The Joint Commission

May 2019 | Volume 39 | Number 5

The Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

The Joint Commission NATIONAL QUALITY FORUM

The Joint Commission and NQF Honor 2018 Eisenberg Award Recipients

On March 25, 2019, The Joint Commission and the National Quality Forum (NQF) presented the 2018 John M. Eisenberg Patient Safety and Quality Awards at NQF's 2019 Annual Conference in Washington, DC. Launched in 2002 by NQF and The Joint Commission, the patient safety awards program honors John M. Eisenberg, MD, MBA, former administrator of the Agency for Healthcare Research and Quality (AHRQ) and member of NQF's founding board of directors.

Eisenberg honorees are recognized for significant and long-lasting contributions to improving patient safety and health care quality. This year's award recipients contributed many years to quality improvement initiatives that have enhanced health care globally.

> *"The Eisenberg Awards are an annual reminder that we, as a nation, cannot take health care quality and safety for granted, and significant work remains to improve the care experienced by every person in communities across the country."*
> **Dr. Shantanu Agrawal, president and chief executive officer, National Quality Forum**

The 2018 Eisenberg honorees received awards in the three annual categories—Individual Achievement, Innovation in Patient Safety and Quality at a National Level, and Innovation in Patient Safety and Quality at the Local Level. The achievements of each award recipient will be featured in *The Joint Commission Journal on Quality and Patient Safety* in summer 2019.

> *"This honor is reserved for individuals and organizations that have made the most significant and long-lasting improvements in patient safety and quality in health care. It is through their passionate and extraordinary work that we continue to see and make great strides toward improving health care for each and every patient. I also want to acknowledge the innovative and successful work of all those who submitted entries this year."*
> **Dr. David Baker, MD, MPH, FACP, executive vice president, Division of Health Care Quality Evaluation, The Joint Commission**

Individual Achievement

Brent C. James, MD, MStat, Salt Lake City

Dr. Brent James was recognized for his passionate work in bringing quality improvement science and methodology to clinical care for more than three decades. Among his many achievements, Dr. James trained a globally diverse group of more than 5,000 senior physician, nursing, and administrative executives in quality improvement science and methodology with proven results, as well as more than 50 "sister" training programs in more than 10 countries.

"I count it a true honor to receive the award that bears [Dr. John Eisenberg's] name—a lifetime achievement. I will cherish it, alongside his memory, as long as I live."
Dr. Brent James, 2018 Eisenberg Award Recipient for Individual Achievement

Innovation in Patient Safety and Quality at the National Level

The Society of Thoracic Surgeons, Chicago

The Society of Thoracic Surgeons

The Society of Thoracic Surgeons (STS) was selected for its extraordinary efforts as a trailblazer and becoming an industry leader in sophisticated performance measurement and consumer-friendly reporting. The centerpiece of the STS quality program, the STS National Database—developed in 1989—is considered a premier clinical data registry in health care. Features of this database include the following:

- Subspecialty registries for adult and pediatric cardiac surgery, mechanical circulatory support, and general thoracic surgery
- Clinician-designed, explicitly defined, standardized data elements
- Broad national penetration among providers
- Externally verified data for accuracy

Using these data, STS has developed risk models and NQF–endorsed composite performance measures for all its subspecialties and major procedures—results of which are used by providers to guide their improvement initiatives.

> *"Receipt of the Eisenberg Award provides external validation by two of the preeminent health care quality organizations in the world that these efforts are recognized and appreciated. It provides our staff and volunteers with renewed energy and focus to continue our efforts to improve cardiothoracic surgical quality."*
> **Dr. David M. Shahian, MD, chair, Society of Thoracic Surgeons Council on Quality, Research, and Patient Safety**

Innovation in Patient Safety and Quality at the Local Level

BJC HealthCare, St. Louis

BJC HealthCare received its award for its systemwide approach to significantly improving in patient safety and consistently sustaining those improvements year to year across its moderately sized health care system. In 2008 the 15-hospital health care system launched a five-year systemwide initiative to reduce preventable harm in a wide variety of categories, including the following:

- Adverse drug events
- Falls with serious injury
- Health care–associated infections
- Pressure ulcers
- Venous thromboembolism

At the end of the five-year initiative, in 2012, BJC HealthCare had reduced aggregate harm in the identified categories by more than 50% (from 10,371 events in 2009 to 5,018 in 2012).

