The Survey Coordinator's Handbook

18th Edition

Jodi L. Eisenberg, MHA, CPHQ, CPMSM, CSHA

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Jodi L. Eisenberg, MHA, CPHQ, CPMSM, CSHA, is the senior director of accreditation education programs at Vizient™, an alliance of hospitals and healthcare organizations including academic medical centers, community hospitals, ambulatory care, and other healthcare providers. She leads efforts to evaluate, develop, and deliver education to member organizations with a focus on continuous patient readiness, approaches for improving compliance with foundational regulations and standards, and strategies to ensure an ongoing focus on quality and patient safety across the continuum.

Prior to this role, Eisenberg was the system lead manager of accreditation, clinical compliance, and policy management at Northwestern Medicine in Chicago. She was responsible for leading the full range of Joint Commission and other accreditation and regulatory compliance activities, including the organization of continuous compliance activities for The Joint Commission and other regulatory agencies. Also under her purview was the programmatic direction for the design, development, and oversight of the hospital and departmental policy and procedure management system. She also served as faculty to the HCPro Accreditation Boot Camp.

Additionally, Eisenberg serves as an editorial advisor for *Briefings on Accreditation and Quality* (previously known as *Briefings on The Joint Commission*), published by HCPro, a division of BLR. She is the original author of the *Survey Coordinator's Handbook* and the coauthor of *Performance Improvement: Winning Strategies for Quality and Joint Commission Compliance,* published by HCPro, which won the National Association for Healthcare Quality David L. Stumph Award for Excellence In Publication in its

second edition in 2000. She authored, edited, and contributed to several other HCPro publications over the past 20 years.

Eisenberg's evolution in healthcare administration began in medical staff services and quality. She holds a master's degree in healthcare administration from the University of St. Francis, as well as certifications as a professional in healthcare quality, a professional in medical staff management, and a specialist in healthcare accreditation.

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Finally, to all of you who are reading this book, remember, the next visit will happen … whether it is The Joint Commission, the Centers for Medicare & Medicaid Services, the Department of Public Health, or another regulatory body with an acronym. Just take a deep breath and keep your focus on the patient. You are doing great work at the bedside, and that will shine through!

Introduction

Since the original publication of this book, we have seen the oversight process for healthcare organizations evolve. The Institute of Medicine's 1999 report *To Err Is Human* brought to light the potential depth and breadth of medical error. Scrutiny by the Centers for Medicare & Medicaid Services (CMS) and the voluntary accrediting bodies on ensuring patient safety and identifying the issues that present potential harm to patients has increased. Due to this increase oversight, the number and frequency of unannounced surveys by all accrediting bodies with deemed status have increased and we are seeing the number of condition-level findings increase as well.

This book is intended for those who will serve as the primary points of contact and liaisons between their healthcare organizations and the regulatory agency. It provides an overview of the history and evolution of the accreditation process, along with suggestions for establishing a culture of continuous readiness for patients each and every day.

Understanding the foundational requirements within the CMS *Conditions of Participation* is critical to this process. Based on that understanding, the survey coordinator can make a positive impact on patient care each day, partnering with operational leaders and effectively managing time, resources, and staff. The goal should not be to comply simply because CMS or the accrediting body requires it; rather, the goal should be to provide effective, efficient, and safe patient care and, as a byproduct, comply with the rules and regulations. To bring this shift in mindset to the organization, leaders must employ keen listening skills, understand the sources of truth, collaborate with frontline staff members and operational leaders, and be open to continuous learning and improvement.

In addition to providing an overview of the regulations and the process, this handbook contains suggestions for managing the process prior to, during, and after regulatory visits. It also contains helpful figures and forms, many of which are currently in use by survey coordinators across the country. Although they are merely illustrations from selected settings, we believe that they will help clarify the recommendations and provide you with a running start in establishing a continuous readiness program within your healthcare organization.

