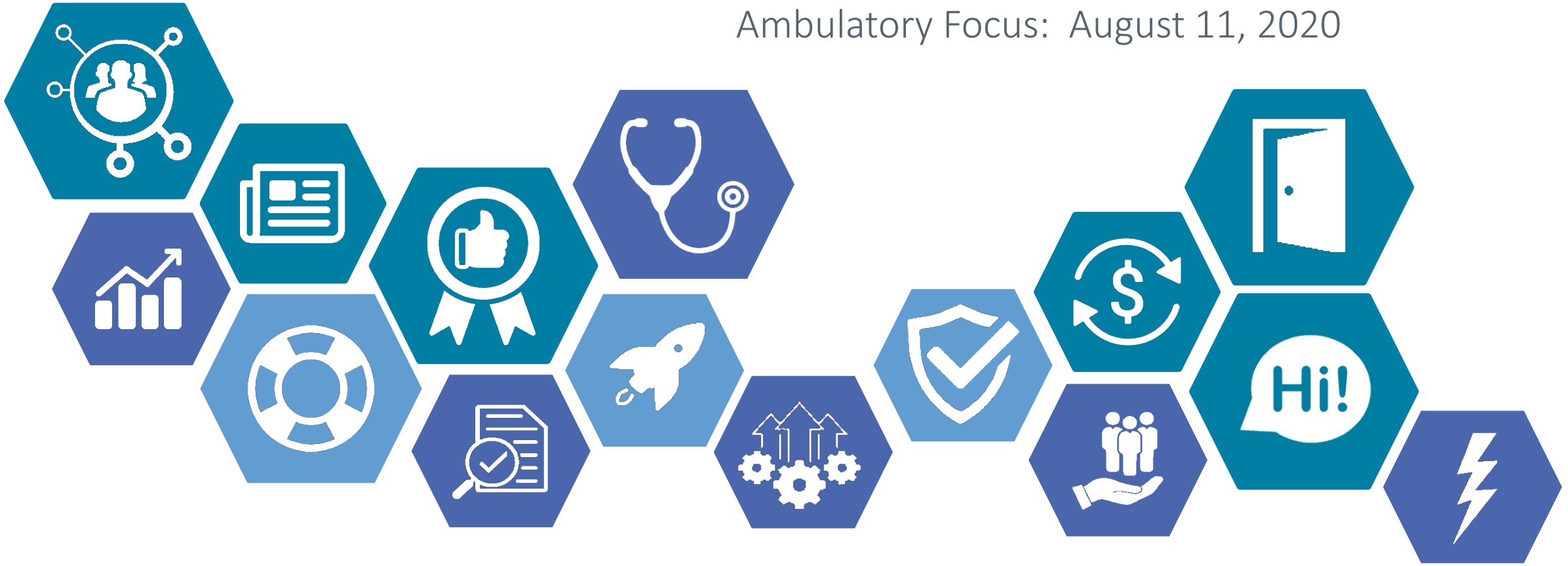
Ambulatory Management

Joint Commission Preparation Webinar Series

Ambulatory Focus: August 11, 2020



Zoom Best Practices

- Join the meeting via Zoom first
  - Use of computer audio is highly encouraged
  - If using the phone to connect audio, prompt the meeting to call you
  - Use your webcam (if possible)
- Please remain muted unless invited to speak
- Please send in questions via the Chat
- **This session will be recorded and the recording distributed**

Purpose & Learning Objectives

- **Purpose:** Ensure ambulatory practices are prepared for the upcoming Joint Commission Survey by having structures and processes in place to meet accreditation standards. Participation in the webinar series will familiarize practices with the survey process.

- At the conclusion of today's activity participants will be able to:
  - Describe how The Joint Commission is scheduling upcoming surveys using infection rate data.
  - Discuss two to three ambulatory focus areas pertinent to their practice and identify potential opportunities for improvement.

Contact hours will be available for individuals who participate in the entire session and claim credit through the on-line evaluation form.

This program meets the requirements of the Board of Registration in Nursing, at 244 CMR 5.00, for 1 contact hour of nursing continuing education.

