

The Joint Commission's Hospital Accreditation Recognized by CMS

The Department of Health & Human Services' Centers for Medicare and Medicaid Services (CMS) has approved the continuation of deeming authority for The Joint Commission's hospital accreditation program through July 15, 2014.

The CMS designation means that hospitals accredited by The Joint Commission may choose to be "deemed" as meeting Medicare and Medicaid certification requirements. CMS found that The Joint Commission's standards for hospitals meet or exceed those established by the Medicare and Medicaid program. CMS' notice of the four-year approval was announced on November 27.

"The Joint Commission is proud of its tradition of collaboration with CMS to provide quality oversight of hospitals," says Mark Pelletier, R.N., M.S., executive director, Accreditation and Certification Services, The Joint Commission. "Accreditation is a proven method for improving the care of Medicare beneficiaries."

Accreditation is voluntary, and seeking deemed status through accreditation is an option, not a requirement. Hospitals seeking Medicare approval may choose to be surveyed either by an accrediting body, such as The Joint

Commission, or by state surveyors on behalf of CMS. All deemed status surveys are unannounced, a policy The Joint Commission instituted in its accreditation process in 2006.

The Joint Commission's hospital accreditation program has held deeming authority since the inception of the Medicare program in 1965. The Joint Commission's hospital accreditation program had previously been granted unique statutory deeming authority;

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IN SIGHT

This column informs you of developments and potential revisions that can affect your accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they were rejected at some point in the process.

IN COMMITTEE OR BOARD REVIEW

- Proposed standards on communication and culturally competent patient-centered care for the **hospital** program
- Proposed revisions to the staffing effectiveness requirements for the **hospital** and **long term care** programs
- Proposed revisions to align with CMS rules for accrediting advanced imaging providers for the **ambulatory care** program
- Revisions to Critical Access Hospitals with Rehabilitation and Psychiatric Distinct Part Units to align with the Centers for Medicare and Medicaid Services requirements for the **critical access hospital** program, effective July 1, 2010.

CURRENTLY IN FIELD REVIEW

- Proposed revisions to National Patient Safety Goal 8 on medication reconciliation for the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, long term care, Medicare/Medicaid certification-based long term care, and office-based surgery** programs

CURRENTLY IN DEVELOPMENT

STANDARDS

- Proposed revisions to the “Provision of Care, Treatment, or Services” chapter for the **behavioral health care** program.
- Proposed revisions to National Patient Safety Goal 8 on medication reconciliation for the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, long term care, Medicare/Medicaid certification-based long term care, and office-based surgery** programs

JOINT COMMISSION INTERNATIONAL

Field review notifications are sent out electronically as well as posted on the Joint Commission International (JCI) Web site at <http://www.jointcommissioninternational.org>. For JCI standards questions, please contact the associate director of Standards Development and Interpretation at jciaccreditation@jcrinc.com.


APPROVED

- International Clinical Care Program Certification Standards, 2nd edition (formerly Disease- or Condition-Specific Care Certification)

IN DEVELOPMENT

- International Accreditation Standards for Hospitals, 4th Edition

ERRATA: Correction to “Joint Commission Launches Center for Transforming Healthcare”

In the November 2009 issue, an article titled “Joint Commission Launches Center for Transforming Healthcare” contained an error on page 3. Intermountain Healthcare was reported to be in Denver. The organization is actually in Salt Lake City. We regret the error. 



CLARIFICATION: Respiratory Care Orders in Hospitals

Two Joint Commission elements of performance address respiratory care for **hospitals that use Joint Commission accreditation for deemed status purposes**. The Centers for Medicare & Medicaid Services (CMS) requires a doctor of medicine or osteopathy to direct respiratory care services but does not limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under state law or a state's regulatory mechanism. Therefore, non-physician practitioners may write respiratory care orders, provided it is within the scope of their license. However, if a doctor of medicine or osteopathy delegates responsibility for writing orders to an eligible non-physician practitioner (such as a physician assistant or

nurse practitioner), the responsible doctor of medicine or osteopathy must co-sign the order.