CHAPTER 1

Accreditation at a Glance

Accreditation started as a minimum set of healthcare standards developed by a group of surgeons for the hospital inpatient setting. From there, it evolved into standards promoting optimal quality and then to those focused on patient safety and outcome measurement and management. This evolution began in the early 1900s and continues today. The current focus is as much on the hospital inpatient setting as it is on the settings across the continuum. Preventive care and wellness, continuity and communication among providers, and consistent care of the chronically ill are areas where we are seeing changing standards and regulations.

The simplest reason that accreditation matters is that most healthcare organizations need it in order to be eligible to receive Medicare reimbursement. Its primary intent is to ensure that the hospital adheres to basic standards and provides consistent, quality care, and it has become a symbol of credibility to insurers, health plans, and patients.

This chapter provides an overview of the accreditation process to help you understand how it has influenced healthcare policy and practices. For those who are new to the field of accreditation, this chapter summarizes the types of services that accrediting agencies provide and includes an overview of the accreditation and certification programs available. It also provides an overview of the issues facing most organizations every day as they work to integrate continuous readiness into daily operations. Acknowledging the many challenges that hospitals face, this chapter offers practical advice, tools that can be easily implemented, and perhaps new insight into identifying solutions and opportunities for improvement.

Figure 1.1 | Accreditation evolution

1913	American College of Surgeons formed
1917	American College of Surgeons establishes "Minimum Standards for Hospitals"
1918	American College of Surgeons conducts its first hospital inspections
1945	American Osteopathic Association (now Healthcare Facilities Accreditation Program) forms
1950	More than 3,000 hospitals receive the American College of Surgeons seal of approval
1951	Joint Commission on Accreditation for Hospitals forms
1965	Medicare Act "deemed status" created—American Osteopathic Association and Joint Commission receive deeming authority
1987	Joint Commission expands scope from hospital accreditation to healthcare organization accreditation
1993	Joint Commission changes to focus on functional standards rather than departmental-based standards
1999	Institute of Medicine's *To Err is Human* report of medical errors in healthcare
1999	Center for Improvement in Healthcare formed
1999	Joint Commission introduces ORYX performance measures
2003	Joint Commission introduces National Patient Safety Goals
2006	CMS requires accreditation organizations to conduct unannounced surveys
2008	Det Norske Veritas Health Care Division formed—integration of ISO 9001 standards with Medicare *CoPs* receives deemed status
2010	Affordable Care Act and introduction of Pay for Performance Measures
2013	Center for Improvement in Healthcare receives deemed status

History of Accreditation

The timeline in Figure 1.1 offers a glimpse into how healthcare standards came into being. Accreditation followed, and it actually predated the Medicare *Conditions of Participation* (*CoP*).

In 1910, Ernest Codman, MD, proposed that hospitals develop procedures for tracking patients long enough to determine whether treatment was effective. By reviewing outcomes, hospitals could evaluate their processes and procedures to gauge whether they needed to make improvements.

His innovative thinking resulted in Codman being forced to leave the esteemed Massachusetts General Hospital. Yet Codman's methods caught the attention of the American College of Surgeons (ACS), an organization founded in 1913, and they became part of the ACS' stated objectives. The ACS also used Codman's ideas to develop the "Minimum Standards for Hospitals," a short list of requirements designed to regulate quality of care. At that time, only five standards were introduced. In 1918, the ACS used this list to begin its first on-site inspection of hospitals. The inspection program was so successful that, by 1950, more than 3,200 hospitals had earned the ACS seal of approval.

Codman's original documents remain stored in a vault, and a replica of his recommended processes is on display in the Center for Quality and Patient Safety at (ironically) Massachusetts General Hospital. From 1997 through 2008, The Joint Commission presented the annual Ernest Amory Codman Award to recognize excellence in performance measurement, but as of this writing, the program is on hold while it undergoes internal evaluation.

In 1951, the ACS joined with the American College of Physicians (ACP), the American Hospital Association (AHA), the American Medical Association (AMA), and the Canadian Medical Association (CMA) to create The Joint Commission (which at the time was called the Joint Commission on Accreditation of Hospitals, or JCAH). In 1952, ACS transferred its standardized program to JCAH, which began to provide voluntary accreditation to hospitals starting in January 1953. CMA withdrew from the group in 1959 to form its own Canadian accreditation organization.

