The Joint Commission

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The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES

Spotlight on Success

UNIVERSITY OF FLORIDA HEALTH JACKSONVILLE'S FOOD PHARMACY PROGRAM

Nutritious food is a cornerstone of good health. This is particularly true for those with chronic conditions such as diabetes or hypertension. Unfortunately, not every patient has reliable access to the affordable, nutritious food they need.

To help overcome the health disparities associated with food insecurity, which the US Department of Agriculture (USDA) defines as a lack of consistent access to enough food for an active, healthy life, University of Florida (UF) Health Jacksonville's Urban Health Alliance created the Food Pharmacy, a prescription-based nutritional health and education program. This article will describe the Food Pharmacy program, which recently celebrated its first anniversary, while also sharing its achievements to date and offering insight on how health care organizations can play a role in addressing health equity.

The Food Pharmacy facility is set up like a grocery store and focuses on fresh vegetables. Photo courtesy of UF Health Jacksonville.

Food Insecurity and Health Equity

The idea for a Food Pharmacy arose in 2018 when Dr. Ross Jones, Medical Director of the Total Care Clinic and Urban Health Alliance, and Linda Lawson, DBA, MSN, RN, Associate Vice President of Nursing at UF Health North, discovered that many patients of UF Health Jacksonville identified themselves as food insecure. The reasons for food insecurity included both financial limitations and limited physical access to nutritious food, such as living in a food desert or lacking sufficient transportation options.

These issues were exacerbated by the COVID-19 pandemic, which further strained individuals' resources. For some patients mandatory shutdowns limited their grocery budgets. Others severely curtailed their movement in public spaces

due to underlying health conditions that put them at increased risk from infection; these individuals are often the same people whose health relies on a healthy diet.

One key component of UF Health Jacksonville's mission statement prioritizes "elimination of health disparities." To Jones and Lawson, this made it clear that the organization had a responsibility to address these problems in its patient population. They began by researching best practices and by tapping internal resources such as Carolyn Tucker, PhD, Director of the UF Health Disparities Research and Intervention Program, and Judella Haddad-Lacle, MD, Medical Director of UF Health Community and Family Medicine–Jacksonville. By adopting ideas and strategies from the work of Tucker and Haddad and in collaboration with Ann-Marie Knight, MHA, FACHE, Vice President of Community Engagement and Chief Diversity Officer at UF Health Jacksonville, and other stakeholders, Jones and Lawson arrived at a plan to create the Food Pharmacy, a first in Florida.

Food Pharmacy: What It Is, How It Works

The Food Pharmacy isn't a food pantry. It is a prescriptive nutritional health program with four primary objectives:

1. Increased access—Greater and recurring access to consistent, dependable supplies of fresh food and vegetables
2. Nutritional empowerment—Expanded educational tools that enable patients to make healthy dietary choices to meet their health needs
3. Health status—Improvement in each patient's health status
4. Peer-to-peer support—Encouragement of peer support through group classes in a safe space

To participate in the Food Pharmacy program, patients must meet certain criteria. First, they must be seeking treatment for chronic or terminal disease from a UF Health Jacksonville provider through its Total Care Clinic. Physicians identify potential candidates by screening for food insecurity. Individuals who rate themselves as food insecure or highly insecure are then further screened to assess their income, transportation, mobility, and access to healthy food. From this information, the physician collaborates with a dietitian to determine whether the Food Pharmacy would be a good fit for the patient's health needs, based on clinical factors such as cholesterol, A1c, and weight.

Appropriate patients then receive a "prescription" from the physician. Every other week, patients visit the Food Pharmacy to redeem their prescription for an individualized food plan that lists all the items they should receive to meet their health needs. The Food Pharmacy itself resembles a small grocery store. On-site dietitians and trained volunteers help patients "shop" for the foods in their prescription. The amount of food patients receive is based on the number of residents in their home—meaning the Food Pharmacy benefits patients and their families.

Food is not the only service the program provides to its patients. It also provides important nutritional education opportunities. Classes in nutrition, cooking, reading food labels, and other topics are offered to patients. These sessions provide patients with valuable information they need to take control of their dietary needs and make choices that support health. They also connect patients with others who have similar experiences and challenges. This peer-to-peer support encourages patients in ways that complement physician-led processes to sustain improvements to health outcomes.

Dietitians and trained volunteers assist Food Pharmacy participants in gathering the food listed in their "prescription." Photo courtesy of UF Health Jacksonville.

Forming Sustainable Partnerships

To be successful, the Food Pharmacy requires significant start-up and continuing support from dedicated partners, both large and small.

An anonymous corporate donor provided full funding for the construction of the Food Pharmacy facility and the equipment needed to run the program. For operational costs (including staffing, supplies, and food), the organization secured a four-year grant from the Florida Blue Foundation. Feeding America, a national nonprofit organization, provides free food for the program and offers below-market prices for purchased food.

Large donations from big partners are supplemented by critical assistance from smaller nonprofits and other organizations.