Joint Commission Survey
An Ambulatory Focus

Patrick Adams, RN
Senior Specialist, Clinical Compliance
August 11, 2020

The Edward P. Lawrence
Center for Quality & Safety

MASSACHUSETTS GENERAL HOSPITAL
MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION

Joint Commission 2020 Survey

- Achieving excellent results on our Joint Commission 2020 hospital-wide survey is an institutional quality & safety priority.
- Every 3 years we have this opportunity to showcase our excellence in quality & safety.
- Our window for survey is open now, and we anticipate Joint Commission to come some time after September 8th
- Excellent performance during survey depends on our focus on the top quality & safety issues between now and survey.
- The Joint Commission SAFER Matrix is a tool that sets our hospital-wide priorities based on the observations from our Interdisciplinary Tracer Program.

Joint Commission 2020 Survey and COVID 19 Pandemic What we know, what we don't know

- Go or No go…it's all about the numbers
  - New infection rates within Suffolk, Essex and Middlesex Counties
  - Staff infection rates within the last 14 days
- We are having conversations with our TJC account rep every 1-2 weeks to review the data.
- Once we are a "Go", we will have 1-4 weeks notice of our unannounced survey.
- There is a chance that we may have a mock survey as we originally planned for March. If so, the real survey will not occur until 30 days after our mock survey.
- If there is a mock survey, we plan to have the reviewers focus on the same areas of risk we identified in March and visit the same locations agreed on in March – we will share more information as it becomes available.

Joint Commission 2020 Survey and COVID 19 Pandemic What we know, what we don't know

- Given the pandemic, we are not exactly sure how the actual survey will proceed.
- Will escort/scribe teams be limited to just an escort?
- Will we still be able to include informatics in this team?
- We suspect system tracers which are typically large group meetings will be limited to much smaller groups or will be entirely virtual.
- We may not get the same type of team. At the moment, TJC surveyors are avoiding air travel, this means surveyors that live locally may make up the entire team.
- Will their team be smaller? Complex question as the size and volume of care at MGH drives the number of surveyor days.

Joint Commission 2020 Survey and COVID 19 Pandemic What we know, what we don't know

- TJC will be quite interested in how we've managed through the pandemic
- They will evaluate the effectiveness of our Emergency Preparedness response to COVID
- Infection control practice modifications are likely ripe for evaluation.
- We don't believe they're looking to cite us here, although that's a possibility if they observe a hand hygiene, PPE or other pandemic related infraction. We believe they want to learn from us given how well we've operated as a whole.

FY20 MGH/MGPO Institutional Q&S Goals: Approved

1. Lead in quality of care and patient experience

a. Strengthen Q&S performance across key 'hubs': Procedural, Ambulatory, MGH Family, Dept of Medicine
b. Improve equity in patient experience and clinical care
c. Advance the use of departmental, registry-based, outcome metrics

2. Improve patient and workforce safety and advance safety culture

a. Improve institutional capacity (ambulatory, ED, inpatient)
b. Reduce preventable patient harm (medication safety, Health Care Associated Infections (HAIs), Serious Reportable Events (SREs))
c. Strengthen Safety Culture: Workforce Safety, Wellness, Professionalism, Just Culture
d. Leverage eCare to improve patient safety: Medication safety, Downtime preparedness, Analytics

3. Achieve excellent performance on important surveys and measures

a. Achieve excellent results on The Joint Commission (TJC) Triennial Survey
b. Improve performance on high risk targets found on tracers: High Level Disinfection (HLD)/Sterilization, Equipment Maintenance, Titration orders, and Compliance with CMS/TJC required documentation
c. Excel on key performance programs and rankings:
- CMS Programs (Readmissions, Value-Based Purchasing, Hospital-Acquired Conditions)
- Partners Internal Performance Framework
- MassHealth P4P
- MSSP Quality Metrics
- Promoting Interoperability (Hospital Meaningful Use)
- US News and World Report
- ACGME Q&S CLER

Priority areas in **bold** font

The five priorities that touch just about everyone

1. Improve equity in patient experience and clinical care

2. Improve institutional capacity (ambulatory, ED, inpatient)

3. Reduce preventable patient harm (medication safety, Health Care Associated Infections (HAIs), Serious Reportable Events (SREs))