In 1965, Congress passed the Medicare Act. The government determined that if it was going to pay hospitals for the care given to certain entitled patients, it needed a way to ensure that the quality of care at those hospitals warranted payment. The sponsoring federal agency in charge of Medicare did not have the resources, personnel, or expertise to conduct these evaluations. To address that challenge, the federal legislation stated that hospitals accredited by JCAH would be "deemed" to be in compliance with most of the Medicare *CoPs* for hospitals. This allowed JCAH to bypass the routine renewal process for maintaining deeming authority. It was able to create and modify requirements outside the realm of the basic *CoPs*.

These *CoPs* are the minimum requirements that hospitals must meet to qualify for reimbursement from Medicare and Medicaid. With the passage of the Medicare Act, JCAH became an official inspection agency, and a JCAH survey was more like an audit than the interactive, educational experience it is today. Surveyors reviewed documents to determine whether policies and procedures were acceptable, meeting minutes were present, the organization addressed clinical problems, and top managers were competent. The survey focused heavily on the safety and physical structure of hospital facilities.

In that iteration, a survey consisted of surveyors arriving at the hospital at a predetermined time, spending lots of time talking with administration, and reviewing the organization's paperwork. At hospitals, policy and procedure manuals were presented for review. There was certainly an element

of preparation, and many hospitals selected their "best" medical records for the types of care that surveyors were most likely to inspect. If the surveyors traveled to a patient care unit, it was more like a tour than an evaluation; perhaps they engaged in minimal conversation in an effort to impress upon staff members that they were integral in the patient care process. There was little review of the actual process of care on the patient care unit.

During this period, staff members usually considered the JCAH survey to be more of an event than a tool that could be used to improve healthcare. Deficiencies were reviewed with hospital leadership but not necessarily with hospital staff. The medical staff interview, for the most part, consisted of a lunch, and discussions were topical and not necessarily related to the organization's individual issues.

Change in Approach

In 1994, The Joint Commission unveiled its Agenda for Change and overhauled the *Accreditation Manual for Hospitals* (*AMH*), renaming it the *Comprehensive Accreditation Manual for Hospitals* (*CAMH*) and doing away with department-specific standards. The new standards were cross-functional, and the standards and survey process started to emphasize actual outcomes and results rather than relying solely on measures of structure, process, and documentation.

This approach placed new demands on hospital staff members. Before the changes, many departments had only concerned themselves with one section of the AMH. For example, nuclear-medicine departments worried only about nuclear-medicine standards, and dietitians focused only on dietetic standards. To meet the CAMH's new cross-disciplinary standards, however, departments had to become familiar with requirements outside of their specific focus, including the chapters of the CAMH on human resources, infection control, and performance improvement, because processes were now dispersed throughout the accreditation manual. Hospitals were to be surveyed on actual performance as well as on the quality of their plans or policies, including how the different departments and disciplines worked together to improve performance.

But the Agenda for Change didn't go far enough. The 1994 overhaul allowed hospitals to prepare for surveys by spending the year (or, in some cases, a couple of weeks) prior to the scheduled survey getting policies and procedures in shape and even painting walls and cleaning floors to create a good impression for surveyors, rather than making changes when they were truly needed.

The Joint Commission especially felt the pressure to examine its standards and survey process after the 1999 release of the Office of Inspector General report, *The External Review of Hospital Quality: The Role of Accreditation*, which questioned the oversight of the accreditation process, and the Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, which sounded a national alarm

on the prevalence of medical errors in the United States. Bad things were still happening in good hospitals, and the accreditation process didn't seem to relate to the outcomes. To address those issues, The Joint Commission decided to evaluate the overall process.

The IOM report revealed that as many as 98,000 patients per year were dying from medical errors, making medical errors the eighth leading cause of death in the United States. The report called for a 50% reduction in medical errors in the five years following the report and recommended that The Joint Commission focus greater attention on safety.