"We couldn't do any of this without all of the agencies involved in this work; they are all committed to the success of this effort," Knight emphasizes. For example, Southeast Grocers provides the program with all the milk it needs. Similarly, the College of Nursing at the University of Florida is helping develop expansive curricula for the educational aspect of the program. Other partners include the Humana Foundation, Freshfields Farm, and individual volunteers who help patients gather their food or, during the height of the pandemic, provide drive-up services.

Sustainable funding is one of Knight's primary concerns for the future. Because ongoing program expenses are entirely funded by grants, the organization has a strong need to identify partners who will continue to provide operational funding into the future.

"In four years," Knight explains, "while these patients' health conditions will improve, their food access won't, and we might be like Cinderella at midnight."

Progress Reports Show Improvements in Patient Health

The Food Pharmacy program has built-in performance evaluation and improvement processes. Semiannual reports provide data on various metrics set by the organization to monitor the impact of the program on patient health outcomes. These results use data pulled from the electronic medical record system.

The first report came in January 2022—six months after the Food Pharmacy opened—and showed significant results. For example, the organization tracked the hemoglobin A1c for participants with diabetes. After six months in the Food Pharmacy program, 78% of those patients had either met their goal or lowered their A1c—surpassing the program's goal of 50%. Similarly, 42% of patients diagnosed as overweight or with obesity either decreased their weight or maintained a healthy weight, compared to the target of 25%. In addition, among patients with hypertension, 36% either lowered or met their goal for healthy blood pressure. This is a considerable improvement, despite the original organization goal of 50%.

Nonclinical measures showed significant improvement, too. Patient satisfaction with the program, product, and staff hit 90% after six months, surpassing the initial goal of 80%. The Food Pharmacy aimed to serve 240 patients. After six months, it had reached 148; by May 2022, that number rose to 252.

The second progress report was due in July 2022. Though those numbers are not available at the time of this publication, Knight is optimistic. "The response to this initiative has been exciting," she says. "Naturally, we are focused on the success of our clients. However, we are also encouraged by the swell of support and interest that we have received from small nonprofits and other hospitals."

Looking to the Future

UF Health Jacksonville and its partners are already looking at ways to improve and expand the Food Pharmacy program. Their plans for Phase II include addressing the needs of homebound patients who otherwise meet the criteria for participation.

They also are excited to share their program with other organizations looking for ways to improve health equity related to food insecurity. One hospital in south Florida has already reached out to UF Health Jacksonville to learn about the program and potentially emulate its model.

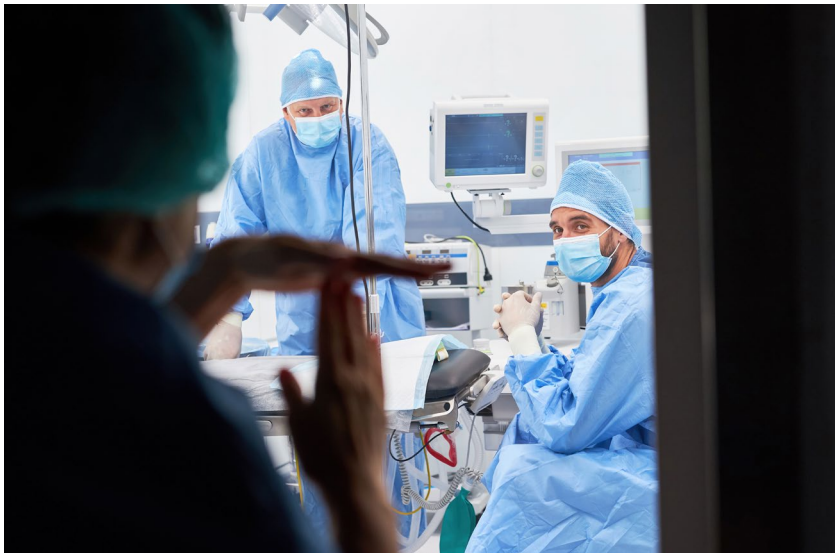
UF Health Jacksonville does not intend this to be a one-way street. Rather, it encourages other organizations to adapt the concept, make improvements, and report back with those improvements.

"Make it better," Knight says, "and tell us what you did to make it better."

Knight and the entire team at UF Health Jacksonville hope that organizations across the state and the nation will work together to fine-tune the Food Pharmacy model to reach as many people in need as possible and to reduce the health inequities associated with food insecurity on a broad scale. She welcomes feedback. If your organization has ideas or feedback to share on the Food Pharmacy, please contact UF Health Jacksonville.

Making Time for Time-Out

BRINGING AWARENESS TO WRONG-SITE SURGERIES



Despite numerous efforts such as presurgical checklists, safety protocols, and education and training to prevent surgery on the wrong patient or wrong site, such incidents continue. According to a recent joint statement from The Joint Commission and the Association of periOperative Registered Nurses (AORN), these events—referred to as "never events" because they are never supposed to happen—have been on the rise in recent years, occurring an estimated 40 times per week in the United States.