4. Strengthen Safety Culture: Workforce Safety, Wellness, Professionalism, Just Culture

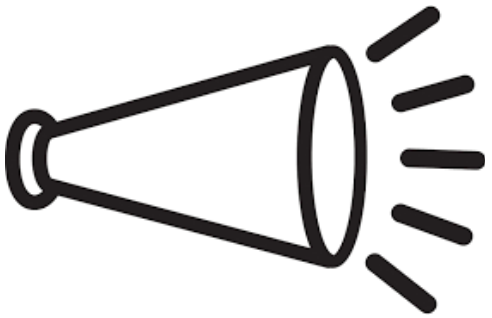
5. Achieve excellent results on The Joint Commission (TJC) Triennial Survey

The Tone from the Top

"I resolve to do whatever I can to help the MGH set a new and higher standard for quality and safety by finding ways to enhance our environment, systems and processes to ensure that our hospital is an ever- safer place for those receiving care as well as for those delivering and supporting that care. In truth this is much more than a resolution for 2007; it is a mandate for the years ahead".

-MGH President, Peter Slavin, MD, New Year's Resolution 2007

- Leadership accountability
- Hospital-wide involvement
- Coordinated communication effort (Excellence Every Day brand)



The Joint Commission Survey Acing the Test

- Each year The Joint Commission states its priorities for the current year
- For 2020 these priorities are:
  - High-Level Disinfection/Sterilization
  - Suicide Prevention
  - Sterile Compounding
  - Hemodialysis

The Joint Commission Survey Acing the Test

- There are several factors that go into performing well during Joint Commission survey
  - Aligning Joint Commission and institutional and departmental priorities
  - Continuously monitoring performance and implementing improvements
  - Organizing the logistics

Joint Commission Survey - Ambulatory Focus

- The Joint Commission surveyors intend to complete ambulatory tracers only in hospital licensed practices.
  - MGPO practices are not subject to survey, and our survey escorts will re-direct surveyors away from these practices.
- TJC typically visits all sites that administer either anesthesia and/or sedation, both on and off main campus.
- TJC surveyors will also plan to visit all practices performing high level disinfection.

Interdisciplinary Tracer Methodology

- Survey method utilizing patient care observations, interviews with frontline staff and review of patient records
  - Patient tracers allow surveyors to get a patient's perspective of the care they receive
  - System tracers allow surveyors to see how well a unit, department or entire facility is performing
- Surveyors:
  - Look for non-compliance trends
  - Provide education to organization staff and leaders
  - Share best practices

Interdisciplinary Tracer Team

- We have over 90 members on the tracer team
- In 2018, we combined the environment of care rounds with the clinical surveillance rounds for a more comprehensive assessment.

Departments included	
Clinical Compliance	Privacy
Infection Control	Police and Security
Pharmacy	Patient Care Services (Nursing and Clinical Support)
Materials Management	MGH eCare
Information Systems	Lab
Biomedical Engineering	Central Sterile Processing
Environmental Services	Clinical Operations, Ambulatory Management