LD.04.01.05, EP 7: For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services:

- Anesthesia
- Nuclear medicine
- Respiratory care

PC.02.01.03, EP 14: For hospitals that use Joint Commission accreditation for deemed status purposes: Respiratory services are provided only on, and in accordance with, the orders of a doctor of medicine or osteopathy.

Joint Commission, HHS Team Up in Language Access Education Effort

Amid growing concerns about racial, ethnic, and language disparities in health care, The Joint Commission and the U.S. Department of Health and Human Services (HHS) Office for Civil Rights have released a video titled *Improving Patient-Provider Communication*, which supports language access in health care organizations. The Joint Commission and HHS agree that effective communication is critical to safe, quality patient care. Many patients of varying circumstances require alternative communication methods, and this new video will help health care organizations determine the best methods of care for meeting these communication needs.

With many competing priorities in health care, the video explains why particular attention should be paid to federal civil rights standards and The Joint Commission's accreditation standards pertaining to effective communication and language access. The video also addresses the obligations of health care organizations with respect to the translation of written documents. The video clarifies that HHS and The Joint Commission do not endorse one specific approach to ensuring language access, but recommend using resources and modes of interpretation that are accessible, in working order, and put into use when necessary to serve the needs of patients and their families.

Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race, color, or national origin in programs that

receive federal funds; a failure to provide language access services for Limited English Proficient (LEP) persons may be a form of discrimination on the basis of national origin. Similarly, Section 504 of the Rehabilitation Act of 1973, which protects the rights of individuals with disabilities, requires health care organizations that receive federal funds to provide effective communication for patients who are deaf or hard of hearing. The Americans with Disabilities Act requires the same standards with respect to health care organizations without regard to their receipt of federal funds.

This video streams from The Joint Commission's Hospitals, Language, and Culture Web site at <http://www.jointcommission.org/PatientSafety/HLC/>. This page also includes related resources from the "Hospitals, Language and Culture: A Snapshot of the Nation" study, a cross-sectional, qualitative study of how 60 hospitals across the country provide health care to culturally and linguistically diverse patient populations, conducted by The Joint Commission with funding from The California Endowment. The video is also available at the Office of Civil Rights (OCR) Web site at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/index.html>. The OCR Web page also includes many resources on effective communication for LEP and deaf and hard-of-hearing persons.

New Process for Developing Accreditation Survey Agenda

The Joint Commission, in its continued efforts to improve customer service, has implemented a new process for developing the survey agenda. This new process ensures regular communication before survey between the Joint Commission account executive and the health care organization to answer questions and convey the future survey length and number of surveyors assigned.

During the survey, organizations will work with the surveyor(s) to determine the best time for scheduling survey activities so they coincide more effectively with patient care and administrative operations. The agreed-upon agenda will be used throughout the survey to ensure the following:


- Consistency so that all required activities occur during the survey
- Coordination and communication so all parties—the health care organization as well as the surveyors—are aware of the timing of survey activities
- Collaboration so that survey activities occur at a time that meets the needs of the organization and its staff.

Beginning in 2010, the revised process will consist of the following steps.

1. The Joint Commission will send an e-mail to the organization to confirm the program(s) to be surveyed per the organization's recently submitted e-Application data and direct the organization to its *The Joint Commission Connect™* extranet page for additional information. The extranet page will include the following information:
 - A list of survey activities for each applicable accreditation program. The survey activity list is a planning tool for an organization to use in conjunction with the Survey Activity Guide.


- A program-specific document list that identifies initial materials surveyors will request to review at the onset of the survey.
2. After an organization has submitted its e-App, it will receive a phone call from its Joint Commission account executive to confirm that it has reviewed and understands the information on its extranet site. At this time, the account executive will provide the anticipated number of days and number of surveyors that will be assigned to the organization's on-site survey.
 3. On the first day of the on-site survey, surveyors will work with the organization to confirm that the schedule considers the organization's operations and needs.

It is important to note that survey activities are *not* changing. The agenda developed collaboratively between the organization and surveyors will be similar to what organizations have historically seen and experienced. What has changed is that The Joint Commission will accurately inform organizations before their survey about the on-site survey length and number of surveyors. Also, the health care organization can now interact with the surveyor(s) during survey to determine the best timing for the various survey activities.