The statement was released in conjunction with this year's National Time Out Day, a day set aside each year since 2004 by AORN and The Joint Commission to remind surgical teams of the importance of taking a time-out before a surgical procedure. The goal of this pause is to ensure that team members can focus on active confirmation of the patient, site, and procedure. The time-out should include active communication among all relevant members of the procedure team. The procedure should not be initiated until all questions or concerns are resolved.

The Joint Commission Universal Protocol

The Joint Commission addresses the surgical time-out in its Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™: **UP.01.01.01** through **UP.01.03.01**, which is part of the National Patient Safety Goals® chapter of the *Comprehensive Accreditation Manuals* (and E-dition®). These standards apply to Joint Commission–accredited hospitals, critical access hospitals, ambulatory care organizations, and office-based surgery practices.

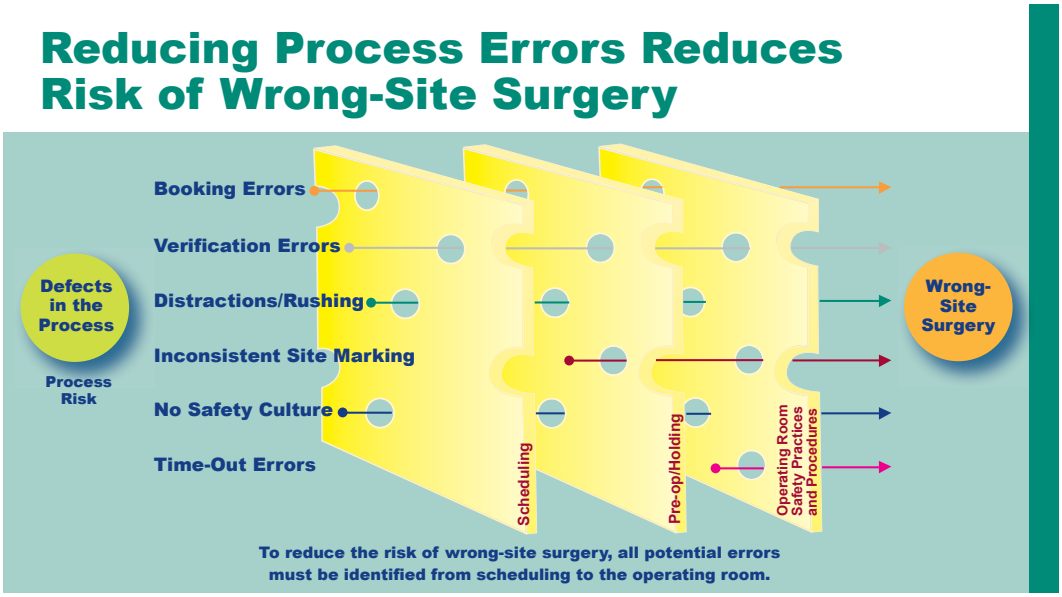
The Universal Protocol calls for the following steps:

1. Conduct a preprocedure verification process. Verify the correct procedure for the correct patient at the correct site. When possible, the patient should be involved in the verification process.
2. Mark the procedure site.
3. Perform a time-out before the procedure begins to ensure that the correct procedure will be performed on the correct patient and the correct site. Every member of the surgical team should participate in the time-out.

According to The Joint Commission, among the most common issues observed in the operating room (OR) are the following:

- Surgical scheduling errors
- Verification and documentation errors
- Distractions
- Hastily performed care processes
- Inconsistent site marking
- Time-out process errors
- Punitive safety culture

The figure below illustrates how such issues can compound to contribute to wrong-site surgery.



Wrong-site surgeries are difficult to study because there usually is no one root cause. Instead, they frequently are the result of a cascade of small errors that penetrate defenses. It is important to examine each error or failed process in an organization's defense to fully understand why it occurred to reduce risk of future errors.

Conduct a preprocedure verification process (UP.01.01.01): This process helps the team address missing information or discrepancies before initiating a procedure and should involve the patient, when possible. This process should also incorporate a standardized list to verify availability of items needed for the procedure. At a minimum, these items include relevant documentation (for example, history and physical, signed consent form, preanesthesia assessment); labeled diagnostic and radiology test results that are properly displayed; and any required blood products, implants, devices, and special equipment. All documents and forms must be consistent and must match the patient. AORN offers a Comprehensive Surgical Checklist that can help organizations meet Universal Protocol requirements as well as World Health Organization standards. The checklist can be customized for a facility's surgical services.

Mark the procedure site (UP.01.02.01): The Universal Protocol requires that, at minimum, the surgical site be marked whenever there is more than one possible location for the procedure and when performing the procedure in a different location could harm the patient. The site marking should be visible after prepping and draping for the surgery. For spinal surgeries, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used to locate and mark the exact vertebral level.