Although The Joint Commission is a widely recognized name in the healthcare market, it is not so widely recognized among the general public. The public understands that someone is overseeing hospitals, but it doesn't really understand the process. In part because of that lack of understanding, after these reports were published, there was a loss of confidence in healthcare institutions. Hospitals felt pressure from patients and employers, and The Joint Commission felt pressure from patient safety groups, payers, hospitals, and the media, which criticized the accreditation process for failing to make healthcare safer. To restore public confidence and improve the quality and safety of healthcare organizations across the United States, The Joint Commission announced in the fall of 2002 that it would make significant changes to the accreditation process.

As part of these changes, The Joint Commission consolidated standards, changed how it scored them, and required hospitals to complete a periodic performance review (PPR)—a lengthy, midcycle self-assessment tool to promote continuous standards compliance. The intent was to keep hospitals connected to The Joint Commission's ongoing focus on safety and quality outside of the triennial on-site review event. We have since seen the PPR change to the Intracycle Monitoring (ICM) process: same concept, different acronym.

The survey process changed as well. During the Agenda for Change era, a Joint Commission survey involved 25% documentation review and 75% interaction with all levels of the staff in the hospital. The survey process today involves about 10% documentation review and 90% interaction with staff members and patients at the point of care. In addition, time is spent tracing a patient's care through the course of the hospital experience. Surveyors are on patient care units for a majority of the survey, asking for patient charts and then tracing, or visiting, the departments or services where the patients received treatment. If a patient is admitted through the emergency department, receives radiology and laboratory services, and is admitted to the floor or ICU, the surveyor will evaluate the standards against the actual care that the patient received.

Surveyors today observe processes including direct care, the medication process, and the care-planning process; interview individual patients or families; review open and closed medical records; interview staff members about performance measurement; inquire about staff members' daily roles and responsibilities; and evaluate staff training and orientation. Surveyors also review policies and procedures

as needed to clarify organizational expectations. Through their tracer activities, surveyors are able to assess a facility's compliance with standards and National Patient Safety Goals (NPSG).

The tracer methodology was a big change and caused some initial concern. However, as staff members became involved in tracer activities, they became excited that patient care was being proactively evaluated. Staff members sometimes get nervous when a surveyor selects them for an interview during the tracer process, but all questions focus on what these staff members do every day in providing care for patients. This new process made sense to the caregivers; therefore, it was easy to support and adopt. To this day, the nursing industry tends to be very supportive of these efforts. And we have seen the Centers for Medicare & Medicaid Services (CMS) unveil their own form of tracers focused on quality assessment and performance improvement (QAPI), discharge planning, and infection prevention and control.

As the number of deemed agencies grows and the emphasis on quality and outcomes continues, accreditation agencies, CMS, and, most importantly, patients expect an organization to continuously focus on the quality and safety of the care it provides; thus, your organization should always be ready regardless of when the surveyors actually present to your facility.

Why Do Organizations Seek Accreditation?

At the time of this writing, The Joint Commission is one of the largest and most well-known accreditation agencies. It accredits and certifies more than 20,000 healthcare programs and organizations throughout the United States. The Joint Commission is one of four entities that have received hospital deeming authority from CMS.

Accreditation is a voluntary process; it is not required by law. However, it is an avenue by which hospitals can validate their compliance with the *CoPs*. It can also provide a range of other benefits, including a positive image in the community, the ability to obtain insurer and employer contracts, the ability to obtain certification through the Accreditation Council for Graduate Medical Education, a focus on risk reduction, and greater ease of staff (especially nurse) recruitment. The most important issue for hospitals, however, is that deemed status from successful accreditation allows them to receive reimbursement from Medicaid and Medicare as third-party payers. As the reimbursement landscape evolves under the Affordable Care Act, we may see changes in the accreditation or certification requirements for other types of healthcare organizations as well.

CMS is the primary deeming authority and has granted deemed status to the organizations outlined in Figure 1.2.

The Joint Commission remains the agency that accredits the largest number of healthcare organizations. All of these agencies conduct surveys as agents of CMS, so although their standards may be written a bit differently, they are all linked to the CMS *CoPs*. Therefore, many of the requirements are consistent across accreditation programs, and regardless of the agency that accredits your organization, you will benefit from adopting the concept of continuous readiness—or, more precisely, continuous readiness for patient care.