The organization has continued its improvement efforts and has seen further reductions in preventable harm for the categories originally identified. From 2009 to 2017, BJC HealthCare has continued reductions in all categories as follows, with a further reduction by nearly 50% to 2,605 events in 2017:

- 85%—Pressure ulcers
- 69%—Adverse drug events
- 41%—Health care–associated infections
- 40%—Venous thromboembolism
- 35%—Falls with serious injury

> *"Quality and safety have been areas of focus for BJC HealthCare since the foundation of the health system. Winning the Eisenberg is very gratifying as external recognition of the excellent work our frontline providers do every day to provide the best possible care for our patients."*
> **Dr. Keith F. Woeltje, MD, PhD, vice president, chief medical information officer, BJC HealthCare**

Nominations for the 2019 Eisenberg Awards open in early September. For more information about the Eisenberg Awards, please visit The Joint Commission website.

NEXT ▼

The Joint Commission Launches New Nursing Care Center Dashboard Report

Other Health Care Settings to Get Dashboard Report Later in 2019

In March The Joint Commission launched a new Dashboard Report for accredited nursing care centers to provide performance measurement data on a select subset of measures. The dashboard, available to both Joint Commission surveyors and accredited nursing care center organizations, is intended to be a springboard for conversations on data, performance measures, and quality improvement during the on-site survey process; in addition, the report is a valuable ongoing resource for accredited organizations.

Aligning Measures and Performance

The report uses the most recent and available external data from the US Centers for Medicare & Medicaid Services (CMS) Nursing Home Compare website. After thorough analysis and vetting with national experts from the field, The Joint Commission chose the following subset of measures from the Compare website to include in the dashboard:

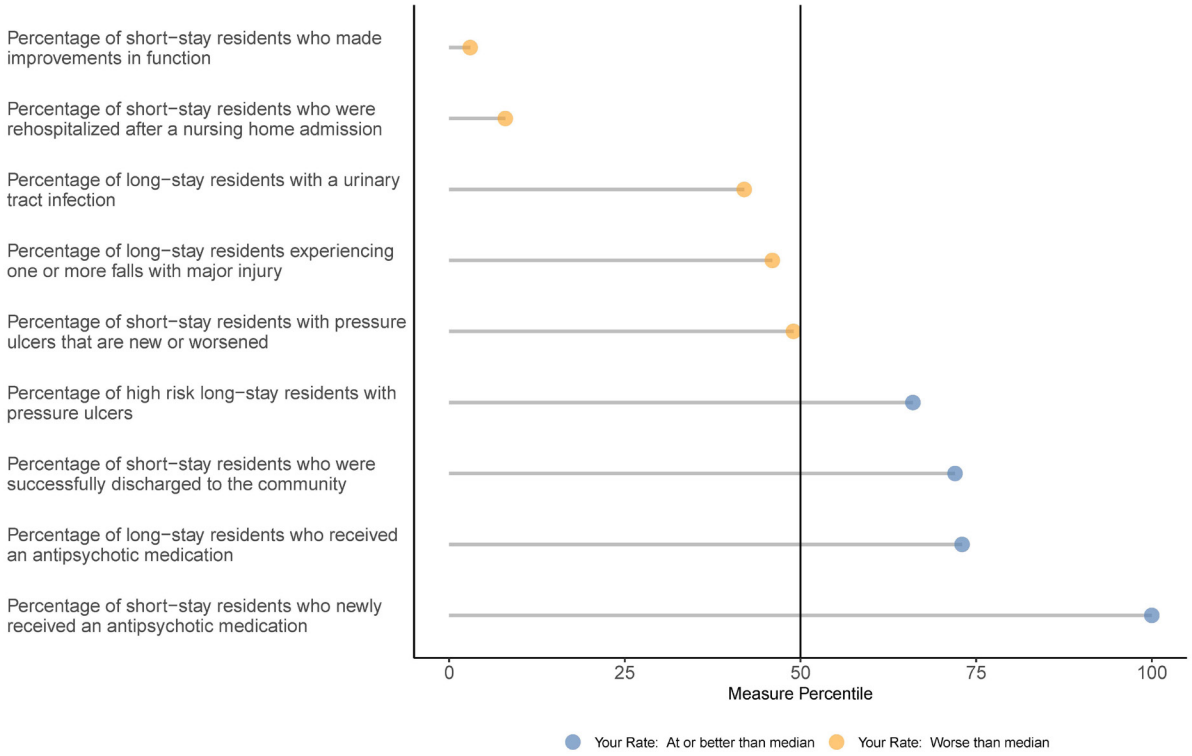
- Long-stay residents with a urinary tract infection
- Long-stay residents who received an antipsychotic medication
- Long-stay residents experiencing one or more falls with major injury
- High-risk long-stay residents with pressure ulcers
- Short-stay residents with pressure ulcers that are new or worsened
- Short-stay residents who were rehospitalized after a nursing home admission
- Short-stay residents who newly received an antipsychotic medication
- Short-stay residents who were successfully discharged to the community
- Short-stay residents who make improvements in function