Perform a time-out before the procedure (UP.01.03.01): After preprocedure verification processes are completed and the surgical site is appropriately marked, the time-out is performed, and the surgical procedure is not initiated until all questions and concerns are addressed and resolved. For full compliance with the Universal Protocol, the time-out is standardized and involves all immediate members of the procedure team; this includes the surgeon, anesthesia providers, circulating nurse, OR technician, and others who will actively participate in the procedure from the beginning.

Health care professionals can download the poster shown on page 10, *Speak Up™ The Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™*, which has been adapted from the full Universal Protocol requirements.

Strategies for Improving Time-Outs

In response to concerns from AORN members that time-outs were being hastily conducted, there has been a renewed push to remind surgical teams to "make time for time-out," which is the theme for this year's National Time Out Day campaign. According to AORN Executive Director and CEO Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN, there has been a "significant uptick in wrong site surgeries over the past three years." She suggests that emphasis on "efficiencies" as well as a backlog of surgical procedures that were put on hold during surges in the COVID-19 pandemic, may be contributing to this trend.

In response to an identified need to bring renewed awareness to wrong-site, wrong-procedure, and wrong-patient surgeries, AORN and The Joint Commission are offering resources and reminders to surgical teams to make time every day for a time-out. From posters to podcasts that can be shared with surgical teams, these resources highlight surgical team members' role in patient care and commitment to safety. In addition, Groah suggests surgical teams evaluate and improve their existing time-out processes by implementing the following best practices:

Audit Time-Out Practices: It can be helpful to assign designated individuals who are typically in the OR setting to observe/audit the quality of the time-out. It is important that all surgical team members are engaged in all steps of the time-out procedure or surgical safety checklist developed for the facility. During an audit, leaders should consider asking team members questions such as the following:

- Does the person designated to lead the time-out *always* lead the time-out?
- Are *all members* of the team fully engaged throughout the time-out?
- Are all other activities in the OR halted for the duration of the time-out?

Review Time-Out Audits as a Team: All members of the surgical team can benefit from reviewing time-out audits (in a nonpunitive way) so that improvements can be made and agreed to.

Test Time-Out Improvements: After changes are proposed by team members, they should be tested before they are implemented and assessed for effectiveness, feasibility, and timing.

Designate a Time-Out Champion: A designated team member should champion each time-out to address safety concerns and to encourage others to address any concerns they may have. This can be the surgeon, a nurse, or a different team member.

Finally, don't underestimate the importance of a strong safety culture. Every team member should feel safe speaking up with concerns during the time-out. Leadership should empower staff to speak up, and any concerns raised should receive an immediate response. When staff members see evidence of a quick response, they feel reassured that their voice will be heard. This builds trust within the organization. TS

Infographic

THE UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE, AND WRONG PERSON SURGERY

SpeakUP™

The Universal Protocol

for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

Guidance for health care professionals

The Joint Commission

Conduct a pre-procedure verification process

Address missing information or discrepancies before starting the procedure.

- Verify the correct procedure, for the correct patient, at the correct site.
- When possible, involve the patient in the verification process.
- Identify the items that must be available for the procedure.
- Use a standardized list to verify the availability of items for the procedure. (It is not necessary to document that the list was used for each patient.) At a minimum, these items include:
  - ❑ relevant documentation
    Examples: history and physical, signed consent form, preanesthesia assessment
  - ❑ labeled diagnostic and radiology test results that are properly displayed
    Examples: radiology images and scans, pathology reports, biopsy reports
  - ❑ any required blood products, implants, devices, special equipment
- Match the items that are to be available in the procedure area to the patient.

Mark the procedure site

At a minimum, mark the site when there is more than one possible location for the procedure and when performing the procedure in a different location could harm the patient.

- For spinal procedures: Mark the general spinal region on the skin. Special intraoperative imaging techniques may be used to locate and mark the exact vertebral level.
- Mark the site before the procedure is performed.
- If possible, involve the patient in the site marking process.
- The site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed.
- In limited circumstances, site marking may be delegated to some medical residents, physician assistants (P.A.), or advanced practice registered nurses (A.P.R.N.).
- Ultimately, the licensed independent practitioner is accountable for the procedure – even when delegating site marking.
- The mark is unambiguous and is used consistently throughout the organization.
- The mark is made at or near the procedure site.
- The mark is sufficiently permanent to be visible after skin preparation and draping.
- Adhesive markers are not the sole means of marking the site.
- For patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (see examples below): Use your organization's written, alternative process to ensure that the correct site is operated on. Examples of situations that involve alternative processes:
  - ❑ mucosal surfaces or perineum
  - ❑ minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
  - ❑ teeth
  - ❑ premature infants, for whom the mark may cause a permanent tattoo

Perform a time-out

The procedure is not started until all questions or concerns are resolved.