Figure 1.2 | CMS deemed status agencies as of 2016

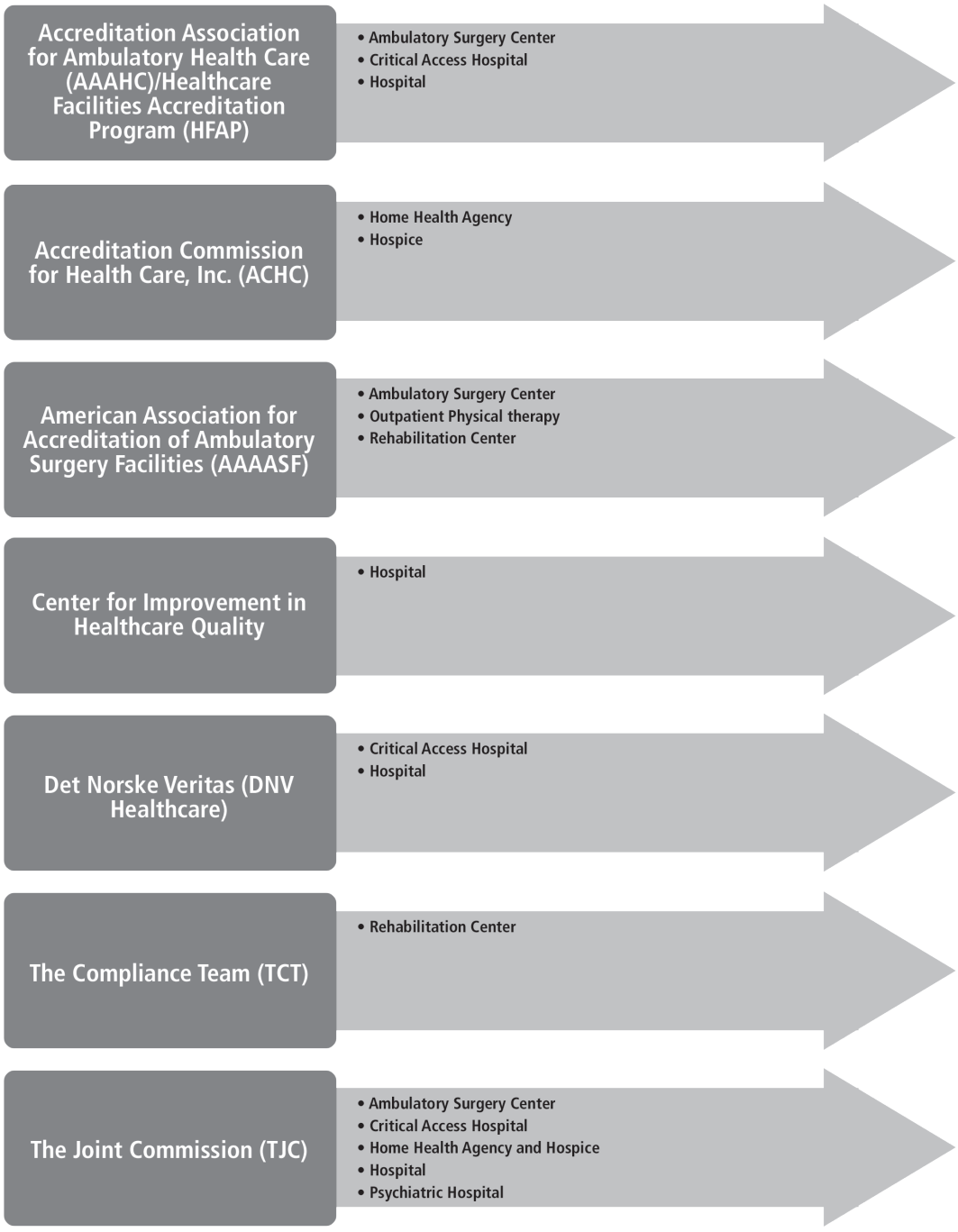

Figure 1.3 | Survey planning session documents

Survey Planning Session Documents				
Received	**Document**	**Responsible Party**	**Update Frequency**	**Location**
❑	Survey confirmation and agenda		Morning of survey	
❑	Priority focus report		Annual	
❑	Organization chart		As needed	
❑	Plan for the provision of patient care		Annual	
❑	List of departments/units/services		Annual	
❑	List of all sites eligible for survey, including campus map		Annual	
❑	List of sites that use deep/moderate sedation		As needed	
❑	Medical-staff bylaws/rules and regulations		As needed	
❑	Medical executive committee meeting minutes (12 months)		Monthly	

