

The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES



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The Road Ahead

WHAT'S NEW IN ACCREDITATION FOR 2018



As 2017 wound down, The Joint Commission announced accreditation changes to become effective January 1, 2018, as well as a few that went into effect in November 2017. These include everything from significant policy changes and new requirements to minor clarifications.

Policy Changes

Data Release

Under certain circumstances, The Joint Commission makes available specific accreditation-related information to federal, state, local, or other governmental

certification or licensing agencies or public health agencies or any other appropriate enforcement agency. Beginning in 2018, The Joint Commission has removed the restriction that complaint information can be shared only if allegations result in an on-site visit.

Risk Areas

The Joint Commission has added to its policy on risk areas language about how surveyors will assess and display the risk associated with findings by utilizing the Survey Analysis for Evaluating Risk™ (SAFER™) Matrix.

Decision Rules

The Joint Commission has modified [decision rules](#) for organizations seeking reaccreditation.

“Our changes are mostly intended to clarify expectations,” says Kevin Hickey, director of operations and standards interpretation, The Joint Commission. “Every year, we go through this exercise—we review issues that staff have noticed or that customers have pointed out and find opportunities to make clarifications.”

In some cases, rules have been added for consistency. “We added some rules to be consistent with those process flows in the accreditation manuals,” says Jennifer Welch, manager, The Joint Commission. “If an organization isn’t successful in its survey, it’s better if we can reference the rules for the organization. For organizations that haven’t performed well, these rules help address issues and understand consequences.”

Standards Updates

Reducing EPs

The element of performance (EP) review component of Project REFRESH™ has continued with [Phase IV](#), and involves the review of EPs to streamline and consolidate similar concepts. The first chapters reviewed during phase IV include the “Human Resources” (HR), “Infection Prevention and Control” (IC), and “Rights and Responsibilities of the Individual” (RI) chapters. Revisions resulting from the first part of Phase IV became effective January 1, 2018. Other chapters are being reviewed and revisions will be published in future editions of the accreditation manuals.

Medication Management

Revisions to “[Medication Management](#)” (MM) chapter apply to all accredited ambulatory care organizations and office-based surgery practices. The standards continue to reflect evidence-based practices and quality and safety issues that have emerged from the field in recent years; the changes also affect requirements in the EC and “Record of Care, Treatment, and Services” (RC) chapters.

New MM standards and EPs require organizations to do the following:

- Implement policies to provide emergency backup for essential medication dispensing equipment

- Provide emergency backup for essential refrigeration for medications
- Describe the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews when automatic dispensing cabinets are used

Pain Management

New standards and EPs regarding [pain management](#) have been developed. Some of the additions focus on opioid use, as health systems across the country deal with the current opioid abuse crisis.

Leadership (LD) Standard **LD.04.03.13**, EPs 1–7, is among those requirements. These requirements help ensure that organization leaders prioritize pain management and safe prescribing of opioids. EPs include identifying a leader to oversee these concerns and ensuring that staff have the necessary resources to address pain management and opioid use appropriately and effectively.

Because some patients may have medical concerns that prevent them from taking certain pain medications (for instance, a recovering opioid addict who needs major surgery or a patient who is at risk for an adverse event, such as sleep apnea, from opioids), the EP requires that hospitals offer nonpharmacologic pain treatment options, resources for referral of patients with complex pain management needs, and any equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.

This standard also includes an EP that requires a hospital to facilitate practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. This EP is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.

Other pain management updates include the following:

- Notes and new EPs to clarify responsibilities for deemed status hospitals as compared to quality improvement organizations (QIOs)(LD.01.03.01, EP 21)
- A new requirement for the active involvement of the medical staff in pain assessment, pain management, and safe opioid prescribing (MS.05.01.01, EP 18)
- A new requirement for maximum sterile barrier precautions during central venous catheter insertion (NPSG.07.04.01, EP 10)
- Revised standards language that focuses on enhanced pain assessment and pain management requirements (PC.01.02.07)
- A new requirement for collecting data on pain assessment and pain management, including types of interventions and effectiveness (PI.01.01.01, EP 56)
- A new requirement for collecting data on pain assessment and pain management to identify areas where safety and quality improvements are needed (PI.02.01.01, EP 18)

Major Revisions to EM, LS, and EC Requirements

Emergency Management

To address the new Centers for Medicare & Medicaid Services (CMS) emergency management rules and to help health care organizations more effectively plan for disasters and coordinate with federal, state, tribal, regional, and local emergency preparedness systems, The Joint Commission has added new EPs for the [Emergency Management \(EM\) standards](#). The new EPs address the following areas:

- ▶ Continuity of operations and succession plans
- ▶ Documentation of collaboration with local, tribal, regional, state, and federal EM officials
- ▶ Contact information for volunteers and tribal groups
- ▶ Documented annual training of all new and existing staff members, contractors, and volunteers
- ▶ Integrated health care systems
- ▶ Transplant hospitals

These requirements, which went into effect November 15, 2017, are applicable to deemed status surveys for hospital, ambulatory, home health, and hospice settings.

