Joint Commission Leaders
Author JAMA Viewpoint on High Reliability Strategies

In the May 12, 2015, issue of the Journal of the American Medical Association (JAMA), a Viewpoint coauthored by The Joint Commission’s president and chief executive officer, Mark R. Chassin, MD, FACP, MPP, MPH, and executive vice president for Healthcare Quality Evaluation, David W. Baker, MD, MPH, calls on physicians to acquire the skills necessary to become leaders for quality improvement and safety in an increasingly complex health care environment.

The Viewpoint, “Aiming Higher to Enhance Professionalism: Beyond Accreditation and Certification,” is part of a JAMA theme issue on the topic of governance and professionalism in medicine. In the column, Chassin and Baker note that medicine has too often tolerated problematic behaviors and is viewed by some stakeholders as failing to address issues such as poor quality of care and safety, lack of access to health care, and the high cost of care. This persistent behavior is now drawing threats to medicine’s self-governance from government officials, private organizations that purport to judge quality, and consumers demanding more accountability. The best way to mitigate those threats, according to the column, is to place physicians at the forefront of health system efforts to improve.

“Physicians could make a much stronger case for continued self-governance if they took a more visible and vigorous leadership role in efforts that led to major improvements in the quality and safety of patient care,” Chassin and Baker write. “In the past, it might have been enough for individual physicians to work hard and provide care to patients to the best of their ability. Medicine was far more art than science. However, health care today is too complex for a single physician’s isolated efforts to be successful. Systems of care are necessary to achieve the highest levels of safety and quality.”

In addition, medical societies and


Continued on page 3


**In Sight**

This column informs you of developments and potential revisions that can affect your 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.

**ACCEPTED STANDARDS**

- Revision related to the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) for microbiology laboratories (see article on page 7)
- Revision related to the May 12, 2014, CMS final rule for for critical access hospitals (see article on page 9)

**APPROVED STANDARDS**

- Revisions to selected requirements for nursing care centers (see article on page 10)
- Revisions to immunohistochemistry requirements for laboratories (see article on page 7)
- Removal of “Life Safety” (LS) chapter and Environment of Care (EC) Standard EC.02.03.03, EP 1 for office-based surgery practices

**PERFORMANCE MEASUREMENT REQUIREMENTS**

- Expanded threshold of births per year for mandatory reporting of the perinatal care (PC) performance measure set for hospitals (see article on page 3)

**CURRENTLY IN FIELD REVIEW**

- Proposed revisions to diagnostic imaging requirements for hospitals, critical access hospitals, and ambulatory care organizations (field review ends June 25, 2015)
- Proposed new comprehensive cardiac center certification option, applicable to accredited hospitals (field review ends July 16, 2015)

Note: To participate in or read more about field reviews, please visit The Joint Commission website at http://www.jointcommission.org/standards_information/field_reviews.aspx.

**CURRENTLY IN DEVELOPMENT STANDARDS**

- Proposed revisions to diagnostic imaging requirements for hospitals, critical access hospitals, and ambulatory care organizations
- Proposed new comprehensive cardiac center certification option, applicable to accredited hospitals
- Proposed new Advanced Certification in Total Hip and Total Knee Replacement option, applicable to accredited hospitals, critical access hospitals, and ambulatory surgery centers
- Proposed new standards addressing housing services for behavioral health care organizations
- Proposed new standards addressing eating disorders care, treatment, or services for behavioral health care organizations
- Proposed revision to Performance Improvement (PNPI) Standard PNPI.2, EP 2, for perinatal care certification standards related to retired performance measure PC-05a
- Proposed new Patient Blood Management Certification program for accredited hospitals
Joint Commission Leaders Author JAMA Viewpoint on High Reliability Strategies (continued)
Continued from page 1

accrediting and certifying organizations must change as well so they can assist physicians in leading this change, the authors state.

“Medical societies have emphasized to their members that working to improve quality is part of physician professionalism. Accrediting and certifying organizations can work in tandem with medical societies to help make this a reality,” Chassin and Baker write in the article. “But just as health care has changed, the organizations that perform standard accreditation and certification functions will need to change to be effective in this new environment.”