A TOTAL OF **193**

INTERDISCIPLINARY TRACERS

performed this year

14+ Improvement Initiatives

Risk areas identified during tracers

- Medication Orders
- HLD/Sterilization
- Suicide Risk

2019 breakdown

48 *Inpatient*

131 *Ambulatory*

14 *Procedural*

20+ Role groups and/or departments participate

The Edward P. Lawrence Center for Quality & Safety

MASSACHUSETTS GENERAL HOSPITAL

MASSACHUSETTS GENERAL PHYSICIANS ORGANIZATION

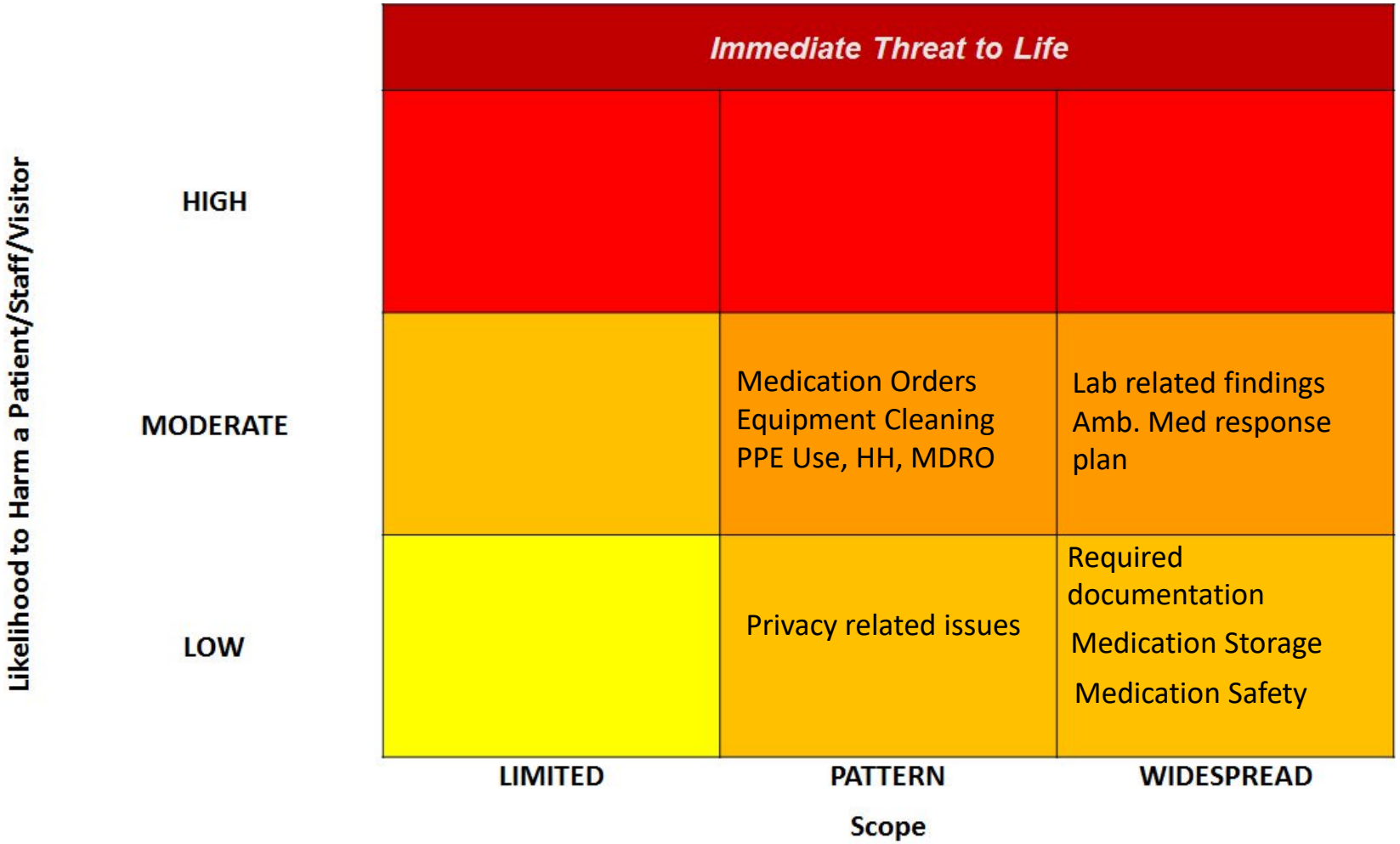
We see room for improvement in other areas: 10 Clinical findings with lowest compliance rates from Interdisciplinary Tracer Program

CY 2019 results N = 193 tracers

Section Title	Compliance Rate
Lab related findings	46%
Medication Storage	50%
MDRO/HAI	55%
Equipment Cleaning	58%
Medication Safety	59%
PPE Use	60%
Required Documentation	61%
Hand Hygiene	62%
Anticoag/high risk meds	67%
Medication Orders	69%

