The Joint Commission

November 27, 2019

The Honorable Danny Davis, Co-Chair
Rural and Underserved Communities Health Task Force
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

The Honorable Brad Wenstrup, Co-Chair
Rural and Underserved Communities Health Task Force
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

The Honorable Terri Sewell, Co-Chair
Rural and Underserved Communities Health Task Force
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

The Honorable Jodey Arrington, Co-Chair
Rural and Underserved Communities Health Task Force
Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Re: Request for Information

Dear Congressmen Davis, Sewell, Wenstrup, and Arrington:

The Joint Commission appreciates the opportunity to comment on the Request for Information (RFI) regarding priority topics that affect health status and outcomes for consideration and discussion in the Rural and Underserved Communities Health Task Force.

Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. An independent, not-for-profit organization, The Joint Commission accredits and/or certifies more than 22,000 health care organizations and programs in the United States, including Critical Access Hospitals (CAHs).

Although accreditation is voluntary, a variety of federal and state government regulatory bodies, including The Centers for Medicare & Medicaid Services (CMS), recognize and rely upon The Joint Commission's decisions and findings for Medicare and licensure purposes. For example, achieving The Joint Commission's accreditation through a "deemed status" survey provides a health care organization with a determination that it meets or exceeds Medicare and Medicaid requirements, including compliance with health and safety requirements known as Conditions of Participation (COP) or Conditions for Coverage that are established by federal regulations.

The Joint Commission recognizes the ongoing challenges that urban and rural underserved areas face in delivering high-quality care when facilities in these areas are resource-limited, including financial restraints, clinical staffing shortages, and low patient volume.[1] The Joint Commission offers

[1] American Hospital Association. *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-quality, Affordable Care* (2019), https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

The Joint Commission
Washington, DC Office
701 Pennsylvania Avenue, NW
Suite 700
Washington, DC 20004

specific suggestions to The Task Force's questions below to help these facilities deliver high-quality and safe care.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

Quality Measures Should Be Designed to Account for Rural Providers

The most significant obstacle in measuring quality among rural providers is that they sometimes must be excluded from qualifying in existing performance measurement programs because of limited patient volume in the clinical areas being measured. Ideal rural-relevant measures should focus on the types of patients that they most receive; facilitate fair comparisons among rural providers; support local access to care; are feasible for data collection by rural providers; exclude measures that have unintended consequences for rural patients; align with other programs; and support the National Quality Strategies triple aim of better care, better health, and affordability.[2]

Utilizing a core set of measures (also advocated by the Institute of Medicine in April 2015),[3] along with a menu of optional measures, would enable providers to address rural heterogeneity and allow a comparison of all rural providers across a limited set of measures. **The Joint Commission recommends that the Task Force convene a group of stakeholders to make recommendations on rural-relevant measures to be used across various programs and settings.** The Joint Commission would welcome the opportunity to participate in this group.

The Joint Commission also recommends that the Task Force review past legislative efforts that would establish a core set of rural quality measures, integrate these measures into value-based payment programs, and allow the Center for Medicare and Medicaid Innovation to test models for CAHs, among other measures.

Emergency Medical Care Center Designation Should be an Option

Rural hospitals continue to face challenges meeting Medicare inpatient service requirements, which lead to hospital closures and ultimately limit access to critical emergency services. **The Joint Commission strongly supports legislation to establish a new emergency medical care center designation under the Medicare program.** Prior legislative efforts and other stakeholders have advocated for this designation as a mechanism to continue providing critical services to rural communities. However, any such legislation must include appropriate quality and safety requirements, including adequate training for the delivery of emergency care.

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[2] US Department of Health and Human Services. *National Strategy for Quality in Health Care: 2015 Annual Progress Report to Congress* (Oct 2015), http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2015annlrpt.pdf.
[3] National Academies of Sciences, Engineering, and Medicine. Health and Medicine Division. *Vital Signs: Core Metrics for Health and Health Care Programs* (Apr. 28, 2015), http://nationalacademies.org/HMD/reports/2015/vital-signs-core-metrics.aspx.

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

External Review at Least Every 3 years Will Drive Quality Improvement

The Joint Commission believes that all health care organizations benefit from external review and education. For example, The Joint Commission's CAH accreditation program provides significant assistance to health care facilities so that they can deliver high-quality care. Accreditation reviews identify gaps in patient safety, good practices, effective processes, and need for specific resources and training. Additionally, The Joint Commission accreditation relies upon evidence-based standards, which is critical for ensuring that health care facilities deliver high-quality care without creating additional burden to facilities that are already resource-limited.

Unfortunately, there is not a statutory requirement to externally review CAHs for compliance with Medicare health and safety standards at least every three years, as is the minimum for accredited facilities, which often are reviewed even more frequently. Since CMS must prioritize surveys for those facilities that have statutorily-driven survey periods, hospitals of all types often fall closer to the bottom of the CMS survey priorities. Therefore, non-accredited CAHs may experience a long period of time without the benefit of any external review and assistance with quality and safety issues.

While The Joint Commission accredits approximately 30% of CAHs, accredited CAHs have access to an in-depth survey by trained surveyors, educational materials and many free resources to assist them as needed. Accredited organizations can also utilize timely standards to address public health issues and the changing health care landscape. For example, The Joint Commission recently announced new standards to improve the prevention, early recognition and timely treatment of two leading causes of maternal death and morbidity: maternal hemorrhage and severe hypertension. Since Medicare does not have similar requirements, only Joint Commission-accredited facilities will be required to meet these standards.

Incentives for Accreditation Will Help Resource-Limited Health Care Facilities

The Joint Commission believes that there should be a policy focus on payment incentivization for CAHs to seek and achieve accreditation. The Joint Commission would welcome the opportunity to discuss innovative Medicare payment policies where CAHs would have more resources to invest in accreditation and quality improvement.

The Joint Commission is pleased to answer any questions you may have regarding our comments. If you have any questions, please do not hesitate to contact me or my staff: Tim Jones at (202) 777-1246 or tjones2@jointcommission.org.

Sincerely,

Margaret VanAmringe, MHS
Executive Vice President for Public Policy and Government Relations

Cc: The Honorable Richard Neal, Chairman, Ways & Means Committee
The Honorable Kevin Brady, Ranking Member, Ways & Means Committee