The authors note that the traditional approach of comparing performance to standards is only able to find deficiencies, such as failure to meet accreditation requirements during an onsite survey or wrong answers on a certification test. That approach, by its design, is unable to recognize or foster excellence. Instead, they recommend an approach built on the principles of high reliability to achieve far-reaching, systemic changes in patient safety and quality of care:

- State simply and clearly that the ultimate goal is zero harm for patients and health care workers. This means always delivering effective care, freedom from complications of care, and elimination of care that has no value (overuse).
- Physicians and organizations should master the tools, methods and science that businesses outside of health care have used to facilitate the magnitude of such improvements.
- Accrediting and certifying organizations must change as well so they can assist physicians in leading this change, the authors state.

These tools of Lean, Six Sigma, and change management, along with the science of high reliability, provide this capability.

- Accrediting and certifying organizations must develop new programs to foster, identify, and publicly recognize consistent excellence. These should be seamlessly integrated with the traditional—and necessary—accreditation functions.

The Joint Commission already has taken on these three strategies and fully adopted Lean, Six Sigma, and change management for all of its internal improvement functions. In addition, the Joint Commission Center for Transforming Healthcare, which functions separately from the accreditation programs, has embraced these tools as well as high-reliability science and uses its programs and tools to engage physicians and health care organizations in this effort.

"Physicians should demand and lead new efforts to eradicate patient harm and produce consistent excellence across the full continuum of care,” Chassin and Baker write at the conclusion of the article. “This strategy is the best way to ensure society will continue to entrust self-governance to the medical profession.”

Please visit http://jama.jamanetwork.com/article.aspx?articleId=2290646&guestAccessKey=20312c34-4f5c-4508-b2b6-411c8f53078e to read the full Viewpoint.

Expanded Requirement for Perinatal Care Measure Set Reporting

Effective with January 1, 2016, discharges, the threshold for mandatory reporting of the Perinatal Care (PC) performance measure set will change from a minimum of 1,100 births to a minimum of 300 births per year.

This revised threshold means that all Joint Commission–accredited hospitals that have 300 or more births per year will be required to collect data and report on all five measures in the PC core measure set shown in Table 1 (see page 4). The Joint Commission chose the new threshold based on the analysis of perinatal care data received to date and because it will encompass more than 80% of accredited hospitals with birthing units.

Hospitals can determine if they meet the threshold for the required use of the PC measure set by calculating the average number of births for the two most recent calendar years (CY) for which there are complete data—that is, CY 2013 and CY 2014. If the average number of births is at least 300, then data collection on the PC measure set is required beginning with January 1, 2016, discharges. An example of the calculation is provided in Table 2 (see page 4). For the purposes of calculating the average number of births, organizations should count the number of actual live births rather than the number of deliveries. (In the case of triplets, for example, one delivery results in three births.)

The Joint Commission strongly encourages hospitals meeting the new threshold requirement to consider adopting this measure set before the required effective date of January 1, 2016. In addition, hospitals must notify The Joint Commission by modifying and updating their measure set selections.
Expanded Requirement for Perinatal Care Measure Set Reporting (continued)
Continued from page 3

by November 1, 2015 (two months before the start of data collection) if they meet this threshold.

The Joint Commission will continue to monitor the threshold of 300 births over the first four to eight quarters of data collection to assess ongoing applicability. Questions about the expanded perinatal care performance measurement requirements for general medical/surgical hospitals can be directed to Frank Zibrat, associate director, Accreditation Systems Integration and ORYX, The Joint Commission, at fzibrat@jointcommission.org or 630-792-5992. ORYX vendors may direct questions to Mary Kay Bowie, BSN, MHSA, RN, CPHQ, associate director, Center for Measurement System Operations, The Joint Commission, at mbowie@jointcommission.org or 630-792-5974. For more information about performance measurement and accreditation, please visit http://www.jointcommission.org/performance_measurement.aspx.

|---------------------|-------------------------|-----------------------|--------------------------|---------------------------------------------------------------|--------------------------------------|

Table 2. Calculation of Average Number of Births

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<td>270</td>
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<tr>
<td>CY 2014</td>
<td>342</td>
</tr>
<tr>
<td>CY 2013 + CY 2014</td>
<td>612</td>
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</table>

Average number of births 612/2 306

Joint Commission Joins White House Effort to Reduce Antibiotic Overuse

As part of the June 2, 2015, White House Forum on Antibiotic Stewardship, The Joint Commission announced its commitment to increase its efforts to promote effective antibiotic stewardship within health care facilities.

The Joint Commission joined representatives from more than 150 major health care organizations, food companies, retailers, and animal health organizations at the forum to announce their commitment to implementing changes over the next five years to slow the emergence of antibiotic-resistant bacteria, detect resistant strains, preserve the efficacy of existing antibiotics, and prevent the spread of resistant infections.