>90%
70-90%
<70%

Clinical Findings



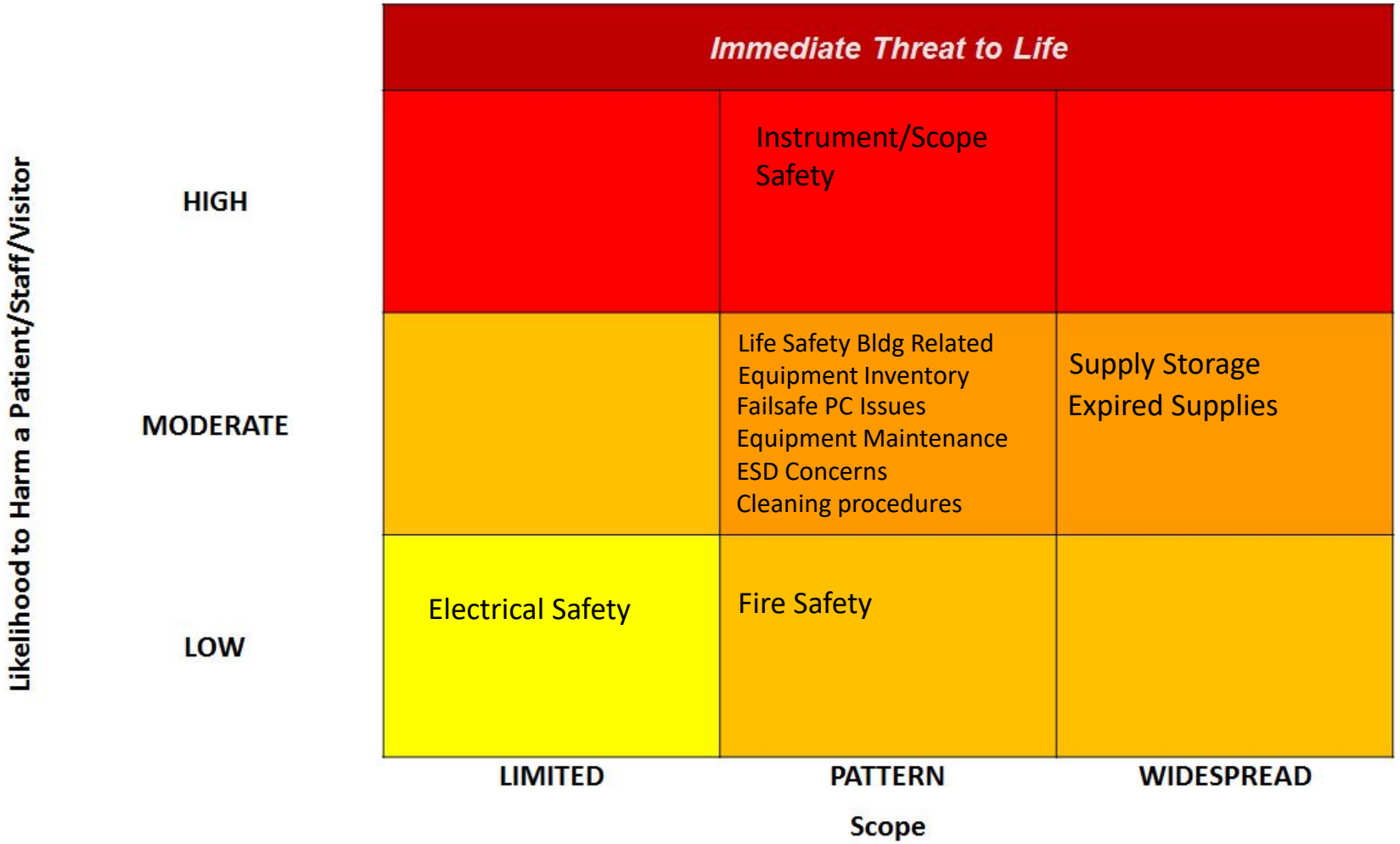
We see room for improvement in other areas: 10 EOC findings with lowest compliance rates from Interdisciplinary Tracer Program

CY 2019 results N = 193

Section Title	Compliance Rate
Life Safety – Building Related	26%
Expired Supplies	36%
Fire Safety	39%
Equipment Maintenance	42%
Environmental Services Concerns	42%
Cleaning Procedures	43%
Failsafe Computer related findings	46%
Standard Comps/Supplies	46%
Supply Storage	48%
Electrical Safety	57%

>90%
70-90%
<70%

EOC Findings



Joint Commission Survey - Ambulatory Focus

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Joint Commission Survey - Ambulatory Focus Areas

Medication Review and Reconciliation

- Medication review is required at every visit
  - This may be done by the MA, RN or provider
  - Remember to click “Mark as reviewed” to acknowledge and document this process
- Reconciliation (ordering/prescribing) is required when a medication is added, changed, deleted or a discrepancy is being resolved, for example: a duplication, dosage or frequency error
  - This action can only be completed by an authorized prescriber – MD, APP as it is considered ordering/prescribing.