Day of Survey Documents				
Received	**Document**	**Responsible Party**	**Update Frequency**	**Location**
❑	Lists of scheduled surgeries		Morning of survey	
❑	Lists of special procedures (cardiac catheter, endoscopy, C-sections, including location of patient and time)		Morning of survey	
❑	Current inpatient list (name, location, age, dx, length of stay)		Morning of survey	
❑	Current ambulatory/dx testing list of patients		Morning of survey	

Performance-Improvement (PI) Data				
Received	**Document**	**Responsible Party**	**Update Frequency**	**Location**
❑	Quality-improvement/patient-safety plan		Annual	
❑	PI data past 12 months—best patient experience dashboard		Quarterly	
❑	ORYX data		Quarterly	
❑	Quality year in review—current list of DMAIC projects		Annual	
❑	Infection-control plan		Annual	
❑	Infection-control minutes (12 months)		Quarterly	
❑	Infection-control surveillance data (12 months)		Quarterly	
❑	Analysis from high-risk process		18-month interval	
❑	List of unapproved abbreviations (Patient-Care Policy 5.22)		As needed	
❑	Organ donation procurement conversion rates		Quarterly	
❑	Medical-record delinquency data		Quarterly	
❑	Organization marketing materials		As needed	

Figure 1.3 | Survey planning session documents (cont.)

Environment of Care				
Received	**Document**	**Responsible Party**	**Update Frequency**	**Location**
❑	Environment of care management plans/annual review		Annual	
❑	Statement of condition		Quarterly	
❑	Standard of care plans for improvement		Quarterly	
❑	Environment of Care meeting minutes (12 months)		Monthly	
❑	Emergency operations plan (EOP), hazard vulnerability analysis, annual evaluation of EOP		Annual	

Additional Documentation/May be Requested				
Received	**Document**	**Responsible Party**	**Update Frequency**	**Location**
❑	List of all contracted services to include nature/scope of services provided		As needed	
❑	Agreement with outside blood supplier			
❑	Grievance policy (Patient-Care Policy 5.42)		Annual	
❑	Governing body minutes to verify compliance with budget requirements		Annual	
❑	Credential files to verify appropriate clinical leadership/oversight for anesthesia, respiratory, and emergency services		Reappointment interval	

Hospital Accreditation Survey Activity List			
Survey Activity	**Responsible Party**	**Suggested Schedule Time (minutes)**	**Participants**
Surveyor arrival and preliminary planning		First day (60)	
Opening conference and orientation		First day (60)	
Surveyor planning initial		First day (60)	
Individual tracer (one per surveyor)		Each day (60–120 minutes each tracer)	Units/visits to be determined day of survey
Lunch		Each day (30)	Surveyors only
Issue resolution		End of day as necessary (30)	Surveyors and organization participants as applicable
Team meeting/surveyor planning		End of day except first/last day (30)	Surveyors only
Organization meeting		End of day (30)	Hospital participants only
Daily briefing		Each day/start of day (30)	
Competence assessment		(60)	
Medical staff credentialing and privileging		(60)	
Environment of care		(90)	
Emergency management		(90)	
Life Safety Code® specialist arrival and preliminary planning session		(30)	

Figure 1.3 | Survey planning session documents (cont.)