The report—posted in the Continuous Compliance section on an accredited nursing care center's secure *Joint Commission Connect*® extranet site—is representative of each organization's relative performance on each of the selected measures. For each measure, the dashboard shows that organization's performance compared to national, state, and Joint Commission–accredited organization averages. The dashboard is not a scorable element on a survey, but rather a tool to facilitate discussion about ongoing quality improvement work. The data also may be used during survey; for example, surveyors may ask an organization how it addresses the subset of performance measures in the report and what action(s) the organization is taking to improve processes.

A Bigger Picture

The Joint Commission developed this dashboard as part of an ongoing project to provide continuous customer engagement. The Joint Commission will analyze aggregate performance in each of these measures and identify the measures for which the greatest opportunities for improvement exist among accredited nursing care centers (*see* the following image for a sample report graph). Updates to the Dashboard Report are anticipated to be quarterly, but a message will be sent to accredited nursing care centers' extranet site when an updated report is available. Based on those findings, an educational webinar series that

addresses the high-opportunity topics will be developed. All accredited nursing care centers will have access to the educational webinar series; additional information about the webinar series will be available at a later date. Organizations with high opportunity for improvement will be particularly encouraged to participate.



This is one of several data representation graphics that are included in the Dashboard Report. This graphic clearly identifies an organization's performance measures from lowest to highest ranking. The easy identification of performance levels allows an organization to prioritize its quality improvement work and identify areas of excellence to propagate.

In addition to nursing care centers, The Joint Commission plans to release a similar Dashboard Report for home health, hospice, ambulatory surgery centers, and hospitals throughout 2019. For additional information, contact your account executive.

NEXT ▼

2019 Spring Update for Accreditation and Certification Manuals: Summary of Changes

Spring Update to E-dition Scheduled

The spring 2019 update to E-dition® for accreditation and certification manuals is expected to post to the *Joint Commission Connect*® extranet site by mid May. These changes—unless otherwise noted—are effective July 1, 2019. In addition, the hard-copy 2019 Update 1 to the *Comprehensive Accreditation Manual for Ambulatory Care*, *Comprehensive Accreditation Manual for Behavioral Health Care*, *Comprehensive Accreditation Manual for Home Care*, and *Comprehensive Accreditation Manual for Hospitals*, have been mailed to those customers who have ordered them; they are available for purchase.

Key revisions from the spring update include the following.

Requirement-Related Revisions

- Added new and revised existing pain assessment and management standards for **behavioral health care** organizations, home health services under the **home care** program, and **nursing care centers** (January 2019 *Perspectives*)
- Revised National Patient Safety Goal (NPSG) Standard NPSG.03.05.01 on anticoagulant therapy for **ambulatory health care** organizations, **critical access hospitals**, **hospitals**, and **nursing care centers** (December 2018 *Perspectives*)
- Added new Note to clarify applicability of NPSG.15.01.01, Element of Performance (EP) 1 for **behavioral health care** settings (March 2019 *Perspectives*)
- Revised Standard NPSG.15.01.01 to focus on reducing the risks of suicide in **behavioral health care** settings and **hospitals** (December 2018 *Perspectives*)
- Clarified Note for Provision of Care, Treatment, and Services (PC) Standard PC.03.01.01, EP 5 related to circulating duties in the operating room in **critical access hospitals** and **hospitals** (February 2019 *Perspectives*)
- Deleted Performance Improvement (PI) Standard PI.01.01.01, EP 21, for **deemed-status ambulatory surgical centers**, regarding collecting data on the medical necessity and appropriateness of procedures (October 2018 *Perspectives*)