As part of its commitment, The Joint Commission will begin by reviewing its current standards and work with accredited organizations and others to identify where new standards may be needed to promote effective antibiotic stewardship. The Joint Commission will develop any new standards as rapidly as possible and simultaneously provide new tools to help providers use antibiotics judiciously. This issue is a high priority for The Joint Commission because the rise of antibiotic-resistant bacteria represents a serious threat to public health. The Centers for Disease Control and Prevention (CDC) estimates at least 2 million illnesses and 23,000 deaths in the United States each year are caused by antibiotic-resistant bacteria, and 20% to 50% of all of the antibiotics prescribed in acute care hospitals in the United States are either unnecessary or inappropriate. Inappropriate use of antibiotics includes, but is not limited to, the following:

- Prescribing antibiotics for viral infections
- Using broad-spectrum antibiotics instead of narrow-spectrum antibiotics
- Prescribing antibiotics in response to pressure from patients/families

“The Joint Commission knows that antibiotic stewardship is a proven method of reducing the inappropriate use of antibiotics and improving patient safety,” states Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer, The Joint Commission. “We are committed to helping health care providers improve their ability to practice effective stewardship in order that the nation can both optimize the treatment of infections and reduce adverse events associated with antibiotic use.”

In order to ensure alignment with stewardship initiatives at the federal level, The Joint Commission will seek the input

Continued on page 11
New Online Publications Focus on Respiratory Protection for Health Care Workers

The Joint Commission recently released a free online monograph designed to assist hospitals in creating, implementing, and sustaining their respiratory protection programs (RPPs). A collaboration between The Joint Commission and the Centers for Disease Control and Prevention (CDC)/National Institute for Occupational Safety and Health (NIOSH)/National Personal Protective Technology Laboratory (NPPTL), Implementing Hospital Respiratory Protection Programs: Strategies from the Field underscores the importance of protecting health care workers from exposure to respiratory hazards such as airborne pathogens, surgical smoke, and antineoplastic drugs.

Implementing Hospital Respiratory Protection Programs: Strategies from the Field features examples, strategies, new resources, and a variety of implementation approaches solicited from the field and vetted through an eight-member Technical Expert Panel (TEP). Intended for those who administer and implement organizationwide respiratory protection programs in acute care and specialty hospitals, the monograph may also be useful in settings such as nursing homes and home care organizations.

The monograph, which is part of a cluster of research activities spearheaded by CDC/NIOSH/NPPTL around respiratory protection programs, is intended to be a companion document to the Hospital Respiratory Protection Toolkit: Resources for Respirator Program Administrators. Developed by the Occupational Safety and Health Administration (OSHA) and NIOSH, this free online toolkit identifies reasons for implementing respiratory protection programs, explains the functions of air-purifying and air-supplying respirators, describes how to perform hazard evaluations, and provides guidance on how to develop policies and procedures for written programs. In addition, links to a variety of references and resources—including Implementing Hospital Respiratory Protection Programs: Strategies from the Field—are provided.

The monograph Implementing Hospital Respiratory Protection Programs: Strategies from the Field is available on The Joint Commission website at http://www.jointcommission.org/implementing_hospital_respiratory_protection_programs_strategies_from_the_field/default.aspx. The Hospital Respiratory Protection Program Toolkit is available at https://www.osha.gov/Publications/OSHA3767.pdf. For more information, please contact Barbara Braun, PhD, associate director, Department of Health Services Research, The Joint Commission, at bbraun@jointcommission.org.
The National Pediatric Readiness Project

Ensuring Appropriate ED Care for Children

Consider this question: Are community hospitals equipped to care for children of any age who require emergency care? Children have unique needs, and the majority of ill and injured children are brought to community hospital emergency departments (EDs) by virtue of their geography within communities. It follows, then, that all hospital EDs should have the appropriate resources (such as medications, equipment, policies, education) and staff to provide effective emergency care for children. In addition, children comprise 27% of the US population and account for approximately 20% of all hospital ED visits—yet data show that 90% of emergency pediatric visits take place in a local general hospital rather than a facility with pediatric specialization.¹

**Background**

Results from a 2003 assessment conducted by the federal Emergency Medical Services for Children (EMSC) Program revealed that most US hospitals did not have the pediatric equipment, trained staff, or policies necessary for the proper care of all pediatric emergencies. In 2009, the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and Emergency Nurses Association (ENA) released the joint policy statement *Guidelines for Care of Children in the Emergency Department.*² Endorsed by 22 national organizations—including The Joint Commission—the Guidelines recommended the equipment, medications, personnel training, and key policies essential for optimal pediatric emergency care.