Hospital Accreditation Survey Activity List			
Survey Activity	**Responsible Party**	**Suggested Schedule Time (minutes)**	**Participants**
Facility orientation/maintenance document review		(90)	
Life Safety Code® building assessment		Two to five hours per day	
System tracer—data management		(60)	
System tracer—med management		(60)	
System tracer—infection control		(60)	

Note that even if you are accredited by any of the agencies with deeming authority, CMS can opt to conduct a post-accreditation validation survey at any time or may follow up on a specific patient complaint. Additionally, your state Department of Public Health may opt to conduct a state licensure survey. When you are a licensed and accredited patient care provider, your door is open to these agencies so that they can ensure standard compliance at virtually any time. Therefore, it is essential to move beyond compliance for any particular regulatory agency and to focus instead on providing efficient, effective, and safe patient care. Figure 1.3 lists survey planning session documents; make sure to reference the most recent annual update of required documents published by the accrediting organization.

If hospitals decide not to seek accreditation and still wish to bill for services provided to Medicare and Medicaid patients, they must undergo a CMS survey. However, most hospitals perceive the voluntary accreditation process to be a more positive, more interactive, and less contentious experience than taking part in a CMS survey, which is usually conducted by the State Department of Public Health. This is part of the reason that hospitals choose accreditation.

For providers that offer services based on referrals from other healthcare providers, Joint Commission accreditation is often a marker of basic quality. The Joint Commission's mission is to evaluate and inspire healthcare providers to achieve overall consistency in quality and patient safety. As a survey coordinator, you are responsible for helping your organization achieve and maintain that consistency by navigating the myriad rules, regulations, and standards. This requires continuous commitment and collaborative efforts to monitor the practices and processes that support and deliver patient care in your facility.

In addition to being the largest deeming authority, The Joint Commission has made a substantial impact in the realm of patient safety and quality in healthcare organizations: It convened The Patient Safety Advisory Group, a group of patient safety experts (including nurses, physicians, pharmacists, risk managers, clinical engineers, and a variety of clinical experts) who are responsible for reviewing and vetting potential National Patient Safety Goals. These goals were developed as a way to get

organizations to focus on issues identified as areas of concern and on potential root causes for serious sentinel events in the nation's healthcare organizations. They were introduced in 2002, and organizations were expected to comply with them starting in 2003. This focus on high-risk, problem-prone areas with a spotlight on transparency has made a significant impact on the healthcare industry.

Accreditation Programs

In addition to accrediting general acute care hospitals, deeming authorities offer accreditation services to a multitude of other healthcare organizations, such as critical-access hospitals, psychiatric hospitals, and ambulatory care clinics, and they have been doing so for many years. In addition, disease-specific certification has been introduced in areas such as stroke care, lung volume reduction surgery, diabetes care, and ventricular assistive device implantation. Many of these specialty certifications are becoming mandatory, as CMS and some third-party payers link them directly to reimbursement.

To determine whether a service falls within the tailored survey option, refer to organizational and functional integration criteria. These criteria focus on identifying the degree to which the component and the accredited organization are linked.

Ambulatory healthcare

Since 1975, The Joint Commission has been accrediting ambulatory services such as ambulatory surgery centers (ASC), urgent and convenient care centers, diagnostic imaging centers, sleep labs, telehealth providers, community health centers, and other outpatient services. Approximately 90 types of ambulatory services can receive accreditation by The Joint Commission. In 2010, CMS designated the ambulatory program as its accreditor for advanced diagnostic imaging centers. Thus, those centers offering magnetic resonance imaging, positron-emission tomography, or computed tomography scans need to be accredited to receive Medicare payment. In 2013, The Joint Commission issued proposed Advanced Diagnostic Imaging Standards for Hospitals, which expanded the standards within hospitals and increased consistency across the continuum in line with CMS. As of this writing, these standard remain in the proposed status. The Joint Commission ambulatory program has many arrangements with individual states that recognize accreditation to meet licensing requirements for ASCs.

Behavioral healthcare

Behavioral healthcare includes a broad base of segments in the field, such as community mental health services, opioid and chemical dependency programs, foster care services, therapeutic schools, and developmental disabilities services. More than 1,800 behavioral health organizations have been accredited since The Joint Commission started offering that accreditation in 1969.

Behavioral healthcare units in acute care hospitals are surveyed under the hospital standards. The Joint Commission behavioral program has been recognized by various state authorities across the country for deeming purposes.