This revised process will be more sensitive to the time demands of the health care organization and its staff during the on-site survey while still providing a thorough survey of the organization. All accreditation customers due for survey in 2010 will experience this revised agenda process. Please contact your account executive for additional information or questions. **Note:** *This new process does not affect certification reviews.* 

Looking for a Few Good Surveyors

Are you interested in a career as a surveyor for The Joint Commission's **home care** team? Now is your opportunity to help make a difference. The Joint Commission offers flexible hours and a caring community of dedicated professionals. For

more information, call the Joint Commission Human Resources department at 630/792-5615 or click on the "Careers" link in the top navigation bar on The Joint Commission Web site at <http://www.jointcommission.org>. 

APPROVED: New and Revised Hospital EPs to Improve Patient-Provider Communication

The Joint Commission has approved new and revised requirements to improve patient–provider communication **applicable to the hospital accreditation program**. These requirements were developed as part of a larger initiative, supported by The Commonwealth Fund, to increase quality and safety through effective communication, cultural competence, and patient- and family-centered care. For many patients, communication can be inhibited by language and cultural differences, or by the patient’s hearing or visual impairment, health literacy, cognitive impairment, disease, or disability.

The new and revised elements of performance (EPs) address the following issues:


- Addressing qualifications for language interpreters and translators (HR.01.02.01, revised EP 1)
- Identifying patient communication needs (new PC.02.01.0X*, EP 1)
- Addressing patient communication needs (new PC.02.01.0X*, EP 2)
- Collecting race and ethnicity data (RC.02.01.01, revised EP 1)
- Collecting language data (RC.02.01.01, revised EP 1)
- Patient access to chosen support individual (RI.01.01.01, new EP Y*)


* Please note: Where X, Y, or Z appear in a standard or EP number, the final enumeration will be determined prior to publication in 2011.

- Non-discrimination in patient care (RI.01.01.01, new EP Z*)
- Providing language services (RI.01.01.03, revised EPs 2 and 3)

See the box below for new language and requirements in underlining and removed language in strikethrough.

The Joint Commission, in collaboration with the National Health Law Program, has also developed an implementation guide to provide example practices and resources that have been found valuable in improving patient-provider communication. The guide will be released to the field in February 2010. The implementation guide presents a variety of effective and efficient methods that hospitals may consider to help them meet the new and revised EPs. Implementation of the new and revised EPs for accreditation purposes will occur no sooner than January 1, 2011; the Joint Commission will determine an appropriate effective date based on the field’s response to the new and revised EPs and to the implementation guide.

For more information on The Joint Commission’s efforts to address effective communication, cultural competence, and patient- and family-centered care, please visit the project Web site: <http://www.jointcommission.org/patientsafety/hlc>, or contact Amy Wilson-Stronks, principal investigator and project director, Division of Standards and Survey Methods, The Joint Commission, at awilson-stronks@jointcommission.org or 630/792-5954. 



Official Publication of New and Revised Requirements
New and Revised Hospital Requirements

APPLICABLE TO HOSPITALS
Effective no sooner than January 1, 2011

Standard HR.01.02.01
The hospital defines staff qualifications.

Elements of Performance
A 1. The hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3)

Note 1: 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).
Note 2: Qualifications for laboratory personnel are described in *Clinical Laboratory Improvement Amendments of 1988 (CLIA '88)*, under Subpart M: “Personnel for Nonwaived Testing” §493.1351–§493.1495. A complete description of the requirement is located at <http://www.cdc.gov/clia/regs/toc.aspx>.

Continued on page 6

New and Revised Hospital Requirements (continued)

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital.

Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience.

Standard PC.02.01.0X*

The hospital effectively communicates with patients when providing care, treatment, and services.

Elements of Performance

C 1. The hospital identifies the patient's oral and written communication needs, including the patient's preferred language for discussing health care. (See also RC.02.01.01, EP 1) **2**

Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

C 2. The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. (See also RI.01.01.03, EPs 1–3) **2**

Standard RC.02.01.01

The medical record contains information that reflects the patient's care, treatment, and services.

Elements of Performance

C 1. The medical record contains the following demographic information: **M**

- The patient's name, address, date of birth, and the name of any legally authorized representative
- The patient's sex
- The legal status of any patient receiving behavioral health care services
- The patient's language and communication needs, including preferred language for discussing health care (See also PC.02.01.0X*, EP 1)

Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication

needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.

