Steven Hirsch and Associates

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Steven Hirsch and Associates

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OUR MISSION

Our mission is to provide dynamic integrated expertise that supports health care organizations in meeting and exceeding patient care standards as mandated by the regulatory environment.

OUR VISION

To provide a positive and supportive environment that fosters professionalism while providing the highest quality client centric consulting expertise in the health care industry.

OUR VALUES

CREDIBLE • ETHICAL
EXPERT • INTEGRITY
PROFESSIONAL
RESPONSIVE

TJC Disease Specific Certification 2014

The Joint Commission (TJC) launched its Disease Specific Care Certification program in 2002. The program is designed to evaluate clinical programs across the continuum of care and is offered to all organizations accredited by The Joint Commission. TJC sets the requirements for certification; the organization itself determines how it will meet the requirements. The three main areas of the requirements are: compliance with consensus-based national standards; effective use of evidence-based clinical practice guidelines to manage and optimize care; and an organized approach to performance measurement and improvement activities. Other accrediting agencies such as Det Norske Veritas (DNV) and Healthcare Facilities Accreditation Programs (HFAP) also offer a limited number of Disease Specific Care Certification options.

Organizations make decisions to pursue Disease Specific Care Certification that are based on regulatory requirements, payers/reimbursement and also on market-driven forces and differentiation. In today's healthcare market, consumers and purchasers are looking to identify providers of care that have the highest quality of service. The Joint Commission Disease Specific Care Certification is the Gold Seal of Approval ™ ….a measure of achievement that is recognized in the health care industry.

The certification standards evaluate the scope of a specific disease, conditions or service and a program's effectiveness in using the clinical guidelines and performance measurements that contribute to improved clinical care. Certification programs include, but are not limited to, the following:

Abdominal aortic aneurysm
Acute coronary syndrome
Acute myocardial infarction
Advanced chronic kidney disease
Advanced chronic obstructive pulmonary disease
Advanced congestive heart failure
Advanced inpatient diabetes
Advanced lung volume reduction surgery
Advanced primary stroke center
Advanced ventricular assist device destination therapy
Alzheimer's disease
Asthma
Bariatric surgery
Bone marrow transplant
Brain injury rehabilitation
Breast cancer
Burn

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Cardiac rehabilitation
Carotid stenosis
Carpal tunnel syndrome
Chemical dependency
Chronic kidney disease
Chronic obstructive pulmonary disease
Colorectal cancer
Congestive heart failure
Coronary artery bypass graft
Depression
Diabetes mellitus
Discectomy
Eating disorders
End stage renal disease
Epilepsy
Fetal cardiac anomaly
Hip fracture
Hyperlipidemia
Joint replacement hip
Joint replacement knee
Joint replacement shoulder
Laminectomy
Low back pain
Lung cancer
Morbid obesity
Multisystem trauma
Normal delivery
Orthopedic trauma
Pancreatic cancer
Pediatric asthma
Pediatric diabetes
Pediatric eating disorder
Pediatric obesity
Pediatric sleeping disorder
Pediatric trauma
Peripheral vascular disease
Pneumonia
Prostate cancer
Pulmonary rehabilitation
Renal cancer
Respiratory distress in preterm
Respiratory failure
Self injury
Sickle cell disease
Sleeping disorders
Spinal cord injury
Spinal fusion
Stroke rehabilitation
Traumatic brain injury
Wound care

One of the newest programs offered is Primary Care Medical Home Certification for Hospitals and Critical Access Hospitals. This certification survey can be scheduled to occur at the same time as the organization's unannounced traditional accreditation survey or at any other time, as an unannounced survey.

Disease-Specific Care Certification is available at the core level and at the advanced level. Advanced certification programs must meet additional clinically specific requirements and expectations. An advanced program does not need to achieve core certification prior to applying for advanced certification. Also, it is important to be aware that the Ventricular Assist Device program and the Lung Volume Reduction Surgery program require certification in order to obtain reimbursement.

Tips for success:

- Structure a disease specific team
- Appoint a program coordinator and physician(s) champion(s)
- Decide upon program team composition
- Identify issues relevant to the disease specific care and patient population served at your organization
- Review clinical practice guidelines in use or chosen for implementation for the disease specific certification program
- Identify/develop program specific performance improvement measures
- Draw on internal expertise as well as published guidelines that are evidence-based
- Develop program mission, goals and objectives
- Define program scope

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- Develop and implement the program
- Evaluate the efficacy of the program
- Assess competency as related and credentialing processes specific to the program seeking certification
- Conduct individual patient tracers and also data tracers
- Implement reviews of the clinical medical record in order to assure continuous compliance with documentation requirements

Keep in mind that the preparation process itself is a learning opportunity, not only in evidence-based practices for the disease but also in Infection Prevention, Performance Improvement, and Communication.