In September 2012, the EMSC launched the National Pediatric Readiness Project (PRP). A collaboration between the federal EMSC Program, AAP, ACEP, ENA, The Joint Commission, and Healthcare Corporation of America, this project helped inform individual EDs whether they had the resources identified as essential for the effective care for children of all ages. It also provided the necessary tools for promoting optimal care for children in EDs nationwide.

The project was divided into two phases. Phase one, completed in July 2013, included a national electronic assessment that garnered the participation of almost 83% of more than 5,000 hospitals across the country. The assessment was designed to show how well prepared the hospitals were in terms of caring for children of any age who came into their EDs. The results of the assessment, which revealed a national hospital pediatric readiness overall score of 69%, confirmed that there is room for improvement in making EDs pediatric ready.³

Phase two activities are currently underway; these include the analysis of collected data, dissemination of important findings, and creation of resources and tools. In October 2014, the EMSC Program released the “Checklist of Essential Pediatric Domains and Considerations for Every Hospital’s Disaster Preparedness Policies.”¹ At the Pediatric Readiness Stakeholder Meeting in April 2015, The Joint Commission joined other established and new partners for Pediatric Readiness and focused on the following key points:

- Reducing gaps in hospital pediatric readiness
- Reviewing projects and providing input
- Identifying other potential resources, initiatives, and strategies

The results of the assessment, which revealed a national hospital pediatric readiness overall score of 69%, confirmed that there is room for improvement in making EDs pediatric ready.

The National Pediatric Readiness Project exists to help facilities become prepared to provide exceptional care for all pediatric patients who enter their EDs. A critical focus for pediatric EDs across the country, this initiative holds particular importance for local community hospitals.

For more information about the National Pediatric Readiness Project, please contact the EMS for Children National Resource Center, visit http://www.PediatricReadiness.org or call 301-244-6234.

**References**

Revised Laboratory Requirements: Immunohistochemistry and Microbiology

The Joint Commission regularly reviews program requirements alongside the latest standards of practice and professional literature to keep pace with significant developments that may necessitate modifications to requirements.

In order to capture emerging trends in laboratories and maintain alignment with the Centers for Medicare & Medicaid Services (CMS) Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) regulations, The Joint Commission recently updated two areas of the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing (CAMLAB). Both areas are in the “Quality System Assessment for Nonwaived Testing” (QSA) chapter of the manual.

Polymer-Based Immunohistochemistry Methods

The first change pertains to the use of a negative control for polymer-based immunohistochemistry (IHC) methods. Polymer-based IHC methods allow for the visualization of target proteins through the use of antibodies conjugated to enzyme-labeled polymers. The polymer-based method is more sensitive than traditional techniques, and the polymers do not bind nonspecifically to the tissue sample. Because the absence of nonspecific binding eliminates the likelihood of false positive results, a negative control is not necessary for this method. This change is reflected in the revision of Standards QSA.02.10.01, EP 7 and QSA.13.06.01, EP 2 shown in the box on page 8.

Quality Control for Microbiology Laboratories

The second change is a result of the January 9, 2015, revision to the CMS CLIA ’88 Interpretive Guidelines that removed all references to the Clinical and Laboratory Standards Institute (CLSI) and CLSI documents. The Interpretive Guidelines previously had included exceptions for the laboratory specialty of microbiology to quality control regulations based on compliance with the CLSI documents. As a result of the revisions, however, microbiology laboratories are now required to comply with all CLIA ’88 quality control regulations. This change is reflected in the revision of Standard QSA.04.01.01, EP 2 shown in the box on page 8.

The revised requirements are currently displayed on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. In addition, they will be posted in the fall E-dition® and published in the 2016 CAMLAB.

For more information regarding these revisions, please continue on page 8.
Revised Laboratory Requirements: Immunohistochemistry and Microbiology (continued)

Continued from page 7

contact Ron Quicho, associate project director, Department of Standards and Survey Methods, The Joint Commission, at rquicho@jointcommission.org or 630-792-5935.

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**Official Publication of Joint Commission Requirements**

**Revisions to Laboratory Requirements**

**Applicable to Laboratories**

**Effective January 1, 2016**

**Quality System Assessment for Nonwaived Testing (QSA)**

**Standard QSA.02.10.01**
The laboratory performs quality control testing to monitor the accuracy and precision of the analytic process.