- Conduct a time-out immediately before starting the invasive procedure or making the incision.
- A designated member of the team starts the time-out.
- The time-out is standardized.
- The time-out involves the immediate members of the procedure team: the individual performing the procedure, anesthesia providers, circulating nurse, operating room technician, and other active participants who will be participating in the procedure from the beginning.
- All relevant members of the procedure team actively communicate during the time-out.
- During the time-out, the team members agree, at a minimum, on the following:
  - ❑ correct patient identity
  - ❑ correct site
  - ❑ procedure to be done
- When the same patient has two or more procedures: If the person performing the procedure changes, another time-out needs to be performed before starting each procedure.
- Document the completion of the time-out. The organization determines the amount and type of documentation.

This document has been adapted from the full Universal Protocol. For specific requirements of the Universal Protocol, see The Joint Commission standards.

Promoting Health Care Worker Well-Being

Health care workers' jobs have always been stressful, but the ongoing COVID-19 pandemic has led to an increased rate of burnout among those who provide patient care. According to Medscape's *2022 Physician Burnout & Depression Report*, 47% of physicians reported burnout in 2021 as compared to 42% in 2020, with 60% of emergency medicine physicians reporting feeling burned out, up from 43% in 2020. Similarly, according to research conducted by McKinsey, 32% of registered nurses surveyed in November 2021 reported that they were thinking of leaving their roles in direct patient care. These statistics are not a surprise given that COVID-19 not only increased patient load but also put a greater burden on administrators and created significant staffing issues. For example, a news release from The Joint Commission to recognize Patient Safety Awareness Week reports that since the beginning of the pandemic, nurses and respiratory therapists in the hospital setting have witnessed mortality rates that are approximately six times higher than ever before in their career.

Increasing rates of burnout have an effect on quality of care and patient safety: High turnover exacerbates staffing issues and access to and continuity of care. In addition, the Agency for Healthcare Research and Quality's (AHRQ) page on physician burnout suggests that exhausted and burned-out clinicians are likely to suffer from impaired attention, memory, and executive function. As a result, the United States is facing a severe shortage of health care workers. The US Bureau of Labor Statistics predicts a shortage of 1.1 million nurses by the end of 2022, and a report from Mercer on the US health care labor market warns of a shortage of approximately 446,000 home health aides and 95,000 nursing assistants by 2025.

Leadership Requirements Related to Health Care Worker Well-Being

In any health care organization, leadership's first priority is to be accountable for effective care while protecting the safety of patients and employees. Joint Commission Leadership (LD) standards are intended to help organizations foster a safety culture and, in turn, maintain an environment that protects health care worker well-being. These requirements apply to all Joint Commission accreditation settings with one exception, as noted.

LD.03.01.01 Leaders create and maintain a culture of safety and quality throughout the [organization].

EP 1 Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

EP 4 Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

EP 5 Leaders create and implement a process for managing behaviors that undermine a culture of safety.

LD.03.09.01, EP 6 The leaders make support systems available for staff who have been involved in an adverse or sentinel event. [Not applicable to the Laboratory Services Accreditation Program.]
Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.

Support for Health Care Workers and Preventing Burnout

To acknowledge the toll the COVID-19 pandemic has taken on their clinicians, many organizations continue to seek ways to better support their health care workers. To assist in these efforts, the National Academy of Medicine (NAM) recently published the Resource Compendium for Health Care Worker Well-Being. These evidence-based resources are organized into six modules, based on NAM's *Organizational Evidence-Based and Promising Best Practices for Clinician Well-Being*. Following is a summary of each of the six modules as well as information about the resources NAM offers to help organizations implement these strategies.

Advance Organizational Commitment

Demonstrate a commitment to the well-being of health care workers by taking visible actions—for example, establishing a chief wellness officer position—to improve organization culture. The resources within this module include toolkits for establishing such a position along with case studies, reports, and other materials to help leaders build the case for these efforts. There also is an educational module from the American Medical Association (AMA) on building a foundation for joy in medicine introducing the concept of the Quadruple Aim. This framework builds on the Institute for Health Improvement's (IHI) well-known Triple Aim—improved patient care, lower costs, and better outcomes—by adding clinician well-being as a fourth area of focus.

Strengthen Leadership Behaviors

Shape leaders at all levels with the tools to improve relationships among staff. This module includes toolkits for management and team building along with instructional videos and a webinar on integrating clinician well-being and patient safety.

Strengthening relationships between organization leadership and clinicians is particularly important in the wake of COVID-19 as administrators seek to keep their health care workers and their patients safe. The team-building toolkit includes a link to the AMA's Building Bridges Between Practicing Physicians and Administrators module, which is designed to help improve communication and build trust.

Source: Used with permission from the National Academy of Medicine.

Conduct Workplace Assessment

Assess current levels of burnout among health care staff so that actions can be taken to improve well-being. The resources in this module include instruments to measure both burnout and health care worker well-being. Organizations that identify a case for implementing initiatives to improve worker well-being also will find resources to measure the financial impact that burnout is having on their organization.

Examine Policies and Practices

Take a look at the policies and practices currently in place to determine their effectiveness and applicability. Getting Rid of Stupid Stuff is a toolkit that can help your organization do just that by examining policies that are no longer relevant or that otherwise hinder clinicians' ability to do their work. Also among the resources in this module is a De-Implementation Checklist.