Written by Linda Paternie, RN, BS, MHA of Associates

Understanding Rapid Influenza Diagnostic Tests - Part 1 of 2

In the hospital setting, a prompt, accurate diagnosis of influenza is essential for many reasons. From a patient perspective, prompt initiation of antiviral therapy can greatly decrease morbidity. Prompt diagnosis of influenza can also prevent unnecessary antibiotic therapy. From an infection prevention standpoint, prompt influenza diagnosis leads to timely initiation of droplet precautions, thus decreasing the risk of transmission to other patients and hospital staff.

Rapid influenza testing has played a part in influenza diagnosis for a number of years. Unfortunately, it can, in many cases, detract from an accurate diagnosis of influenza if the test itself is not well understood. The following paragraphs serve to clarify the role of rapid influenza testing in the diagnosis of influenza.

Conventional laboratory diagnostic tests for influenza are considered gold standards, but are seldom able to give clinicians a timely result. Viral culture has a turnaround time of at least 48 hours, and even RT-PCR (real-time reverse-transcriptase polymerase chain reaction), which has a turnaround time of 4–6 hours, is usually run in batches, which may delay the results. This has led to the development of an array of rapid influenza diagnostic tests (RIDTs). This test uses a nasal swab to determine the presence or absence of antibodies to the influenza virus in nasal secretions. The test can tell the difference between Type A and Type B virus, but it is unable to distinguish between virus subtypes of type A viruses like H1N1 or H3N2. The test is simple to use, gives a simple yes/no result in 15–20 minutes and can be licensed to be used at the point-of-care, such as a physician's office or an emergency department.

Sputum and nasal aspirates or washes are the best specimen types for detection of influenza virus by the antigen detection method of RIDTs. Swab specimens (particularly throat swabs) are least sensitive and specific. Specifically, isolation rates for influenza virus are approximately 18% to 28% lower in nasal swabs and 39% to 43% lower in throat swabs or gargles than from nasopharyngeal secretions. This probably reflects the higher virus loads found in nasopharyngeal washes compared to nasal or throat swabs.

The reported accuracy of RIDTs varies widely, with sensitivity ranging from 10 to 80%. Many factors can decrease the sensitivity and accuracy of a rapid influenza antigen test, including improper specimen collection; not testing the recommended clinical specimen, because results may vary by the kind of respiratory sample tested or use of a swab that is not recommended (e.g., using an unapproved tip or shaft material or not using the foam swab supplied with the test); prolonged time from illness onset to specimen collection, because viral shedding may have decreased to undetectable

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Understanding Rapid Influenza Diagnostic Tests - Part 1 of 2 Continued...

levels; and improper handling or storage procedures before testing of specimens.

The low sensitivity of RIDTs was problematic in the 2009 H1N1 pandemic. In a study described in Emerging Infectious Disease, the California Department of Public Health (CDPH) supplied rapid influenza test kits to clinicians participating in the Centers for Disease Control and Prevention (CDC) Sentinel Provider Influenza Surveillance Program. In the findings, 404 patients had pandemic (H1N1) 2009 by polymerase chain reaction (PCR) result. Of these 404 patients, 266 (66%) had positive results and 138 (34%) had negative results by rapid influenza testing. During the pandemic, it was found that clinical decision-making based on false-negative results complicated infection control and medical management, according to a study published in Clinical Infectious Diseases. For example, additional transmission of illness at schools may have occurred as a result of children returning to school after receiving negative RIDT results. In California, 8 obstetric and gynecological patients with H1N1 died, none having received antiviral treatment. Six of these eight women had false negative RIDTs.

The 2009 flu pandemic emphasized the poor performance of point-of-care flu tests available at the time. Subsequently, the FDA has proposed new performance standards for rapid influenza testing. The proposal would increase performance requirements for RIDTs to attain at least a sensitivity of 90 percent for influenza A and 80 percent for influenza B versus viral culture and/or 80 percent versus PCR methods. If these minimum clinical performance criteria are not met, marketed devices will need to be withdrawn from the market one year after the rule is finalized. The FDA continues to work with manufacturers to facilitate research and development and to review and approve new influenza diagnostic tests.

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Written by Judy Hagerty, RN, MS, CIC of Associates

About Steven Hirsch & Associates

As recognized experts on Joint Commission, HFAP, and DNV accreditation, licensure preparedness and facility management issues, Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987.

Beyond accreditation and licensure survey preparedness, our healthcare consulting team can provide assistance in a number of areas including Medicare certification, performance improvement, nursing management, infection prevention and control, Life Safety Code compliance, clinical lab management and compliance with HIPAA.

For more information on how Steven Hirsch & Associates can assist you with accreditation and licensure preparedness, Medicare certification and other management challenges, please contact us at (800) 624-3750 or go to our web site at www.shassociates.com.