- The patient's race and ethnicity

Standard RI.01.01.01

The hospital respects, protects, and promotes patient rights.

Elements of Performance

C Y. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay. **3**

Note: The hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (See also RI.01.02.01, EPs 6–8 regarding surrogate or family involvement in patient care, treatment, and services.)

A Z. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. **3**

Standard RI.01.01.03

The hospital respects the patient's right to receive information in a manner he or she understands.

Elements of Performance

C 2. The hospital provides language interpreting and translation services, as necessary. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.0X*, EP 2; HR.01.02.01, EP 1)

M 3


Note: Language interpreting options may include hospital employed language interpreters, contract interpreting services, or trained bilingual staff, and may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.


C 3. The hospital provides information to ~~communicates with~~ the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs. (See also RI.01.01.01, EPs 2 and 5; PC.02.01.0X*, EP 2) **M 3**

* Please note: Where X, Y, or Z appear in a standard or EP number, the final enumeration will be determined prior to publication in 2011.

APPROVED: Staffing Effectiveness Requirements for Hospitals and Long Term Care Organizations

Due to comments received from the field, The Joint Commission has revised and is now releasing the final approved interim staffing effectiveness requirements **applicable to the hospital and long term care programs**. These requirements are **effective July 1, 2010**, and serve as the interim replacements for PI.04.01.01 (the suspended staffing

effectiveness standard). These interim requirements will be in effect while more extensive research is done to improve the staffing effectiveness requirements. More information on the status of the staffing effectiveness requirements will be available in 2010. The approved staffing effectiveness requirements appear below in underlined text. 

Official Publication of New and Revised EPs

Revised Staffing Effectiveness Requirements for Hospitals and Long Term Care


APPLICABLE TO HOSPITALS AND LONG TERM CARE

Effective July 1, 2010

Standard PI.02.01.01

The **(HAP: hospital) (LTC: organization)** compiles and analyzes data.


Elements of Performance


A 12. When the **(HAP: hospital) (LTC: organization)** identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. 

Note 1: *Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, **(HAP: hospitals) (LTC: organizations)** may also wish to examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation, training, and education.*

Note 2: ***(HAP: Hospitals) (LTC: Organizations)** may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues. (See the “Staffing Effectiveness Indicators” (SEI) chapter.)*

A 13. When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the organizationwide **(HAP: patient) (LTC: resident)** safety program (as addressed at LD.04.04.05, EP 1) are informed, in a manner determined by the safety program, of the

results of this analysis and actions taken to resolve the identified problem(s). (See also LD.03.05.01, EP 7, and LD.04.04.05, EP 13) 

A 14. © At least once a year, the leaders responsible for the **(HAP: hospital-wide patient) (LTC: organization-wide resident)** safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. 

Standard LD.04.04.05

The **(HAP: hospital) (LTC: organization)** has an organizationwide, integrated **(HAP: patient) (LTC: resident)** safety program **(HAP: within its performance improvement activities)**.

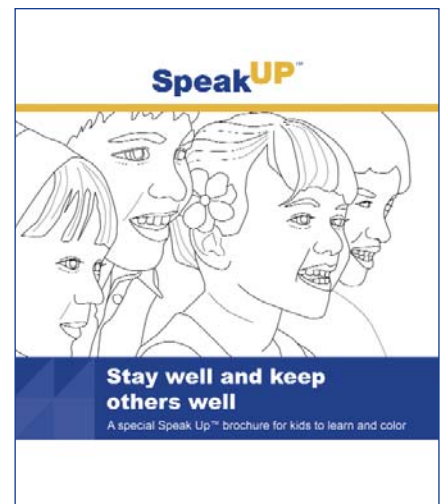
Elements of Performance

A 13. © At least once a year, the **(HAP: hospital) (LTC: organization)** provides governance with written reports on the following:

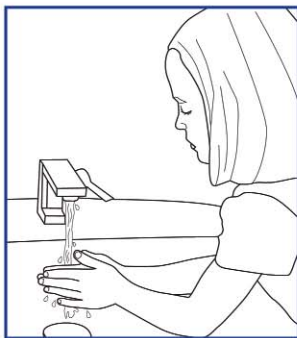
- All system or process failures
- The number and type of sentinel events
- Whether the **(HAP: patients) (LTC: residents)** and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences
- **HAP only: For hospitals that use Joint Commission accreditation for deemed status purposes:** The determined number of distinct improvement projects to be conducted annually
- All results of the analyses related to the adequacy of staffing (See also PI.02.01.01, EP14)

New Speak Up Coloring Book About Infection Control Available

A Speak Up™ coloring book called *Stay Well and Keep Others Well* is now available to help children learn how to prevent infections. The two-page booklet talks about proper hand washing, covering your nose when you sneeze, covering your mouth when you cough, staying home if you are sick, and getting a flu shot. The coloring books are available for free download on The Joint Commission Web site at http://www.jointcommission.org/PatientSafety/SpeakUp/speak_up_coloring_book.htm. Organizations can download and print as many copies as they would like to distribute to patients. **P**



SPEAK UP



Wash your hands.

- Use soap and warm water.
- Rub your hands good.
- Sing the birthday song twice – that's how long it takes to kill germs.
- It is OK to use hand gel. Rub it all over your hands until your hands are dry.
- Wash your hands before eating.
- Wash your hands after you use the bathroom.
- Wash your hands after you play.



Cover your mouth when you cough.

- Use a tissue!
- Throw away the tissue.
- If you do not have a tissue, cover your mouth and nose with the bend of your elbow or hands.
- Wash your hands if you sneeze or cough on them.

Free on the Web: Webinar on Health Care–Associated Infections

To help organizations prepare for and understand how to meet the requirements of National Patient Safety Goal 7, The Joint Commission has developed a free education program, **Health Care–Associated Infections, From the Bedside to the C-Suite**, available at <http://www.jointcommission.org/PatientSafety/InfectionControl/>. No registration is required and the program is available for viewing at any time. The Webinar provides information about the following:

- Reducing health care–associated infections (HAIs) by complying with NPSG.07.03.01 (multi-drug-resistant organisms), NPSG.07.04.01 (central line–associated bloodstream infections), and NPSG.07.05.01 (surgical site infections).
- Understanding how these three NPSGs and the infection prevention and control and leadership standards

work together to help organizations put systems in place to reduce HAIs.

- The role infection prevention and control plays in high-reliability organizations.

By January 1, 2010, accredited organizations are expected to be in full compliance with the three NPSGs pertaining to HAIs (NPSG.07.03.01, NPSG.07.04.01, and NPSG.07.05.01). Introduced in January 2009, the three HAI-related NPSGs included a one-year phase-in period with defined expectations (or milestones) for planning, development, and testing at three, six, and nine months during 2009 for the **ambulatory care, critical access hospital, home care, hospital, long term care, and office-based surgery programs.** **P**

The Joint Commission Appoints New Directors

The Joint Commission has appointed **Jennifer F. Rhamy**, M.B.A., M.A., M.T. (ASCP), S.B.B., H.P. as executive director of the **laboratory** accreditation program.


Rhamy, a veteran health care professional with experience in both hospitals and blood centers, has extensive knowledge of the inner workings of hospital-based and freestanding clinical laboratories. Most recently, Rhamy worked as a blood center consultant and served as vice president of Laboratory Services for the Indiana Blood Center in Indianapolis for eight years. She served on the Board of Directors of the AABB (formerly the American Association of Blood Banks) and has led multiple committees for America's Blood Centers and AABB. She was president of Indiana State Association of Blood Banks and the South Central Association of Blood Banks.

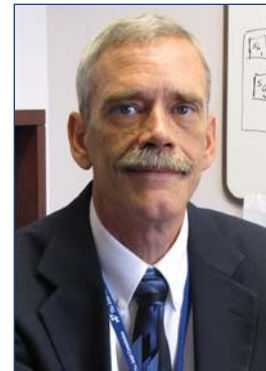
Rhamy holds a certificate in Lean Six Sigma and earned a master of arts in language and communication from Regis University, Denver, and an M.B.A. from Colorado State



Jennifer F. Rhamy, M.B.A., M.A., M.T. (ASCP), S.B.B., H.P., Executive Director, Laboratory Accreditation Program

University. She earned a bachelor of science degree in medical technology from the University of Arizona, Tucson and is registered as a medical technologist, a specialist in blood banking, and a hemapheresis practitioner by the American Society of Clinical Pathology.

