Revised NPSG on suicide prevention takes effect July 1, 2019

Seven new and revised elements of performance (EPs) to be scored at National Patient Safety Goal (NPSG) 15.01.01 for all Joint Commission-accredited behavioral health care organizations are set to take effect July 1.

These new requirements are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide.

Because suicide is the 10th leading cause of death in the country and there has been no improvement in suicide rates in the U.S., The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

The revised requirement — which now is more specific and instructional, and aligns with current research and expert panel recommendations — includes the following:

- Conduct an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and take necessary action to minimize the risk.
- Individuals being treated or evaluated for behavioral health conditions as their primary reason for care need to be screened for suicide risk using a validated tool. In a behavioral health organization, this would be all individuals served. (Note: The NPSG does not require universal screening in non-BHC settings.)
- Organizations must develop a plan to mitigate suicide based on an individual’s overall level of risk.
- Organizations must follow written policies and procedures for counseling and follow-up care for individuals identified as at risk for suicide.

View the prepublication standards.

For more information about the revisions, a new issue of R3 Report provides a rationale statement for each EP, along with references that support each requirement.
Learn about new, revised BHC pain assessment and management standards
Effective July 1, 2019, new and revised pain assessment and management standards will be applicable to Joint Commission-accredited behavioral health care organizations.

While the new requirements have limited applicability in the behavioral health care program, they outline a multi-level approach to pain management to help care staff deliver safe, individualized pain care. The prepublication standards are available online, and they will be published in the spring 2019 E-dition® update to the Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC).

To help organizations better understand these new standards, The Joint Commission published an R³ Report to provide more in-depth rationale statements for each element of performance (EP), as well as the references for the evidence that supports the requirement. View the R³ Report on the pain assessment and management standards. Additionally, learn more in the January 2019 issue of Perspectives.

4-1-1 on Survey Enhancements webpage examines suicide prevention, other high-risk areas
The Joint Commission recently launched its 4-1-1 on Survey Enhancements interactive webpage dedicated to covering four high-risk areas that Joint Commission surveyors evaluate, including suicide prevention.

Beginning in 2018, The Joint Commission enhanced its evaluation of this high-risk area along with sterile medication compounding, high-level disinfection and sterilization, and hemodialysis.

While the increased attention on these areas did not involve any new accreditation standards, each area does require leadership engagement and oversight — both of which are evaluated by the survey team through tracers and interviews. Visit the new 4-1-1 on Survey Enhancement’s webpage.

Quality and safety

Journal article focuses on ways to improve depression screening, follow-up
A new study in the January 2019 issue of The Joint Commission Journal on Quality and Patient Safety details the work of a Virginia community health center as it improved the efficacy of Screening, Brief Intervention and Referral to Treatment (SBIRT) for depression, which is an evidence-based approach to identify and treat disorders related to substance abuse.

The article — “Not Missing the Opportunity: Improving Depression Screening and Follow-Up in a Multicultural Community,” by Ann M. Schaeffer, DNP, CNM, and Diana Jolles, PhD, CNM, and coauthors — is available for free online until the end of the year.

Depression is the leading cause of disability, and it often goes unaddressed — particularly for minorities, immigrants and refugees. While evidence-based guidelines recommend screening for the adequate diagnosis, treatment and follow-up of depression, only seven states report depression screening and follow-up.

Researchers at Harrisonburg Community Health Center (HCHC), Virginia — a rural Federally Qualified Health Center (FQHC) with three clinic sites — implemented four core interventions:

- Use of written standardized Patient Health Questionnaire (PHQ) screening tools in six languages.
- The Option Grid™, a standardized tool to help clients who screen positive for depression to share what matters most to them.
• A “right care” tracking log to assist providers in documenting follow-up phone calls and visits for clients who screen positive for depression.
• Team meetings and in-services to support capacity building.

Surveys, charts and registry data were used to analyze and evaluate the population health impact of the interventions. Results showed:
• Provision of evidence-based care increased to 71.4 percent.
• Adherence to follow-up increased from 33.3 percent to 60 percent.
• Screening in the client’s preferred language increased to 85.2 percent, identifying a positive PHQ incidence of 45.5 percent.

“The project demonstrated the feasibility of using rapid-cycle improvement to improve depression screening and follow-up within a multicultural community health center,” the authors noted. “This project also brought attention to a chronic condition with long-standing implications for individual and community health that too often go unidentified and therefore unaddressed.”