**Note:** This standard is considered in combination with the specialty and subspecialty requirements found in this chapter (for example, blood gas testing requires three levels of quality control materials each day of patient testing).

**Element of Performance for QSA.02.10.01**

**C 7.** The laboratory uses a negative and positive reactivity control material to check fluorescent and immunohistochemical stains for intended reactivity each day the procedure is performed. The quality control results are documented.

**Note:** For polymer-based immunohistochemical methods, a negative control is not required.

**Standard QSA.04.01.01**
The laboratory tests chemical and biological solutions, reagents, and antisera used in bacteriology, mycobacteriology, and mycology for reactivity and deterioration.

**Element of Performance for QSA.04.01.01**

**A 2.** The laboratory uses a positive and, as appropriate, a negative control material for each qualitative procedure in bacteriology, mycobacteriology, and mycology, at a frequency consistent with laboratory policy or the manufacturer’s instructions, if more stringent, unless the laboratory demonstrates satisfactory performance that would qualify the laboratory to perform streamlined quality control. The quality control results are documented.

**Note 1:** Streamlined quality control is applicable only for commercial microbial identification systems (MIS) and follows the Clinical and Laboratory Standards Institute (CLSI) document, “Quality Control for Commercial Microbial Identification Systems Approved Guideline,” M50-A.

**Note 2:** A negative control is not required for the mycology germ tube test.

**Standard QSA.13.06.01**
The equipment, methods, and stains used in producing microscopic slides provide tissue sections that facilitate a diagnosis.

**Element of Performance for QSA.13.06.01**

**C 2.** The laboratory performs quality controls on histologic stains for intended reactivity. The quality control results are documented.

**Note:** For example, immunohistochemical (IHC) stains have positive and negative controls, and for periodic acid-Schiff (PAS) stains, documentation of typical cellular staining characteristics is acceptable. For polymer-based immunohistochemical methods, a negative control is not required.

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**“Clarifications and Expectations” Column Back in August**
The column “Clarifications and Expectations,” authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission, is on hiatus this month. It is scheduled to return in the August 2015 issue of Perspectives®.
Revisions to Outpatient Record Review Requirements for Critical Access Hospitals

The Joint Commission recently revised a Medical Staff (MS) requirement for critical access hospitals based on the Centers for Medicare & Medicaid Services (CMS) January 16, 2015, revisions to its interpretive guidelines related to the review of outpatient records (S&C: 15-19-CAH).* Effective July 1, 2015, Standard MS.03.01.03, element of performance (EP) 11 has been revised to clarify that a sample of outpatient records must be reviewed when required by state law. The Note at EP 11 was also revised to delete the 25% sample requirement and to clarify that each critical access hospital determines by its own policy the size of the sample reviewed.

These revisions are in addition to those made last year to the same EP as a result of CMS’s revisions to Conditions of Participation for critical access hospitals published in the May 12, 2014, Federal Register (see the September 2014 Perspectives, page 10). Those changes were part of CMS’s efforts to remove unnecessary, obsolete, or excessively burdensome requirements.

The revised requirement, which is displayed on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx, will be posted in the fall E-dition® and published in the 2016 Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH). The box below displays the revised requirement.

Questions may be directed to Laura Smith, project director, Department of Standards and Survey Methods, The Joint Commission, at lsmith@jointcommission.org or 630-792-5098.

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Official Publication of Joint Commission Requirements
Revision to Standard MS.03.01.03, EP 11

**Applicable to Critical Access Hospitals**

**Effective July 1, 2015**

**Medical Staff (MS)**

**Standard MS.03.01.03**
The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

**Element of Performance for MS.03.01.03**

A 11. When state law requires outpatient record reviews, or

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**Errata:** Diagnostic Imaging Requirement—EP Location

As announced in the February 2015 Perspectives, several new and revised diagnostic imaging requirements for hospitals, critical access hospitals, and ambulatory care organizations will be effective July 1, 2015. However, one of the new elements of performance (EPs) in the “Environment of Care” (EC) chapter was placed at the wrong standard in the recently published print copy of the 2015 Update 1 to the Comprehensive Accreditation Manuals for the abovementioned programs. EP 17 at Standard EC.02.01.01 should actually be at Standard EC.02.02.01. The placement of this EP is correct in the electronic manual (E-dition®). We regret the error and apologize for any inconvenience.
Revised Requirements for Nursing Care Centers

As part of its ongoing evaluation and review process, The Joint Commission has revised five elements of performance (EPs) for accredited nursing care centers. The revisions become effective with on-site surveys beginning January 1, 2016.