Wayne Murphy, R.R.T., M.P.S., was appointed by The Joint Commission as associate director of the **home care** accreditation program. An expert in the home medical equipment industry, Murphy has served as a home care surveyor for The Joint Commission since 1993. Murphy most recently was district manager and quality assurance coordinator for B&B Medical Services, Inc., Oklahoma City. Previously, he worked as a branch manager for several home health care organizations and as a respiratory therapist in a variety of settings. He graduated from Mohawk Valley Community College's Respiratory Program, Utica, NY, and has a bachelor's degree and master's degree in Professional Studies—Health Services Administration from The New School, New York. 




Wayne Murphy, R.R.T., M.P.S., Associate Director, Home Care Accreditation Program

Standards BoosterPak™ Now Available for MM.03.01.01

For the first time ever, The Joint Commission is providing a Standards BoosterPak™ for accredited hospitals and critical access hospitals. The BoosterPak provides detailed information about a complex standard or topic, with the goal of ensuring more consistent interpretation and understanding of a standard among Joint Commission customers, staff, and surveyors. The first BoosterPak focuses on MM.03.01.01: Safe medication storage for hospitals and critical access hospitals. BoosterPaks are available only via *The Joint Commission*

Connect™ extranet to accredited organizations. The Joint Commission is developing BoosterPaks for other standards. The MM.03.01.01 BoosterPak contains the following:

- A description of the standard and implementation tips
- Frequently asked questions, definitions, and additional information
- Supporting documentation, evidence, value, and historical information
- Additional references and links 

The Joint Commission Names New Board Members

Former General Electric executive Charles R. Buck, Jr., Sc.D., has been appointed as a Public Member to The Joint Commission Board of Commissioners and long term care expert Connie S. March has been appointed as the Board's Long Term Care Representative.

Connie S. March is president and CEO of Provena Senior Services in suburban Chicago. Her appointment is part of an ongoing effort to build and strengthen relationships between long term care organizations and The Joint Commission. March has strategic leadership and operations oversight for both Provena Senior Services and Provena Home Care's 26 sites, which include nursing homes, housing, home health, pharmacy, and adult and child day care centers located in Illinois and Indiana. A registered nurse for more than 30 years, March has led Provena Senior Services and its predecessor organization since 1987. She was previously certified as an adult and geriatric nurse practitioner and has worked in various education, clinical, consultation and administration positions in nursing.

March is past board chair of Life Services Network (LSN), the Illinois not-for-profit association for aging senior services; a member of the House of Delegates and board of the American Association of Homes and Services for the Aging (AAHSA); and was a member of the AAHSA task force on surveys and certification. She received her bachelor's and master's degrees in nursing from the University of Illinois and has authored various articles and books pertaining to long term care. She also serves on the Continuing Care Committee of the Catholic Health Association.


"Connie holds a wealth of expertise from clinical, academic and administrative roles in long term care. Chuck brings to the Board a vast amount of experience in business with process involvement strategies and tools such as Six Sigma," says Mark R. Chassin, M.D., M.P.P., M.P.H., president, The Joint Commission. "Their knowledge, experience, and insights will serve the Board well and enhance The Joint Commission's commitment to safe, high-quality care for all patients."

Buck's work focuses on creating a consumer-centric health care market that connects active consumers with

providers committed to process excellence. Buck also serves provider organizations interested in applying the lessons of Six Sigma as an institutional business strategy. His clients have included health plans, employers, and start-up companies.

Buck was previously responsible for General Electric's health benefits and the purchasing of \$1 billion worth of health services for approximately 600,000 GE employees, dependents and retirees under age 65. Later, he was responsible for leading GE's health care quality initiatives, "E"-health, and strategic benchmarking initiatives, including the application of the GE-wide Six Sigma Quality Program, to 50-plus external health care suppliers and 100 in-house medical treatment sites. Before his work at GE, Buck was executive director of the Hospital of the University of Pennsylvania, Secretary of the Department of Health and Mental Hygiene for the State of Maryland, and Director of Planning for the Johns Hopkins Medical Institutions. Buck served on the Institute of Medicine (IOM) Committee on the Quality of Health Care in America that produced the "To Err is Human" and "Crossing the Quality Chasm" reports. He also served on the IOM committee focused on the roles of government in fostering improved health delivery quality.