Enhance Workplace Efficiency

Health care organizations can improve efficiency by exploring new tools or reviewing existing tools, such as their electronic health record (EHR) systems, which have more flexibility than some facilities may realize. Online toolkits in this module include Taming the EHR and the Saving Time Playbook. Included case studies demonstrate how organizations have successfully made processes more efficient.

Cultivate a Culture of Connection and Support

Support health care workers by providing resources for those who need mental and emotional health services and by giving them what they need to do their jobs.

This module emphasizes the need to provide peer and emotional support for clinicians and includes A Nurse's Guide to Preventing Compassion Fatigue, Moral Distress, and Burnout. Other highlights include information related to COVID-19 and suicide prevention support.

Looking Ahead

As the pandemic persists, preventing health care worker burnout is increasingly critical for both worker and patient well-being. Putting ongoing support in place can give clinicians the tools they need to do their jobs effectively during crisis and beyond. In an effort to provide such support, US Surgeon General Dr. Vivek Murthy recently released an advisory on the threat of health care worker burnout and the steps organizations can take to prevent it. *See* Top News on page 15 of this issue for a link to the advisory and check out the video below to watch his message on the subject.

Top News

A Digest of Accreditation and Health Care News

The Joint Commission Joins Pledge to Decarbonize Health Care Sector

The Joint Commission recently announced that it will join the Biden administration's Health Sector Climate Pledge to reduce greenhouse gas emissions by a minimum of 50% by 2030 and to achieve net zero emissions by 2050. Jonathan B. Perlin, MD, PhD, The Joint Commission's new President and CEO, has targeted climate change as one of his top strategic priorities. In a recent statement, Perlin notes, "As the largest standards-setting and accrediting body in healthcare, it is vital that we take a leadership role and work with healthcare organizations nationally and internationally to reduce the carbon footprint."

The Joint Commission has convened a group of health care organizations to learn about the steps they have taken to address their impact on the climate. It also plans to identify and curate resources to help organizations reduce their carbon emissions.

Managing Packaged Sterile Supplies and Devices

The Joint Commission has released a new *Quick Safety* that addresses the challenges health care organizations face when managing commercially prepared sterile supplies and devices. *Quick Safety* Issue 65: Managing Packaged Sterile Supplies and Devices provides guidance for dealing with these challenges so organizations can keep patients safe from infection and from other potential harm caused by expired or compromised supplies and devices. It includes information about device labeling and the hierarchical approach to infection prevention and control for packaged sterile supplies and devices. Safety actions to consider include the following:

1. Educate staff to recognize the labeling used for supplies and devices, including the stand-alone symbols and their meanings.
2. Provide posters and other graphic devices that are quick references to the meanings of the stand-alone symbols.
3. Educate staff to follow the hierarchical approach to infection prevention for packaged sterile supplies and devices.
4. Educate staff to recognize when a commercially prepared sterile medical device would be inappropriate to use (for example, when expired or if packaging is torn or damaged). Include next steps when this occurs and report concerns per your organization's guidelines.
5. Educate staff on where to find information specific to manufacturer's instructions for use should a question or concern be identified.

Visit The Joint Commission's website to download the complete issue, which includes a number of resources for health care providers.

Addressing Diagnostic Overshadowing Among Groups Experiencing Health Disparities

A new *Sentinel Event Alert*—Issue 65: Diagnostic Overshadowing Among Groups Experiencing Health Disparities is available from The Joint Commission. *Diagnostic overshadowing,* defined as the attribution of symptoms to an existing diagnosis rather than a potential comorbid condition, is a risk to patient safety. Medical literature includes extensive evidence that diagnostic overshadowing exists within clinician/patient interactions with patients of all ages who have physical disabilities or previous diagnoses. The *Sentinel Event Alert* highlights a patient experience with diagnostic overshadowing—told from the patient's point of view—as well as case examples. It also includes suggested actions to address diagnostic overshadowing, which include the following:

- Create an awareness of diagnostic overshadowing during clinical peer and quality assurance reviews and by addressing it in training and education programs.
- Use listening and interviewing techniques designed to gain better patient engagement and shared decision-making.
- Collect and aggregate data about preexisting conditions and disabilities and create electronic health record prompts for clinicians.
- Use an intersectional framework to overcome cognitive biases and look beyond previous diagnoses when assessing patients in groups identified as prone to diagnostic overshadowing.
- Review your organization's Americans with Disabilities Act compliance using the added perspective of diagnostic overshadowing to ensure that it meets the needs of patients with physical disabilities.

Visit The Joint Commission's website to download the complete issue, which includes a number of resources for health care providers.