Eligibility-Related Changes

- Revised requirement for participation in a national joint replacement registry for **hospitals**, **critical access hospitals**, and **ambulatory surgery centers** that participate in the advanced certification for Total Hip and Total Knee Replacement (November 2018 *Perspectives*)
- Reinstated mechanical thrombectomy eligibility requirements for **thrombectomy-capable stroke center** (TSC) and **comprehensive stroke center** (CSC) certification programs (February 2019 *Perspectives*)

Other Important Revisions

- Added two new advanced disease-specific care certification programs—**primary heart attack center** (PHAC) and **acute heart attack ready** (AHAR)—for heart attack (February 2019 *Perspectives*)
- Added a specialty pharmacy accreditation option as well as three new EPs to support the option (**home care**) (March 2019 Perspectives)

Review the "What's New" section in your online or print accreditation or certification resource for specific changes for your program.

Managing Your Manuals

Contact Customer Technical Support for help in accessing updated standards in the E-dition release on your *Joint Commission Connect* extranet site. If you are missing a purchased hard-copy accreditation manual product, contact Customer Service or call 877-223-6866 with your order number and organization name. Hard-copy and online manuals, as well as other accreditation resources, are also available for purchase on the Joint Commission Resources website. P

NEXT ▼

Additional FAQs: Suicide Risk Reduction Recommendations

The Joint Commission convened the Suicide Risk Reduction Expert Panel in 2017 and 2018 to provide guidance to customers and surveyors on safeguards to prevent suicide. Since then, it has released risk reduction recommendations from the panel's discussion of issues related to prevention of suicide in health care settings as well as frequently asked questions (FAQs) about those recommendations. (*See* the November 2017, January 2018, July 2018, and January 2019 issues of *Perspectives*.) The following set of FAQs is intended to further clarify the recommendations. Suicide risk recommendations, clarifying FAQ documents, and additional resources can be found on the Suicide Prevention Portal.

For questions related to the FAQs or the suicide risk recommendations, please contact the Standards and Interpretation Group (SIG) via the Standards Online Submission Form.

QUESTION: Can video monitoring or "electronic sitters" be used to monitor patients at high risk for suicide?

ANSWER: *For patients identified as high risk for suicide, constant 1:1 visual observation (in which a qualified staff member is assigned to observe only one patient at all times) should be implemented. This allows the assigned staff member to immediately intervene should the patient attempt self-harm. The use of video monitoring or electronic sitters is not acceptable in this situation because staff is not immediately available to intervene. Video monitoring is acceptable only as a complement to 1:1 monitoring, not as a stand-alone intervention.*

Video monitoring should be used only in place of direct line-of-sight monitoring for patients at high risk for suicide when it is unsafe for a staff member to be physically in the patient's room. In addition, for both direct line-of-sight and video monitoring of patients at high risk for suicide, the monitoring should be constant 1:1 at all times (including while the patient sleeps, toilets, bathes, and so on), and the monitoring must be linked to immediate intervention by a qualified staff member when required.

Video monitoring or electronic sitters for patients not assessed to be at high risk for suicide is up to the discretion of the organization. There are currently no leading practices on video monitoring of those at risk for suicide. It is important to reassess patients who are at risk for suicide, regardless of monitoring method; patients should be reassessed according to the organization's policies.