Patient Orders

- We strongly encourage authorized prescribers to write their own orders.
- We understand the nuances of ambulatory care and recognize there are circumstances that allow for a verbal/telephone order to be taken, however these should be limited to the extent possible.
- Selecting the correct order mode is essential
  - Avoid the use of “per protocol, co-sign required” unless there is an hospital approved protocol in place
  - Departmental protocols must be approved by both Clinical Policy and Record Committee as well as the Medical Policy Committee
  - Use of the order mode “per protocol, no co-sign required” is rarely acceptable. This order mode is audited frequently and feedback is directed to practice leadership

Problem Lists

- An up to date problem list helps to ensures continuity of care
- Problem lists should be reviewed and updated (as needed) at every visit
- For new ambulatory patients, ideally a problem list will be initiated at the first visit but no later than the 3rd visit.
- Problems should be documented in the problem list module of the EHR for every patient.
- It is the shared responsibility of all providers (Physicians, NPs and PAs) to document problems on the problem list and maintain its accuracy.
- Other licensed clinicians, e.g., RNs, LPNs, Pharmacists, shall maintain and update the problem list in the EHR as is appropriate to the scope of their practice, job description, institutional policy and in communication with the appropriate providers.

Problem Lists (continued)

- All licensed clinicians are encouraged to add problems that come to their attention outside of their specialty, within their scope of practice, as defined by their license.
- As a provider, if you identify a new problem, you are responsible for adding it to the Problem List.
- Non-licensed users such as medical assistants and secretaries may assist with updating the problem list under clinical supervision.
- The patient, and if necessary, the family, should be a key participant in problem list management.

Board of Registration in Medicine – Informed Consent Regulations

- Key provisions:
  - Attending physician/primary operator shall obtain and sign informed consent
  - Names of those participating will be listed on the consent, when known
  - The medical record will reflect the presence and absence of the attending surgeon
- MGH procedural consent policy has been updated.
- Mass General Brigham work group is exploring technology solution to record ins/outs.
- Monitoring of compliance is being completed by clinical and billing compliance teams.

Pre-procedural Documentation

- Cases involving anesthesia
  - An H&P is required within 30 days of the procedure
  - If the H&P is completed greater than 30 days prior to the procedure, the entire H&P must be re-done.
  - If the H&P was done within 30 days but prior to the day of procedure, a Day of Procedure Update note must be completed. The note should state that ***"The patient was seen and examined, there was/was not any change in either the patient's history or exam since the last H&P was completed on xx/xx/xx."*** Of course, if there were notable interval changes, those should be documented.

Pre-procedural Documentation

Cases involving procedural (aka moderate or conscious) sedation

- If the Pre-sedation evaluation (PSE) is completed on the day of procedure, nothing else needs to be done.
- If the PSE is completed prior to the procedure, but less than 30 days prior, a Day of Procedure Update note must be completed as described on prior slide.
- If the PSE is completed greater than 30 days prior to the procedure, it must be completely re-done.
- A properly completed PSE is actually an H&P+ as it should contain all the elements of a history and physical exam, plus some elements of a pre-anesthesia evaluation – ASA, airway evaluation and sedation plan.

Pre-procedural and intraprocedural observations

- All staff should be prepared to have a surveyor observe a portion of the procedure, here a few key things the surveyor is looking for:
  - Accurate patient identification
  - Medication labeling
  - Provider direction of sedation using verbal orders with repeat back
  - Site marking as appropriate
  - A complete stop of all activities during the time-out with all procedural staff making eye contact and engaged with the exchange of information to re-verify correct patient, correct site, correct procedure and any special considerations – allergies, implants, images needed for the procedure

Documentation of the Universal Protocol

- In many locations this is a shared responsibility and there should be some agreement in advance who will complete the documentation
  - In areas where a flow sheet view is available, all elements of the UP can be “wrenched in” to the flow sheet
  - If an RN or provider would like to include UP documentation in there note, simply typing “.timeout” will pull all required elements into the note
  - Paper documentation is allowable but generally not encouraged.

Patients at risk for Suicide

- NPSG.15.01.01: Identify patients at risk for suicide.

Elements of Performance for NPSG.15.01.01

1. The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
   Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).
2. Screen all individuals served for suicidal ideation using a validated screening tool.
3. Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.
   Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.
4. Document individuals' overall level of risk for suicide and the plan to mitigate the risk for suicide.
5. Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following:
   - Training and competence assessment of staff who care for individuals served at risk for suicide
   - Guidelines for reassessment
   - Monitoring individuals served who are at high risk for suicide
6. Follow written policies and procedures for counseling and follow-up care at discharge for individuals served identified as at risk for suicide.
7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance.