Life Safety

The Joint Commission has updated the business rules that determine the number of days a *Life Safety Code*^{®*} Surveyor will be part of a hospital's survey. These rules became effective January 1, 2018.

The original business rules consider square footage as well as the number of inpatient buildings to determine survey length for *Life Safety Code* surveyors, while the revised business rules consider square footage only to more accurately indicate how many days the *Life Safety Code* surveyors are needed on site.

Another business rule change ensures that there will be a minimum of two days of *Life Safety Code* survey time allotted for any additional hospitals. Under the old rules, the additional site would have a one-day survey.

These changes will enhance The Joint Commission's work as an improvement organization that helps its customers identify and mitigate risks.

Environment of Care[®]

The Joint Commission has revised the [LS and Environment of Care \(EC\) standards](#) following adoption of the 2012 editions of the National Fire Protection Association's (NFPA's) NFPA 101: *Life Safety Code*[®] and NFPA 99: *Health Care Facilities Code*.

Additional revisions to the LS and EC standards include changes to EPs that address the following topics:

- ▶ Testing of emergency lighting systems
- ▶ Inspection and testing of piped medical gas and vacuum systems
- ▶ Updating of pertinent NFPA code numbering in references
- ▶ Addition of more specificity to existing EPs

These changes became effective January 1, 2018.

* The *Life Safety Code*[®] is a registered trademark of the National Fire Protection Association, Quincy, MA.

Stroke Certification Updates

The Joint Commission has announced a new [Thrombectomy-Capable Stroke Center \(TSC\)](#) certification program, with requirements effective January 1, 2018. Recent studies have shown the efficacy of mechanical thrombectomy for large vessel occlusive ischemic strokes.¹ A dispersed network of hospitals capable of providing mechanical thrombectomies can help patients with large vessel occlusive ischemic strokes receive care more rapidly.

In addition to meeting a minimum mechanical thrombectomy volume, requirements for this certification include the following:

- Demonstrating the ability to perform mechanical thrombectomy 24/7
- Maintaining dedicated intensive care beds for acute ischemic stroke patients
- Demonstrating the ability to perform expanded advanced imaging 24/7
- Meeting the expectations for the availability of staff and practitioners (closely aligned with comprehensive stroke center requirements)

This advanced certification program was developed in collaboration with the American Heart Association/American Stroke Association in response to the need to identify hospitals that meet rigorous standards for performing endovascular thrombectomy (EVT) and caring for patients after the procedure. Organizations interested in pursuing TSC advanced certification may apply beginning January 1, 2018.

Performance Measurement Data Submission

Beginning with the March 2018 submission deadline for calendar year 2017 data, The Joint Commission will begin accepting [direct submissions](#) of electronic clinical quality measure (eCQM) data from more than 500 selected hospitals and health systems. After March 2018, the direct submission option will be provided to all accredited hospitals for submission of eCQM data for calendar year 2018 and going forward.

The ability to receive eCQM data submissions directly from accredited hospitals has been an important goal for The Joint Commission for several years. This initiative is based on feedback from accredited organizations as well as The Joint Commission's commitment to using innovative, practical systems for health care data measurement to guide quality improvement and advance health care quality and patient safety. 

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NEXT ↓

Part 1. Body, Mind, Spirit

HOSPITAL CHAPLAINS CONTRIBUTE TO PATIENT SATISFACTION AND WELL-BEING

This article is the first in a two-part series exploring how chaplains improve the satisfaction and well-being of hospitalized patients and their families. The second part will describe how chaplains help hospitals meet various Joint Commission standards; perform spiritual or religious screenings, histories, and assessments; assist in decisions about end-of-life care; and conduct evidence-based research.

When patients are diagnosed with chronic, debilitating, or life-threatening diseases that inevitably lead to one or many hospitalizations, they often experience stress, anxiety, or depression in addition to their physical symptoms. Patients receiving palliative care often struggle with the emotional and spiritual impact of their conditions (see the sidebar below). During these times, many patients and their family members find comfort in their religious or spiritual beliefs; however, some may experience transient or prolonged religious or spiritual struggles.

