (ASHP) has issued a fact sheet for healthcare organizations with potential actions to cope with the shortage, noting that "healthcare professionals should use their professional judgment in deciding how to use the information in this document, taking into account the needs and resources of their individual organizations."

The shortages are a result of manufacturing problems as well as a reluctance by the Drug Enforcement Agency to increase the amount of raw materials necessary to step up production elsewhere. The American Hospital Association (AHA), ASHP and others are working with the DEA to ensure production quotas are adjusted, according to information from the AHA. To find the ASHP fact sheet on injectable opioids, go to: *https://www.ashp.org/Drug-Shortages/Shortage-Resources/Injectable-Opioid-Shortages-FAQ*
— *A.J. Plunkett (aplunkett@h3,group)*