Office of Environmental Justice Established to Address Environmental Health

Groups that have been economically/socially marginalized are often unfairly burdened by health problems caused by environmental issues. To address this inequity, The US Department of Health and Human Services (HHS) recently announced that it is establishing an Office of Environmental Justice (OEJ). Admiral Rachel Levine, Assistant Secretary for Health, notes that "[m]illions in the U.S. are at risk of poor health because they live, work, play,

learn and grow in or near areas of excessive pollution and other environmental hazards. The Office of Environmental Justice is an important avenue through which their well-being and quality of life are receiving our full attention."

The OEJ will be responsible for the following:

- Integrating environmental justice into the mission of HHS
- Developing a strategy for environmental justice and health and implementing it through HHS
- Producing annual reports
- Offering environmental justice expertise to the HHS Office of Civil Rights
- Promoting training opportunities to build a workforce devoted to environmental justice

Learn more here.

Advisory from US Surgeon General Seeks to Address Health Care Worker Burnout

An advisory from US Surgeon General Dr. Vivek Murthy seeks to address a growing crisis that has been exacerbated by the COVID-19 pandemic: health care worker burnout. According to a report from the Association of American Medical Colleges, the United States could face a shortage of approximately 139,000 physicians by 2033. The Surgeon General advisory seeks to sound the alarm on this urgent issue, outlining takeaways that include the causes of burnout, estimated workforce shortages, differential impacts on health workers, and how health worker burnout affects society as a whole. It also includes steps that can be taken to prevent burnout. The news release quotes Murthy as saying, "The nation's health depends on the well-being of our health workforce. Confronting the long-standing drivers of burnout among our health workers must be a top national priority." Download the advisory here.

Coronavirus (COVID-19) Resources

The Joint Commission continues to offer free COVID-19 resources to support health care organizations and workers on the front lines of the pandemic. Resources are updated frequently and are applicable to most Joint Commission accreditation settings.

Other Learning Opportunities

JCR LIVE EVENTS

Hospital Executive Briefing (September 13). Featuring a keynote address by Dr. Jonathan B. Perlin, the new President and CEO of The Joint Commission, the 2022 Joint Commission Hospital Executive Briefing will be available both in-person and via live webcast. Content will include data-driven observations, trends, themes, and advice based on aggregate survey data and experience from Joint Commission leadership. Learn how health care teams that strive to reduce risk, improve safety, and enhance quality of care can also achieve cost containment and more resilient workplaces.

Hospital CMS Update (September 14). Navigate the challenging aspects of the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation for hospitals with the key information provided in this educational program. CMS experts from Joint Commission Resources will offer tips and compliance strategies to help your organization fulfill CMS requirements. This program is geared toward individuals who already have a working knowledge of CMS compliance issues.

Behavioral Health Care and Human Services Conference (September 29–30). Gain a better understanding of upcoming changes at The Joint Commission and maintain compliance in 2023 by participating in this in-person event covering the hottest behavioral health care and human services topics. Attendees will have the option to choose between two tracks: one designated for organizations accredited under the Behavioral Health Care and Human Services accreditation manual and one designated for organizations accredited under the Hospital accreditation manual.

Note that the event team continues to monitor the COVID-19 pandemic. Visit the Health & Safety tab for guidelines and updates.

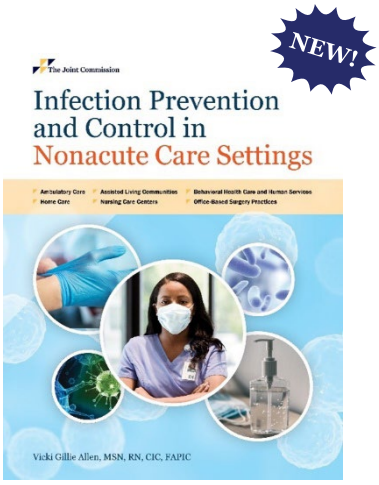
Digital Learning Center

Be sure to check out JCR's Digital Learning Center (DLC) for top webinars, videos, select e-books, *PolicySource,*™ digital newsletters—including *The Source*—and other resources. This subscription-based virtual learning service provides self-paced education and allows staff to customize their learning experience. Content is developed, curated, and regularly updated by JCR subject matter experts.

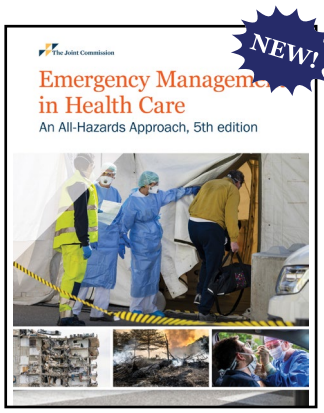
DIGITAL LEARNING CENTER

Must-Have JCR Books

Fundamentals of Health Care Improvement: A Guide to Improving Your Patients' Care, 4th Ed., is intended to help health professional learners diagnose, measure, analyze, change, and lead improvements in health care, with the aim to shape reliable, high-quality systems of care in partnership with patients. Copublished by Joint Commission Resources and the Institutes of Healthcare Improvement, this fourth edition includes updated resources and a new focus on health equity and disparities of care brought to light by the COVID-19 pandemic.