Caring for Palliative Care Patients

Palliative care addresses a patient's physical, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice. The contribution of chaplains to meeting these patients' needs is substantial.

For example, chaplain care was part of a multidimensional 12-month intervention for palliative care outpatients. Forty patients were in the control group and received usual care. Fifty patients received the comprehensive care team (CCT) intervention, which consisted of a multidisciplinary assessment; case management by a social worker; medication review by a pharmacist; and invitations to a patient-family support group and other interventions. All CCT patients had one chaplain visit and 42% had additional consultations with the chaplain or other religious advisors.¹

Compared to those in the control group, patients who received the CCT intervention had improved scores on a measure of spiritual well-being. They also had reductions in shortness of breath, improvements in anxiety and sleep, and reduced health care utilization.¹

Reference

1. Fitchett G. Recent progress in chaplaincy-related research. *J Pastoral Care Counsel.* 2017 Sep;71(3):163-175.
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“Unmet spiritual needs have been associated with greater emotional distress, more pain, and poorer quality of life,”¹⁻⁵ says Stephen King, PhD, BCC, manager of Chaplaincy, Child Life, and Clinical Patient Navigators, Seattle Cancer Care Alliance. In addition, patients with spiritual struggles often have poorer daily physical functioning, more depression and anxiety, higher costs of medical care, poor satisfaction with care, and increased mortality.¹⁻⁵

For these and other reasons, The Joint Commission asks health care providers to respect patients' cultural and personal values, beliefs, and preferences and accommodate patients' rights to religious and other spiritual services through Rights and Responsibilities of the Individual (RI) Standard **RI.01.01.01**. (See "Related Requirements" for this and other standards that can be met by chaplains below.) Although everyone on the hospital's interdisciplinary care team is responsible for meeting this standard, chaplains are specifically trained to respect, assess, and fulfill the religious and spiritual needs of patients and families.

Related Requirements

Standard RI.01.01.01

The hospital respects, protects, and promotes patient rights.

Elements of Performance (EPs) 6, 7, and 9 for RI.01.01.01

6. The hospital respects the patient's cultural and personal values, beliefs, and preferences.
7. The hospital respects the patient's right to privacy. (See also IM.02.01.01, EPs 1–4)

Note 1: *This element of performance (EP) addresses a patient's personal privacy.*

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: *The resident's right to privacy includes privacy and confidentiality of his or her personal records and written communications, including the right to send and receive mail promptly.*

9. The hospital accommodates the patient's right to religious and other spiritual services.

Standard LD.04.04.05

The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.

EP 9 for LD.04.04.05

9. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

Note: *Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.*

Standard PC.02.01.05

The hospital provides interdisciplinary, collaborative care, treatment, and services.

EP 1 for PC.02.01.05

1. Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner.

Overview of Chaplaincy

Chaplains are theologically and clinically trained health care professionals who receive clinical pastoral education and go through supervised training in the health care setting. Often, they attain board certification through a professional chaplaincy organization, such as the Association of Professional Chaplains (APC).⁶

“Most people don’t realize how much clinical training goes into becoming a chaplain,” says Amy Greene, DMin, director of Spiritual Care at the Cleveland Clinic. “Professional chaplains have also done training in the clinical setting, much like other clinicians.”

At a basic level, chaplains give patients access to familiar spiritual or religious rituals, such as prayer. “We can also create rituals that mark important times that allow people to feel the sacredness and specialness of the moment, even if they don’t come from well-established religions,” says George Fitchett, DMin, PhD, professor and director of research, Department of Religion, Health, and Human Values at Rush University Medical Center in Chicago. “For patients who come from a particular religious background, these rituals can be an important source of grounding and reassurance.”

In addition, chaplains provide emotional support, ease anxieties during times of uncertainty, and help patients and family members find strength during stressful times.³ Chaplains also help patients and family members navigate through difficult medical choices, grounding their decision-making process in their values, beliefs, and preferences.³ (See the sidebar on [page 9](#) for more about what chaplains do for patients and family members.)



Chaplains provide emotional support to patients, families, and colleagues.

In Their Own Words: Chaplains' Perspectives on Health Care

Chaplains see the same patients and family members that health care providers see, but they view patients and family members through a different lens. Chaplains assess how a patient's or family member's religion and spirituality can help with his or her decisions about medical care as well as assist with or detract from the coping process. Several chaplains have described their role as assisting patients and family members along their religious and spiritual journey within the health care system.