QUESTION: Please clarify the requirement around self-closing and self-locking doors in Recommendation #1.*

ANSWER: *The intention in Recommendation #1 is to address areas in inpatient psychiatric units behind self-closing **and** self-locking doors. That is, The Joint Commission expects both self-closing **and** self-locking doors—not one or the other—to separate areas required to be ligature resistant from those that are not. The intent is to eliminate any staff reliance on closing or locking those doors to prevent patient harm. In addition, devices to hold open a self-closing and self-locking door are prohibited (such as magnetic hold-open devices, door wedges, and so on). The door should self-close and self-lock to prevent free access by patients into the space that is not required to be ligature resistant.* P

** Recommendation #1 was published in the November 2017 issue of Perspectives.*

NEXT ▼

Consistent Interpretation

Joint Commission Surveyors' Observations of Missing or Incorrectly Followed Medication Management Policy Requirements

The monthly **Consistent Interpretation** column is designed to support organizations in their efforts to comply with specific Joint Commission requirements. Each installment of the column draws from a de-identified database containing surveyors' observations (in the column to the left) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on how to interpret the observations (in the column to the right).

The requirements highlighted in this column are not necessarily those with high rates of noncompliance. Rather, they are EPs that have the potential to negatively impact the delivery of high-quality care or create risk from a safety perspective if found out of compliance. That is, they may appear in the upper right corner of a *Survey Analysis for Evaluating Risk*® (*SAFER*™) Matrix if cited on survey. Featured EPs are applicable to the hospital program; however, the guidance in this column may be extrapolated to apply to other accreditation programs that offer similar services and populations served.

This month, **Consistent Interpretation** highlights two Medication Management (MM) requirements related to a health care organization's noncompliance with its own or missing written medication orders policy(ies).

Note: *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.*

Standard MM.04.01.01: Medication orders are clear and accurate.
EP 1: Ⓓ The hospital follows a written policy that identifies the specific types of medication orders that it deems acceptable for use. **Note:** *There are several different types of medication orders. Medication orders commonly used include the following:* ● *As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom* ● *Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances* ● *Automatic stop orders: Orders that include a date or time to discontinue a medication* ● *Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status* ● *Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval* ● *Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status* ● *Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)* ● *Orders for compounded drugs or drug mixtures not commercially available* ● *Orders for medication-related devices (for example, nebulizers, catheters)* ● *Orders for investigational medications* ● *Orders for herbal products* ● *Orders for medications at discharge or transfer*

Compliance Rate	In 2018 the noncompliance percentage for this EP was **3.96%**—that is, **58** of **1,463** hospitals surveyed were out of compliance with this requirement.
Noncompliance Implications	Failure to clearly define the types of medication orders permitted by the organization can result in errors in how orders are interpreted, transcribed into the medication profile, and administered to patients.

Surveyor Observations	**Guidance/Interpretation**

• The health care organization did not address the following in its medication order policy(ies):
  ❍ Range orders
  ❍ Titration orders
• Range orders were utilized but not addressed in the organization's medication order policy(ies).
• The organization used unapproved range/double-range orders.
• The organization did not follow its policies on medication orders.
Note: *An RFI must clearly state that noncompliance is based on a requirement of the health care organization's medication order policy(ies).*
	• Compliance with this requirement is applicable to the type of medication orders permitted by a health care organization's medication order policy(ies).
	• *See* Standard MM.04.01.01, EP 2, for failure to define the required elements of a complete medication order.
	• Do not score for double-range orders (for example, "Morphine 2 mg to 4 mg every 4 to 6 hours PRN pain") that are permitted in accordance with the organization's medication order policy(ies)
	Note: *The Joint Commission does not have a standard or EP that prohibits a health care organization from including double-range orders in its medication order policy(ies).*
	• The Joint Commission does not require organizations to start dispensing medication using the lowest dose and longest frequency; this is an example of one type of order that may be implemented.
	• Evaluate the medication order implementation process in accordance with the requirements outlined by the organization's policy(ies) to determine compliance.
	• Score failure to document medications administered at Record of Care, Treatment, and Services (RC) Standard RC.02.01.01, EP 2.*
	• Score failure to complete RASS/Ramsay assessments/reassessments at Provision of Care, Treatment, and Services (PC) Standard PC.01.02.01, EP 1.†

EP 2: Ⓓ The hospital follows a written policy that defines the following:

- The required elements of a complete medication order
- When indication for use is required on a medication order
- The precautions for ordering medications with look-alike or sound-alike names
- Actions to take when medication orders are incomplete, illegible, or unclear

Compliance Rate	In 2018 the noncompliance percentage for this EP was **0.14%**—that is, **2** of **1,463** hospitals surveyed were out of compliance with this requirement.
Noncompliance Implications	Failure to clearly define the required elements of medication orders can lead to errors and inconsistencies in administration. The risk increases when complex medication orders need to be implemented. Examples of such orders may include range orders, double-range orders, and titration orders. Additional information on range and titration orders is available on The Joint Commission's Standards FAQ website.