Patients at risk for Suicide

- NPSG.15.01.01: Identify patients at risk for suicide.

- Any patient who presents with an emotional or behavioral issue must by screened and assessed for risk of harming themselves.
- If the screen and/or assessment identifies such risk, initiate the following actions:
  - Address patient's immediate safety needs and most appropriate setting for treatment
    - Keep patient under direct and constant observation
    - Obtain a psychiatric consult
    - Provide a safe environment
  - When a patient at risk for suicide leaves the hospital, provide suicide prevention information (e.g. crisis hotline) for patient and family.

Patients at risk for Suicide

- NPSG.15.01.01: Identify patients at risk for suicide.

Ambulatory Checklist for the Care of the Patient at Risk for Suicide and/or Self Harm

ELEMENTS	
Initial Actions	**Notes**
Keep patients in acute suicidal crisis in a safe health care environment under one-to-one- Call Security or 911 for escort to ED (Acute Psychiatric Services)	
Do not leave patient unattended at any time (patient must be visualized, including bathroom)	
Environmental Monitoring	**Notes**
While providing one to one supervision, be aware of environmental risks including anchor points for hanging and material that can be used for self-injury.	
Emergency Management of Patient Attempting Harm	**Notes**
DO NOT PLACE SELF AT RISK, if available, wait for security to intervene, call for "HELP", press panic button or call Dr. Johnson	
If patient is trying to leave do not block patient but follow if possible and try to keep sight of patient DO NOT PUT HANDS ON PATIENT	
Remove other patients from area, if able and have staff assist patients and family members in the waiting area	
If medical emergency, activate emergency response	

Emergency Management of Actively Suicidal Patient on Phone
When a caller identifies her/himself as actively suicidal, licensed staff will remain on the line with the caller until an appropriate emergency response is activated.

Wrapping up…

- General reminders
  - Wear your ID badge where it is above the waist and visible
  - Welcome the surveyors to your practice. Smile, be confident and answer honestly. If you don't know the answer to a particular question, demonstrate how you would find out (refer to policy, ask your manager or chief, etc.)
  - Don't forget the basics: consistent hand hygiene and PPE use, consistent patient identification
  - A clean, orderly environment with all equipment up to date with preventive maintenance and in good working order.

Joint Commission Survey Conclusions

- Excellent performance during our Joint Commission survey is a top hospital-wide goal for 2020.
- Focusing on these top priorities between now and our survey is a critical success factor.
- Thank you for your commitment to Excellence Every Day.

Contact Hours

- We will be offering CEUs for participation. Each session will be equivalent to one contact hour. To receive credit, you must complete the evaluation*:
    - https://www.surveygizmo.com/s3/5768360/JC-Prep-Webinar-6-Ambulatory-Provider-Focus

*Only individuals who fully attend and complete the evaluation will be eligible to claim the Contact Hours.

This program meets the requirements of the Board of Registration in Nursing, at 244 CMR 5.00, for 1 contact hour of nursing continuing education.

Stay informed

- Ambulatory Communication:
  - MGH/MGPO Ambulatory Management News - weekly e-mails:

  - Ambulatory Blueprint
  - Ambulatory Joint Commission Preparation

- What if I Have Questions?
- We are here to help:
  - Ambulatory Management Clinical Operations Nurses MGH Ambulatory Clinical Programs
  - Management Project Managers/Liaisons: MGH Ambulatory Management

2020 Joint Commission Preparation Webinar Series

Date/Time		Topic
July 7th	12:00-1:00pm	Joint Commission 101 ✓
July 14th	12:00-1:00pm	Environment of Care, BioMed, Police & Security and Emergency Management ✓
July 23rd	12:00-1:00pm **(Thursday)**	Human Resources ✓
July 28th	12:00-1:00pm	Safeguard High Risk Patients, Falls, Suicide ✓
August 4th	12:00-1:00pm	Infection Control ✓
August 11th	12:00-1:00pm	Provider Oriented Overview of Key Standards
August 18th	12:00-1:00pm	Lab and Point of Care Testing (POCT)
September 1st	12:00-1:00pm	Pharmacy