“A key element of chaplaincy is active and empathic listening. We pay attention to what is on the patient's mind and invite them to share more. We listen to the joys and sorrows they are experiencing. When people feel heard, they feel less alone. My favorite research comes from a satisfaction survey at Mayo Clinics, where 78% of respondents stated that part of the reason for seeing a chaplain was to remind them of God's love and presence during a stressful time.”

—George Fitchett, DMin, PhD, Professor and Director of Research, Department of Religion, Health, and Human Values, Rush University Medical Center, Chicago

“Chaplains tend to be good in a crisis—if people are sad, upset, or angry; we have a high tolerance for those emotions. We have the training to get people support or affirm their ability to call upon their internal and external resources. Chaplains help people find their own way back to courage. We provide a listening ear so that people can talk their own way back to a balanced perspective of what is happening to them. When everything goes wrong and they didn't get the outcome they wanted, patients and family members can still feel cared for.”

—Amy Greene, DMin, Director of Spiritual Care, Cleveland Clinic

“Chaplains often provide a representative role; we represent God or a faith community to many. If we are experienced as loving, then we can further reinforce or reinterpret their beliefs and help patients and family members feel supported. We value patients' spirituality and acknowledge what is important or sacred to the patient.”

—Stephen King, PhD, BCC, Manager of Chaplaincy, Child Life, and Clinical Patient Navigators, Seattle Cancer Care Alliance

Improve Patient and Family Satisfaction

When chaplains are involved in a patient's care, their satisfaction with the overall health care experience increases. “For more than 10 years, there has been a growing body of evidence about the impact of chaplain care on patient satisfaction,” says Fitchett. For example, a recent study reviewed nearly 9,000 patient responses on six items from the Hospital Consumer Assessment of Healthcare

Providers and Systems (HCAHPS) and Press Ganey satisfaction survey for Mount Sinai Hospital in New York City.⁸ Researchers found that chaplains had visited 5.6% of the patients who completed surveys, and these patients gave higher ratings for all six satisfaction items than did the patients who had not been visited by a chaplain.⁸

Patient satisfaction scores now affect the bottom line, and it is more important than ever before for health care leaders to make plans to improve the experience of hospitalized patients as well as their family members. Chaplains who help patients feel respected and who assess and fulfill their spiritual and religious needs can be part of the plan to improve the patient experience.

Respect Patient Rights

Chaplains are naturals when it comes to fulfilling The Joint Commission's Standard RI.01.01.01 for respecting patient's rights to cultural and personal values, beliefs, and preferences (EP6) as well as their right to religious and other spiritual services (EP9). "We must practice cultural humility," says King. "We may think we know a lot about one particular culture, but every individual is different. Chaplains have an active wonder to get to know an individual better and find out what's important to them."

Although chaplains are religious, they support any belief that patients and family members may have, even if they don't subscribe to a specific religion or believe in a god. "We enjoy contact with people of diverse faith traditions or no faith tradition," says Fitchett. "Our training includes learning about different faith traditions. Often, patients and their families are also happy to explain more about their religion when we ask. For example, I could meet a family and say, 'I'm not Buddhist, but tell me what will be helpful for your family.' And I can get someone from their Buddhist organization to come to the hospital."

Chaplains are prepared to provide or find religious and spiritual resources for patients and family members no matter what the beliefs may be. Of Cleveland Clinic, Greene says, "We do mass regularly and have a Muslim prayer room as well as a Muslim chaplain on the team. We have silent meditation that is led by a chaplain. We also have a thick notebook of community representatives for everything from Amish to Zoroastrianism beliefs."

Part of the Interdisciplinary, Collaborative Team

Chaplains should play an integral role on the interdisciplinary care team, as required by Joint Commission Provision of Care, Treatment, and Services (PC) Standard **PC.02.01.05**. Chaplains attend multidisciplinary rounds and document discussions with patients and family members in a clear and concise manner in the electronic medical record. "What do you write in the chart?" says Fitchett. "Do you write something that is easy to understand, or do you use 'chaplain-speak' that no one understands? Our notes must be efficient because everyone is busy, and they don't have time to read long notes."

Often, chaplains use face-to-face communication in addition to progress notes in the electronic medical record. "Chaplains also have a practice of checking in

with the nurse before visiting a patient,” says King. “We ask the nurse, ‘Is there anything I should be aware of?’ And then we loop back with the nurse after we meet with the patient. We also follow up with social workers and doctors.”