Buck earned a bachelor's degree in industrial engineering from Northwestern University, masters' degrees in public health and in industrial engineering from the University of Missouri, and a doctorate degree from the Johns Hopkins School of Public Health.

The 29-member Board of Commissioners serves as The Joint Commission's governing body. Its composition includes representatives from each of The Joint Commission's corporate members from the American Hospital Association, American Medical Association, American College of Physicians, American College of Surgeons, and American Dental Association, six public members, one at-large representative of the nursing profession, and Joint Commission president, Mark R. Chassin, M.D., M.P.P., M.P.H. 


NEW! Pay Your Accreditation and Certification Fees Online

Joint Commission accreditation and certification customers are now able to electronically pay their accreditation and certification invoices using a secure transaction from their subscription billing extranet site.

New accreditation and certification customers will be able to electronically pay their deposit by selecting a link from the “What’s Due” tab on their *The Joint Commission Connect™* extranet main page.

The types of payments accepted include VISA and MasterCard (either credit or debit), American Express, Discover, and electronic checks.

A frequently-asked questions page and navigation tool are also available on the subscription billing site. If you have any questions, please call the following numbers for:

- Questions regarding navigation: 630-792-5026
- Questions regarding payments: 630-792-5662 


Speak Up: How Patients Can Make the Most of a Visit to the Doctor

A visit to the doctor is a time to talk and learn, and just like doctors, nurses, and other caregivers, patients play a critical role in their health care, according to The Joint Commission’s “Tips for Your Doctor’s Visit” Speak Up™ educational campaign. Patient-doctor communication is a vital component to safe, effective care. Approximately 902 million visits were made to doctors’ offices in the United States during 2006, according to the Centers for Disease Control and Prevention. The Joint Commission’s new brochure includes tips for visits



to the doctor to help patients become more active and involved in their health care. Topics covered include the following:

- Talking with the doctor
- Preparing for a physical examination
- Lab tests
- Treatment or surgery
- What to do after the appointment


“A visit to the doctor’s office can be an overwhelming and confusing experience for patients and families,” says Mark R. Chassin, M.D., M.P.P., M.P.H., president, The Joint Commission. “Whether seeing the doctor for a routine checkup or for a specific condition, being informed and involved will help patients and their doctors get the most out of the visit. With knowledge and action, patients can take steps to make sure they receive the best care possible.” 

The Joint Commission’s Hospital Accreditation Recognized by CMS (continued)

Continued from page 1

however, in July 2008, section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) revoked the statutorily-guaranteed deeming authority and required The Joint Commission to be recognized as a national accrediting body for hospitals only after applying to CMS, subject to terms and conditions. Based on a 24-month transition period allowed by section 125 of

MIPPA, The Joint Commission’s term of approval as a recognized accreditation program for hospitals was set to expire July 15, 2010.

In addition to hospitals, The Joint Commission has federal deeming authority for ambulatory surgery centers, critical access hospitals, durable medical equipment suppliers, home health organizations, hospices, and laboratories. 

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The Role of Hospitalists in Patient Safety



Edited by Danielle Schurer, M.D., M.S.C.R.

The Role of Hospitalists in Patient Safety addresses the urgency of patient-centric care for the nearly 30,000 hospitalists expected to be practicing in North America and abroad by the year 2010, including a focus on areas crucial to hospitalist practices. The book includes a foreword from Robert M. Wachter, M.D., a leader in the hospitalist movement, and is co-published by Joint Commission Resources with the Society of Hospital Medicine.

The Role of Hospitalists in Patient Safety also offers the following features:

- Tried-and-true methods for hospitalists to improve patient safety
- Details on how Joint Commission standards and the National Patient Safety Goals can direct hospitalists toward patient-centric care
- Real-world examples of how hospitalists are making patients safer within their organizations

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