The revisions include the following requirements:

- The smoking policy (for organizations that allow smoking) must state how often patients and residents are assessed and reassessed regarding where and when they may smoke and whether supervision is needed.
- An initial assessment of patients’ and residents’ ability to meet the organization’s written criteria for allowing an individual to smoke (if the organization allows smoking) is required.
- Information obtained from the National Practitioner Data Bank (NPDB) includes details about all newly appointed licensed independent practitioners providing care, treatment, and services.
- At least every two years after their initial appointment, information is obtained from the NPDB about all licensed independent practitioners who continue to provide care, treatment, and services.
- A valid and reliable tool must be used to evaluate the culture of safety and quality.
- Initial assessments of patients and residents include an evaluation of their skin condition.

The revised requirements will be displayed on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx, posted in the fall E-dition®, and published in the 2016 Comprehensive Accreditation Manual for Nursing Care Centers (CAMNCC). The box that begins below displays the revised requirements; new text is underlined, and deleted language is crossed out.

For more information, please contact John Fishbeck, associate project director, Department of Standards and Survey Methods, at jfishbeck@jointcommission.org or 630-792-4758.

Official Publication of Joint Commission Requirements
Revisions to Requirements for Nursing Care Centers

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</table>

**Environment of Care (EC)**

**Standard EC.02.01.03**
The organization prohibits smoking except in specific circumstances.

**Element of Performance for EC.02.01.03**

A 3. © If the organization decides that certain patients and residents may smoke, the leaders develop written criteria identifying the specific circumstances under which they may smoke, as determined by an initial smoking assessment. The criteria also describe where and when they may smoke, and whether supervision is required, and the frequency of smoking reassessments. (See also PC.01.02.01, EP 13)

**Human Resources (HR)**

**Standard HR.02.01.04**
The organization permits licensed independent practitioners to provide care, treatment, and services.

**Elements of Performance for HR.02.01.04**

A 3. © Before permitting licensed independent practitioners new to the organization to provide care, treatment, and services, the organization does the following: The organization obtains and documents information from the National Practitioner Data Bank (NPDB) on physicians and dentists. The medical director evaluates this information.

A 6. © At least every two years, before permitting licensed independent practitioners to continue to provide care, treatment, and services, the organization does the following: The organization obtains and documents information from the National Practitioner Data Bank (NPDB) on physicians and dentists. The medical director evaluates this information.
Revisions to Requirements for Nursing Care Centers (continued)

Leadership (LD)

Standard LD.03.01.01
Leaders create and maintain a culture of safety and quality throughout the organization.

Element of Performance for LD.03.01.01
A 1. Leaders regularly evaluate the culture of safety and quality using a valid and reliable tool.*

* An example of a valid and reliable tool is the Agency for Healthcare Research and Quality (AHRQ) Nursing Home Survey on Patient Safety Culture found at www.ahrq.gov.

Provision of Care, Treatment, and Services (PC)

Standard PC.01.02.01
The organization assesses and reassesses its patients and residents.

Element of Performance for PC.01.02.01
A 13. The organization defines, in writing, the information to be gathered during the initial assessment(s), including the following:

- The patient’s or resident’s current diagnosis, pertinent history, medication history (including allergies and sensitivities), current medication, and current treatments
- The patient’s or resident’s physical and neuropsychiatric status

Joint Commission Joins White House Effort to Reduce Antibiotic Overuse (continued)

Continued from page 4

of government entities charged under President Obama’s September 18, 2014, Executive Order focusing on combating antibiotic-resistant bacteria. That order requires the Centers for Medicare & Medicaid Services, the Department of Defense, and the Department of Veterans Affairs to develop requirements for antibiotic stewardship programs. These and other federal agencies and stakeholder groups will have input into the research associated with the development process for any changes in accreditation standards.

In addition to evaluating its standards, The Joint Commission has committed to developing several publications to raise providers’ awareness level of the benefits of engaging in stewardship practices, creating patient-based materials to engage consumers in this important area, and updating its tool kit to support organizations in the implementation of stewardship programs. For more information, please visit The Joint Commission website at http://www.jointcommission.org.
Back-to-back updates on Joint Commission standards, CMS CoPs, and performance improvement!

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<th>Location</th>
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