Finally, chaplains may have to assert themselves on the interdisciplinary care team to remind other health care providers of how they can help with certain patients.⁹ “Few clinical colleagues have had meaningful education about patients’ spiritual concerns or a chaplain’s role in addressing them. It’s our job to educate clinicians on the chaplain’s role,” says Fitchett. “People in health care are always moving along, and they may not have a good understanding of what the chaplains do. Once they are educated, they make better use of chaplains.”

Uplift and Support Clinical Staff

Not only can chaplains provide spiritual and religious support to patients and family members, they can also support their coworkers at the hospital. This support for other health care providers can occur in formal and informal ways.

“We are available for staff to catch us on the run or to set up formal one-on-one appointments,” says King. “Staff can talk to chaplains when they are feeling overwhelmed, they’ve gotten close to some patients who are not doing well, or they’re feeling moral despair because their patients aren’t making choices with which they agree. We also have something called ‘Tea for the Soul,’ which is where the chaplain sets up shop in a staff lounge, offers hot tea and treats, and staff are invited to drop in. It’s a way for chaplains to express appreciation for staff on every floor on every unit once a month. Our nurse managers are saying ‘please don’t stop’ because it is very meaningful for the staff.”

When health care providers feel cared for, they are rejuvenated and can provide better care to their patients and family members. In addition, The Joint Commission requires health care leaders to make support systems available to staff who have been involved in an adverse or sentinel event through Leadership (LD) Standard **LD.04.04.05**, EP 9, and chaplains can play a vital part of that support system.

“We actually put a good deal of focus on staff care because we know that this pays big dividends in patient care,” says Greene. “For every nurse whose load you lighten even a little, you’ve helped all their patients, too. At Cleveland Clinic, we have a team of holistic nurses and chaplains who work together to do a rapid response to crisis, called a Code Lavender, to indicate the desire and urgency to bring calm to staff. Anyone can call a Code Lavender on a teammate or on a whole team. Most recently a unit lost a beloved colleague suddenly, and the Code Lavender team set up shop in the break room and offered listening, Reiki, prayer, silence, and light shoulder massage. We give them a lavender wrist band to remind them—and others around them—to take it a little easy on themselves.” 

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CJCP: Certified Joint Commission Professional

SPOTLIGHT ON THE “HUMAN RESOURCES” CHAPTER

Joint Commission Resources offers a unique credential for accreditation professionals—Certified Joint Commission Professional™ (CJCP®). CJCP examinations take place in January, April, July, and October of each year.

To help candidates prepare for the CJCP examination and understand what to expect, this column features sample questions similar to those that could appear on the examination. The [answer key](#) on page 14 provides the context for the correct answer. All of the CJCP examination questions are multiple choice, offering three possible choices from which you should pick the best answer. Also, the examination does not have any true/false questions or include any answers that are “All of the above” or “None of the above.” Please note the questions that follow are not actual examination questions; they are simply indicative of the types of questions a candidate may see on the exam.

About This Chapter

The contribution that human resources management makes to a hospital’s ability to provide safe, quality care cannot be overestimated. The quality of the hospital’s staff will, in large part, determine the quality of the care, treatment, and services it provides. After staff are hired, even the smallest hospital has a responsibility to see that they receive the orientation, education, and training they need to provide quality care and to keep patients safe.


The standards and elements of performance in the “Human Resources” (HR) chapter address the hospital’s responsibility to establish and verify staff qualifications, orient staff, and provide staff with the training they need to support the care, treatment, and services the hospital provides. After staff are on the job, human resources must also provide for the assessment of staff competence and performance.

