2016 Joint Commission Update for Hospital Imaging Departments

A changing format and new requirements for dose optimization and technologist certification reflect the continuing shift of healthcare reform.

As healthcare continues to march forward with numerous reforms, it falls to its various accrediting bodies to set standards to guide actual progress. Radiology is subject to many such accrediting bodies, but perhaps the largest is the Joint Commission, which oversees accreditation for all healthcare specialties. The most recent updates — including changes to the survey process itself as well as the scoring system — could have a major impact on radiology departments as a whole. Judith M. Atkins, RN, MSN, president and CEO of McKenna Consulting, spoke to radiology administrators at the 2016 annual meeting of the Association for Medical Imaging Management (AHRA) to help them parse through some of the latest updates and decide how best to address them.

Format of the Standards
Rather than develop department-specific requirements, Joint Commission standards are function-based. This means each category can be applied to any department, albeit in varying degrees. Essentially, the standards follow the patient to ensure consistent levels of care across the healthcare organization. The central theme of all standards, according to Atkins, is proactive risk reduction. “You learn from what mistakes other people have made and proactively put things in place to keep it from happening in your organization,” she explained.

The Survey Process
The Joint Commission surveyors have traditionally used what is called a tracer methodology to gather information on-site. Essentially, this means they follow the patient care experience throughout the entire healthcare delivery processes, and they do this in one of two ways:
They look at individual tracer activity, where individual patient experiences are used as a frame of reference to investigate care processes; or

They look at system tracer activity, following one particular process and seeing how it is employed across the hospital, as well as how it interacts with other processes.

The latest revision of the standards adds new facets to tracer methodology, with an increased focus on radiation exposure, including how dose is recorded and how staff are avoiding overexposure. There are also new tracer elements related to cleaning, disinfection and sterilization; contracting for nuclear radiotracers; and patient flow in the emergency department.

**Intra-cycle Monitoring**

As important as the surveys themselves are, Atkins noted that the periods between surveys are just as crucial. During these phases, facilities are required to undertake intra-cycle monitoring (ICM) and perform self-assessments of compliance. The Joint Commission offers all of the necessary resources on its website, including the Focused Standards Assessment (FSA) scoring tool. The FSA provides a set of customized standards for a facility’s accredited programs and services against which the facility can compare its progress. Atkins cautioned that looking at the final report from the most recent survey is essential during these intervening periods. “Repeat findings are critical. If they find it again, then you have a pattern or a trend of ignoring your responsibility to fix it,” she told her AHRA audience.

**New Scoring System**

Perhaps one of the biggest changes to the accreditation process is how surveyors score a facility’s progress. Traditionally, each standard is designated as an A (all-or-nothing, either the requirement is met or it is not) or a C (deficiencies are assessed based on frequency), and each standard is scored 0, 1 or 2 (non-compliant, partial or compliant).

Beginning in January, however, this system will be replaced and every report will be based around the Survey Analysis for Evaluating Risk (SAFER) matrix. A product of the Joint Commission’s multiphase process improvement Project REFRESH, the matrix is designed to better demonstrate aggregate risk scoring while prioritizing and focusing on corrective actions.

The matrix itself consists of a 3 x 3 grid, where the Y-axis (vertical) illustrates the likelihood an action will harm a patient, staff or visitor (low, moderate, high) and the X-axis denotes the scope of the issue (limited, pattern or widespread). Each deficiency is plugged into the matrix as it is discovered, with widespread, high-risk deficiencies requiring the most immediate attention. The SAFER matrix is also color-coded, with the highest priorities at the top in red and the lowest at the bottom in yellow.

Atkins said that the new system shifts the focus of risk scoring. “It’s not just about the wording of the EP [element of performance], it’s also about the surveyor and about their judgment on-site,” Atkins said. The color coding also serves a secondary purpose: For deficiencies in the red and dark orange sectors, facility response must include details of how executive leadership will be involved in addressing the fix, as well as the full preventive plan to avoid future recurrences. All deficiencies must be brought up to code within 60 days of receiving the final report.
Dose Optimization
Concerns about radiation exposure during diagnostic imaging have increased in recent years, driving the development of new technologies and techniques to optimize dose, with the goal of achieving the best possible image quality at the lowest possible dose. The latest Joint Commission standards reflect this enhanced focus on patient safety through regular evaluation of dose protocols and operator certification.

Much of the concern over radiation is directed toward computed tomography (CT), one of the most commonly used diagnostic tests, and the modality featured prominently throughout the new Joint Commission standards. Perhaps most importantly, accredited facilities are required to have a diagnostic medical physicist conduct a full performance evaluation of all CT imaging equipment at least annually and fully document the results. Phantoms must be used to assess a host of parameters, including image uniformity, slice thickness accuracy and artifact evaluation, among others.

A separate EP requires the diagnostic medical physicist to also conduct an annual review of CT dose protocols for adult brain, adult abdomen, pediatric brain and pediatric abdomen. Dose must be measured in the form of CT dose index (CTDIvol) for all CT imaging systems, and the physicist must ensure that the calculated value is within 20 percent of the CTDIvol value displayed on the scanner console.

Similar testing must be conducted at least annually for all nuclear medicine imaging equipment by a diagnostic medical physicist or nuclear medicine physicist.

MRI Requirements
While radiation dose concerns are eliminated with magnetic resonance imaging (MRI), The Joint Commission standards still feature several patient safety requirements for the modality.

One of these requirements relates to patients’ physical comfort inside the MRI scanner. Under the standards, facilities are required to manage safety risks related to:
• Claustrophobia, anxiety or other emotional distress;
• Medical implants, devices and other embedded metal;
• Ferromagnetic objects; and
• Acoustic noise.

Like all other diagnostic imaging equipment, all MRI scanners in an accredited facility must have a performance evaluation at least annually, ensuring quality for parameters such as signal-to-noise ratio (SNR), image uniformity, magnetic field homogeneity, and high- and low-contrast resolution.

Training and Certification
In addition to the imaging equipment itself, The Joint Commission standards also encompass the technologists who operate these systems. By the standards’ organizational structure, these requirements largely fall under the Human Resources chapter.

In February of this year, the commission added new requirements stipulating that CT technologists must obtain advanced-level CT certification by January 2018. Further, accredited organizations had to demonstrate that
their CT technologists were participating in educational opportunities to prepare for certification. The Joint Commission eliminated these requirements in June after receiving feedback that the January 2018 deadline could have a negative impact on patient access to CT services.

The standards do still require technologists to participate in annual CT-specific training/education, including dose optimization techniques and tools related to the Image Gently and Image Wisely campaigns. MRI technologist training and education requirements include topics such as patient screening criteria, positioning, patient hearing protection and others.