Surveyor Observations	Guidance/Interpretation
• Review of the health care organization's medication order policy(ies) did not address when indication for use must be included in a medication order. • The organization's medication orders policy(ies) was not comprehensive, and it did not define the necessary elements for a complete titration medication order. • Incomplete or inaccurate medication orders—as defined and mandated by the organization's policy(ies)—were noted in the patient's medical record. **Note:** *The RFI must include a specific example(s) of noncompliance with the health care organization's policy(ies).* • The medication order for IV fluids did not include the type of fluid to be initiated. • PRN medication orders were written without a specific indication as required by the organization's medication orders policy(ies). • Verbal orders were observed without all required elements. • The organization's medication orders policy(ies) did not address orders for the look-alike/sound-alike medications, such as epinephrine.	• This EP is specific to defining the required elements of a complete medication order. • For failure to define the type of medication orders permitted by the health care organization, *see* Standard MM.04.01.01, EP 1. • For additional requirements regarding look-alike/sound-alike medications, *see* Standard MM.01.02.01 and its EPs.‡ • Score failure to document medications administered at Record of Care, Treatment, and Services (RC) Standard RC.02.01.01, EP 2.* • Score failure to complete RASS/Ramsay assessments/reassessments at Provision of Care, Treatment, and Services (PC) Standard PC.01.02.01, EP 1.†

RFI, Requirements for Improvement; RASS, Richmond Agitation-Sedation Scale; IV, intravenous.

* Standard **RC.02.01.01, EP 2**: Ⓓ The medical record contains the following clinical information:

- The reason(s) for admission for care, treatment, and services
- The patient's initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments (*See also* PC.03.01.03, EPs 1 and 8)
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the patient's medical history and physical examination
- Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.
- Any consultation reports
- Any observations relevant to care, treatment, and services
- The patient's response to care, treatment, and services
- Any emergency care, treatment, and services provided to the patient before his or her arrival
- Any progress notes
- All orders
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, route, date and time of administration
- Any access site for medication, administration devices used, and rate of administration
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care (*See also* PC.01.03.01, EP 23)
- Results of diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge

- Discharge diagnosis
- Discharge plan and discharge planning evaluation

(*See also* PC.01.02.03, EP 6)

† Standard **PC.01.02.01, EP 1**: Ⓓ The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements. R

Note 1: *In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry*.

Note 2: *Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, his or her medication(s)*.

‡ Standard **MM.01.02.01**: The hospital addresses the safe use of look-alike/sound-alike medications.

EP 1: Ⓓ The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.

Note 1: *One source of look-alike/sound-alike medication name pairs is the Institute for Safe Medication Practices (https://www.ismp.org/recommendations/confused-drug-names-list)*.

Note 2: *This element of performance is also applicable to sample medications*.

EP 2: The hospital takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications. R

Note: *This element of performance is also applicable to sample medications*.

EP 3: The hospital annually reviews and, as necessary, revises its list of look-alike/sound-alike medications.

Note: *This element of performance is also applicable to sample medications*.

NEXT ▼

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **April 2019** Table of Contents for *The Joint Commission Journal on Quality and Patient Safety* (*JQPS*). The Joint Commission works closely with *JQPS* (published by Elsevier) to make it a key component in helping health care organizations improve patient safety and quality of care.

To purchase a subscription or site license to *JQPS*, please visit The Joint Commission Journal on Quality and Patient Safety website.

Editorial

Care Processes

Adverse Events

Performance Improvement

Rapid Response Systems

Safety Culture

Infection Prevention and Control

Innovation Report

Tool Tutorial

NEXT ▼

In Sight

This column lists developments and potential revisions that can affect 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.