Sample Questions

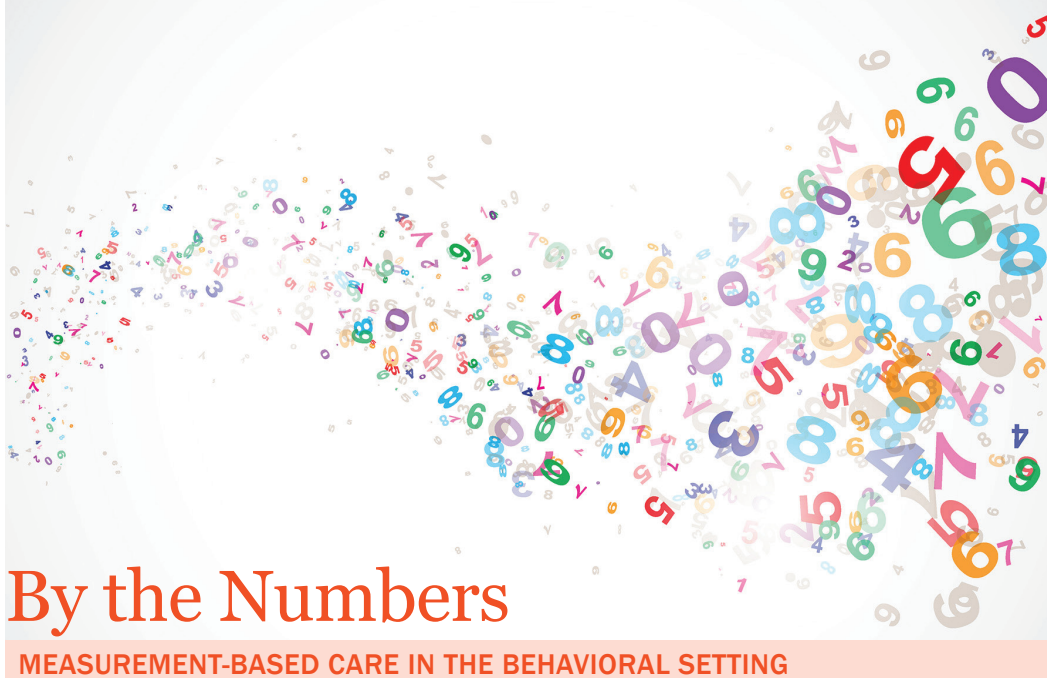
1. Which of the following is one acceptable method of defining and verifying qualifications for infection prevention and control staff?
 - a. Staff interviews
 - b. Peer review
 - c. Ongoing education

2. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital must include which of the following, among others?
- a. Documented peer recommendations
 - b. Confirmation of credentials from previous employers
 - c. Annual written examinations to demonstrate knowledge and competency
3. How often must a hospital evaluate staff performance?
- a. Annually
 - b. Once every three years
 - c. Once every two years

Answer Key

1. **The correct answer is c.** Standard **HR.01.01.01** requires hospitals to define and verify staff qualifications. Elements of Performance (EP) 1 for that standard states that the hospital must define staff qualifications specific to their job responsibilities. Explanatory notes indicate that qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).
2. **The correct answer is a.** Standard **HR.01.02.01** requires physician assistants and advanced practice registered nurses who practice within the hospital to be credentialed, privileged, and reprivileged through the medical staff process or an equivalent process. According to EP 2 of that standard an equivalent process must include the following:
- A documented evaluation of the applicant’s credentials
 - An evaluation of the applicant’s current competence
 - Documented peer recommendations
 - Input from individuals and committees, including the medical staff, to make an informed decision regarding requests for privileges
3. **The correct answer is b.** According to Standard **HR.01.07.01**, EP 2, hospitals must evaluate staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. This evaluation must be documented. 

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By the Numbers

MEASUREMENT-BASED CARE IN THE BEHAVIORAL SETTING

Measurement-based care (or routine outcome measurement) involves using objective data to track the impact of care, treatment, or services. In 2016, The Joint Commission revised its Care, Treatment, and Services (CTS) Standard **CTS.03.01.09** to align with the increased emphasis on measurement-based care in behavioral settings. Organizations had a one-year grace period to prepare for compliance with the new language in the standard, which became effective January 1, 2018. (See “Related Requirements” below for the complete standard.)

The long-standing requirements detailed in CTS.03.01.09 direct behavioral health care organizations to assess the outcomes of the care, treatment, or services they provide. The recent revisions to Elements of Performance (EPs) 1–3 require organizations to use a standardized tool or instrument to conduct this assessment. The purpose of these revisions is to help organizations know—on an ongoing basis and based on objective measures—whether the care, treatment, or services being provided to the individuals they serve is having a positive effect and to also help them use that information to drive continuous quality improvement.

Related Requirements

Standard CTS.03.01.09

The organization assesses the outcomes of the care, treatment, or services provided to the individual served.

Elements of Performance for CTS.03.01.09

1. The organization uses a standardized tool or instrument to monitor the individual’s progress in achieving his or her care, treatment, or service goals.
2. The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual’s plan for care, treatment, or services as needed
3. The organization evaluates the outcomes of care, treatment, or services provided to the population(s) it serves by aggregating and analyzing the data gathered through the standardized monitoring effort.