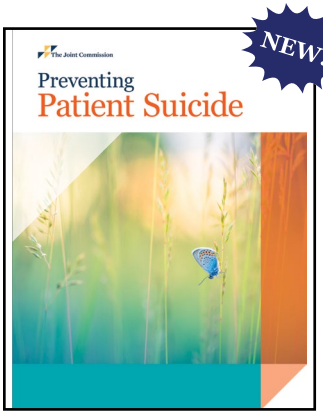


Infection Prevention and Control in Nonacute Care Settings is geared to address infection prevention and control challenges in ambulatory care, assisted living communities, behavioral health care and human services, home care, nursing care centers, and office-based surgery practices. It outlines Joint Commission infection prevention and control requirements for nonacute care settings and focuses on where organizations struggle, providing timely, accessible solutions.



Emergency Management in Health Care: An All-Hazards Approach, 5th Ed., helps organizations understand The Joint Commission's Emergency Management (EM) standards and how to plan for and address a range of emergencies. Includes the new EM standards for hospitals and critical access hospitals, effective July 1, 2022.

Treatment Planning in Behavioral Health Care and Human Services delivers practical strategies on the #1 topic requested by Joint Commission BHC organizations. Developed to help accredited BHC organizations tackle compliance challenges related to planning, developing, monitoring, and revising individualized treatment plans, this brand-new book takes a deep dive into key requirements found in the "Care, Treatment, and Services" (CTS) chapter of the *Comprehensive*



Accreditation Manual for Behavioral Health Care and Human Services (*CAMBHC*) and its corresponding E-dition®.

Preventing Patient Suicide is a new resource for professionals working in hospitals, behavioral health care, and psychiatric hospitals aimed at addressing strategies to identify, mitigate, and prevent suicide risk for their patients. This book offers insights and clarifications for meeting The Joint Commission's National Patient Safety Goals® (NPSG) Standard NPSG.15.01.01—reducing the risk of suicide among patients. It contains information vital to anyone who needs to understand Joint Commission requirements related to patient suicide, including not only assessing individuals at risk of suicide but also assessing for potential risks in the environment of care.

JCR Online Learning

JCR offers several virtual workshops and training opportunities for today's health care leaders.

The online *Leaders Facilitating Change*® Training equips staff, managers, and leadership to lead systemic change in their organization. This training session is two half-days and will help you inspire organizational change, foster a culture that can rely on leadership support, and facilitate the most effective meetings to achieve those goals.

The October *Leaders Facilitating Change* Training kickoff session is September 28, 2022. The time to register is now.

Online Yellow Belt Certification program offers effective process improvement tools and methods to move health care organizations out of their current state toward zero harm. This online program is the foundation of Robust Process Improvement® (RPI®),* which blends Lean, Six Sigma, and formal change management. Organizations will learn from a certified team of instructors how to do the following:

- Optimize quality and performance improvement efforts.
- Increase the spread of improvements in clinical and nonclinical processes.
- Increase alignment and staff engagement in improvement initiatives with common language and methodology.

The RPI Green Belt Certification Training Program is an engaging three-part training course designed to equip students to lead improvement efforts and apply formal change management and Lean Six Sigma methods to their organizations' most complex issues. Through this program, Green Belt students will identify a project that aligns with their organization's strategic goals and deploy this methodology to a real-life project with the training and guidance of RPI Master Trainers.

*Robust Process Improvement® or RPI® is a blended approach that combines change management and Lean Six Sigma to make sustainable improvements to even the most complex issues in health care.

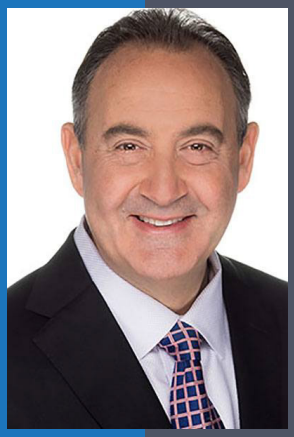
The RPI Green Belt Certification Training Program will teach you to do the following:

- Solve some of health care's most complex safety and quality problems.
- Increase acceptance and accountability when implementing and sustaining organizationwide improvements.
- Identify specific root causes to those pressing issues and target solutions that are sustained over time.
- Statistically validate key performance indicators based on process performance, voice of the customer, and process capability that goes beyond averages.

The Fall RPI Green Belt Training kickoff session is August 29, 2022. The time to register is now.

The Joint Commission

Joint Commission Resources



Meet our President and CEO

Join us in-person or by live webcast to hear from our new President and CEO of The Joint Commission, as he presents the keynote at the Hospital Executive Briefing in September.

LEARN MORE

Jonathan B. Perlin
M.D., Ph.D., M.S.H.A., M.A.C.P., F.A.C.M.I.
President and Chief Executive Officer

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Joint Commission Resources

Fall Education Events

View our upcoming events and webinars for all health care settings. Additional details are available on each event page.

VIEW ALL EVENTS

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