APPROVED

- No approved requirements at the time of publication

CURRENTLY IN FIELD REVIEW

- Proposed standards revisions for **ambulatory health care**, **critical access hospital**, and **hospital** programs that elect The Joint Commission Primary Care Medical Home option (field review start date to be determined)
- Proposed perinatal safety standards for **critical access hospital** and **hospital** programs (field review start date to be determined)

Note: *Please visit the Standards Field Reviews pages on The Joint Commission website for more information. Field reviews usually span six weeks; dates are subject to change.*

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Developing proposed new antimicrobial stewardship requirement for the **ambulatory health care** and **office-based surgery** programs
- Developing proposed requirements to address Conditions for Coverage for **ambulatory health care** organizations that provide treatment for end-stage renal disease
- Identifying proposed deletions in the **laboratory** program to reduce redundancies between the hospital and laboratory survey processes
- Evaluating current National Patient Safety Goal (NPSG) Standard NPSG.02.03.01 on follow-up of all test results (**program applicability to be determined**)
- Developing proposed **behavioral health care** requirements related to substance use disorders
- Developing proposed new and revised requirements to incorporate updated American Heart Association/American Stroke Association Acute Ischemic Stroke Guidelines in all **disease-specific care** advanced stroke programs
- Researching issues related to dental and vision care for the **behavioral health care** program
- Researching potential perinatal care standards for the **critical access hospital** and **hospital** programs
- Researching issues related to management of biosafety threats (**program applicability to be determined**)
- Evaluating current requirements related to credentialing and privileging practitioners providing contract services for the **ambulatory health care**, **behavioral health care**, **critical access hospital**, **hospital**, **nursing care center**, and **office-based surgery** programs
- Evaluating current **advanced total hip and total knee replacement** certification standards for relevance and scientific merit
- Researching quality and safety gaps in the **nursing care center** program

The Joint Commission
Perspectives®

Executive Editor
Kathy DeMase

Project Manager
Heather Yang

Associate Director, Publications
Helen M. Fry, MA

Executive Director, Global Publishing
Catherine Chopp Hinckley, MA, PhD

Joint Commission Editorial Advisory Group

Department of Corporate Communications

Caron Wong, Associate Director, Publications & Multimedia

Division of Accreditation and Certification Operations

Emily Wells, CSW, MSW, Project Director and Behavioral Health Care Surveyor, Survey Management and Development

Division of Health Care Improvement

John Wallin, MS, RN, Associate Director, Standards Interpretation Group

Division of Health Care Quality Evaluation

Tricia Elliott, MBA, CPHQ, Director, Quality Measurement

Christina Wichmann, MA, Associate Project Director

Subscription Information:
Individual online license—$379
Online site license—$1029
Online system license—Contact jcrcustomerservice@pbd.com or 877-223-6866 for pricing.

Perspectives (ISSN 1044-4017) is published monthly by Joint Commission Resources, 1515 West 22nd Street, Suite 1300W, Oak Brook, IL 60523.

Joint Commission Resources, Inc. (JCR), a not-for-profit affiliate of The Joint Commission, has been designated by The Joint Commission to publish publications and multimedia products. JCR reproduces and distributes the materials under license from The Joint Commission. The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

Visit us on the Web at
https://www.jcrinc.com.

Joint Commission Resources

Practical Infection Control Resources from the Experts at JCR!

From live events, to webinars and publications, JCR offers a wide variety of resources to tackle one of the most challenging areas to demonstrate and maintain compliance.

IC Made Easy: Your Key to Understanding Infection Prevention and Control

2019 Infection Control Webinar Series

Environment of Care & Infection Prevention & Control: A Partnership

Joint Commission Resources, Inc. (JCR), a wholly controlled, not-for-profit affiliate of The Joint Commission, is the official publisher and educator of The Joint Commission. JCR is an expert resource for health care organizations, providing advisory services, educational services, software and publications to assist in improving quality and safety and to help in meeting the accreditation standards of The Joint Commission. JCR provides advisory services independently from The Joint Commission and in a fully confidential manner.