4. **For organizations that provide eating disorders care, treatment, or services:** The organization assesses outcomes of care, treatment, or services based on data collected at admission. Examples of such data include complete history and physical including height, weight, frequency of binge eating and purging (when applicable), eating disorder diagnosis, body mass index (BMI), heart rate, date of last period, and other appropriate lab tests such as potassium, phosphorus, thyroid, hemoglobin, glucose, as determined by the organization and in accordance with the level of care provided. (*See also* CTS.02.03.11, EP 1)

The Importance of Measurement-Based Care

Research from the past two decades demonstrates the benefits of measurement-based care.¹ This approach enables behavioral health care organizations to accomplish the following:

- Identify potential treatment failures
- Justify changes in treatment plans and levels of service
- Demonstrate outcomes to internal and external stakeholders, as well as individuals served and their families
- Establish performance improvement priorities
- Evaluate progress on performance improvement efforts



Careful measurement can help make care, treatment, or services more patient-centered.

All these activities improve the quality of care, treatment, or services, which directly benefits the individuals served. According to the Joint Commission's Lynn Berry, MLA, project director, and Scott Williams, PsyD, director of health services research, the most immediate benefit of measurement-based care is to individuals who are currently struggling with or failing to benefit from the care, treatment, or service. For these individuals, outcome measurement helps identify risks of treatment failure and prompts the treatment team to discuss potential modifications to the plan for care, treatment, or services with the individual served.

For individuals who are making steady progress during their care, treatment, or services, measurement data may offer objective evidence to support their perceptions of improvement, increasing their confidence in services. Further, at the organization level, measurement-based care data adds to the overall picture of the care, treatment, or services the organization provides.

Standard CTS.03.01.09 applies to virtually all behavioral health care organizations. In general, Berry states, “if the organization maintains a record of care, treatment, or services for an individual served, then the organization will be able to track the individual’s progress and should therefore be able to use a standardized tool or instrument to do so.”

One example of a program that would not fall into this category is prevention and wellness promotion services. However, these organizations are still required to evaluate the quality of their programs; they just use different ways of doing so.

Open Your Toolbox

An organization can use data from measurement tools for monitoring progress and also in the planning of an individual’s care, treatment, or services. Berry explains that data from measurement-based care instruments—especially those that are completed by the individual served—can be used to support identification of specific, individualized goals.

“For example,” Berry says, “if I am using a client-rated assessment tool, an initial score of *X* on a particular measure may suggest that the individual is struggling with interpersonal relationships. I can then add this to the individual’s treatment goals.” In the plan of care, treatment, or services, this information might be expressed as follows:

Jane indicated that she would like to improve the relationship with her partner, specifically by improving their communication. Her Interpersonal Relationship score on the instrument was an X out of Y. Progress toward her goal will be measured by increasing scores on the Interpersonal Relationship Scale.

A measurement-based care metric can be used to individualize a treatment goal and to measure progress made toward meeting that goal.

Choosing a Measurement Instrument

Measurement instruments come in many forms and address many different populations and types of service and settings. One of the most important factors contributing to compliance with CTS.03.01.09 is choosing the right measurement tool (or tools) for the organization.

Good measurement instruments or tools share certain characteristics, including the following:

- They have well-established reliability and validity.
- They are designed and tested for use as repeated measures.
- They contain established thresholds for estimating reliable change over time.



Document assessments of individuals served as well as progress on performance improvement goals.

- They can distinguish between populations of individuals served, such as the following:
 - Clinical versus nonclinical
 - Health functioning versus nonhealthy functioning
 - Symptomatic versus nonsymptomatic

Beyond these basic criteria, each organization must choose an instrument that collects the data it needs in a way that supports that organization’s provision of high-quality care, treatment, or services. For example, many tools are completed by the individual served and therefore provide a very patient-centered perspective of progress. In some cases, however, it may be more appropriate to evaluate progress from the perspective of a parent or teacher—or even an independent clinician who is not working directly with the individual served. In other words, a tool that works for one setting and population may not work for another.

The Joint Commission offers an online portal of measurement tools used by accredited organizations. See the sidebar below for information on this resource.

Choosing Measurement Instruments

The Joint Commission has developed a list of measurement-based care tools and instruments that is currently available to behavioral health care organizations. This portal is available through the Joint Commission website, at <https://manual.jointcommission.org/BHCInstruments/WebHome>. This list is intended to serve as a resource to help accredited behavioral health organizations comply with revised Standard CTS.03.01.09. There is no one prescribed tool that organizations must use, and The Joint Commission does not endorse the use of any particular tool or instrument. Organizations should use their discretion in choosing any product based on their needs and the needs of the populations they serve.

Leadership plays an important role in instrument selection and in setting a tone for consistent use of the instrument. Leadership should ensure that the instrument selected meets the basic psychometric criteria and is fit for its intended purpose: monitoring progress and informing individual care.

Documenting Assessments and Improvements

The Joint Commission does not give explicit direction on how to store or document data from measurement instruments. Such decisions are up to each organization, based on its specific needs. The key to demonstrating compliance with CTS.03.01.09, however, is to be able to show that the data are being regularly reviewed by clinicians and discussed with the individuals served, supervisors, and/or treatment teams. The organization must also provide evidence that the data have been used to monitor and inform the individual's care, treatment, or services.

An organization must be able to show—at the organization level—how the data were aggregated for quality improvement purposes. This may include using the data to prioritize issues for improvement and/or using the data to track the results of improvement activities.

Strategies for Compliance

When assessing an organization's compliance with CTS.03.01.09, Joint Commission surveyors look at several factors. First, they want to know which instruments are being used to measure care, why the instruments were chosen, and how the instruments are being used. Also, surveyors look at how the organization is using the data it has collected. It is not enough to simply collect data. To comply with the standard, an organization must use collected data to improve care, treatment, or services at both the individual level and the aggregate level for quality improvement purposes.

Organizations should consider using several strategies to ensure compliance, according to Berry and Williams. Perhaps the most fundamental measurement strategy is having the right tool.

“Start by putting in the work to identify an instrument (or instruments) that will work for your organization,” Williams says. “Look for instruments that are designed for repeated use, are appropriate for the range of individuals served by your organization, and can give clinicians some insight into problem areas. Don't fall into the trap of selecting an instrument just because you have been using it for years or because some stakeholder requires it for some other purpose. If an instrument you are already using is designed and tested for measurement-based care, that is great—but don't try to force a square peg into a round hole.”

Also be aware of what are *not* standardized tools or instruments, such as patient satisfaction questionnaires, measures that assess the use of evidence-based care or clinical practice guidelines, measures of medication/treatment compliance, and assessments of outcomes *after* the completion of services. In addition, organizations should review potential and existing measurement instruments to

determine whether they are appropriate for use in measurement-based care. For example, a tool should provide key metrics, such as the amount of change that is considered significant or reliable.

Carefully Implement New Tools and Processes

Done incorrectly, implementation of a new measurement tool and/or process can be overwhelming and frustrating for behavioral health providers. Organization leaders failing to manage such a change well will limit the potential for improving care, treatment, or services at the individual and/or organization level.

Berry says that implementing a new measurement tool or process is a big change for many organizations. Her advice? “Don’t underestimate the importance of preparing for it.”

Berry and Williams recommend starting slowly. It is important to facilitate change by involving the right stakeholders across the organization, including leadership, supervisors, and frontline staff, in decision making and implementation. In addition, an organization can take advantage of clinician champions to build support for the changes. Champions can assist their peers in learning how to use data to inform care.

Even with careful change management, there may be resistance or reluctance to adopt new measurement processes or methods. “Don’t fall for the argument that ‘good behavioral health care cannot be measured,’” Williams warns. “Objective data from measurement tools are intended to support clinical decision making, not replace it.”


Williams encourages organizations to utilize champions to address clinicians who are slow to adopt new measurement practices. Organizations should track use of the instruments and identify providers who would benefit from being teamed with a champion who can coach them through the changes.

Embracing the Change

When done carefully and correctly, incorporating measurement-based care into behavioral health organizations can have a profound impact on individual progress, improving how progress is monitored and the overall quality of care, treatment, or services.

“The revised standard provides organizations with an important and potentially powerful source of data to help improve care for the individuals they serve,” Williams says. “In my own experience with measurement-based care, it did not take long for me to shift from a perspective of skepticism to one of security and reliance. Providing service without objective feedback quickly began to feel like performing without a net. I could do it, but why would I want to?”

“Ultimately,” Williams says, “organizations that seek and maintain Joint Commission accreditation make a commitment to quality and safety. This commitment isn’t always easy, but these organizations will be better positioned to meet this commitment by using the steady stream of data generated through

implementation of the revised standard. As experience with measurement-based care grows, these accredited organizations will also be in a unique position to objectively demonstrate the value of the behavioral health care services they deliver.” 

Reference

1. The Joint Commission. “Revised Outcome Measures Standard: Behavioral Health Care Accreditation Program.” Accessed Nov 16, 2017. https://www.jointcommission.org/accreditation/bhc_new_outcome_measures_standard.aspx.



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