Clinical laboratories

Laboratories have been surveyed by The Joint Commission since 1979. Currently, labs representing 3,000 Clinical Laboratory Improvement Amendment certificates in 2,000 organizations are accredited. The laboratory program is on a two-year accreditation cycle as a requirement of meeting its CMS deeming status.

Please note: The Joint Commission still maintains a cooperative agreement with both the College of American Pathologists (CAP) and the Commission on Office Laboratory Accreditation (COLA) for accreditation and recognizes these competitors' processes as equivalent. If your hospital uses one of these accreditors for your laboratories, expect less scrutiny of the lab during your hospital accreditation survey visit. However, CAP and COLA are required to report adverse findings to the designated accrediting body for follow-up consideration. Refer to the earlier note regarding the impact of services on the hospital's overall accreditation decision.

Critical-access hospitals

A hospital that has no more than 25 beds, keeps patients for fewer than 96 hours, and is certified by its state is considered a critical-access hospital. There are a few nuances to the critical-access hospital standards, such as for the (2010) distinct psych and rehab parts of the standards, so if this pertains to you, refer to your accreditation manual. The Joint Commission received federal deeming authority (which is a separate deeming recognition) in 2002 and accredits 358 of the 1,300 critical-access hospitals in the United States.

Homecare

Since 1988, The Joint Commission has accredited homecare organizations. Currently, 5,200 organizations offering home health services, personal care and support services, home infusion and pharmacy services, home medical equipment, and hospice services are accredited. The Joint Commission has enjoyed federal deeming authority for home health and hospice services since the 1990s. In 2006, it was also awarded deeming authority for home medical equipment, orthotics, and prosthetics, as well as for medical supply services.

Long-term care

One of the longest-standing programs includes accreditation of nursing homes; it has been in existence since 1966. Programs in nursing homes, such as subacute services and dementia programs, can be included in the survey process if they are offered by the facility. However, being Joint Commission accredited does not eliminate the facility's obligation to undergo an annual state survey, as there are no federal deeming arrangements for nursing home facilities.

A few years ago, The Joint Commission began offering a shorter version of its accreditation program, choosing to rely on the most recent state survey results and therefore evaluating only the additional standards above and beyond the states' criteria. Both options result in accreditation if the facility is successful in meeting the standards. Currently, only about 1,000 nursing homes are accredited, which is a small percentage given that the government estimates that there are more than 16,000 nursing homes in the United States.

If your hospital occupies fewer than 20 skilled beds on a daily basis, you can opt for the long-term care component to be surveyed with the hospital. If you do not have this done, your hospital accreditation award will specifically state that the long-term care component is not included in the accreditation decision.

Office-based surgery

Office-based surgery accreditation started in 1999 and is reserved for organizations that have fewer than four practitioners and are physician owned or operated. The standards are a subset of the larger ambulatory care program's standards. The Joint Commission accredits more than 400 surgery practices, including oral surgery, podiatry, and plastic surgery practices; endoscopy suites; and laser surgery clinics.

International accreditation

Launched in 1999, The Joint Commission International (JCI) accreditation program, provided under the JCI name, encompasses the globe with accreditations in more than 40 countries. JCI accredits hospitals, ambulatory facilities, laboratories, ambulance transport, public health agencies, primary care, and care continuum practices. JCI has many partner organizations, including entities in Spain, Brazil, and Italy, as well as arrangements with ministries of health in certain countries.

Certification Programs

Disease-specific care

In 2002, The Joint Commission launched certification programs in recognition of the fact that accreditation was reserved for organizations and that other services, such as disease management programs, also affect the quality and safety of care. The Disease-Specific Care program offers certification for clinical programs that are in compliance with standards, use evidence-based practice guidelines, and implement performance improvement (PI) activities through data collection. There are more than 1,300 certified disease programs of all types, including heart failure, inpatient diabetes management, and wound care, among others.

The Advanced Disease-Specific Care programs are designed with a nationally recognized partner to assist with the development or use of specific clinical practice guidelines. Such is the case with the Advanced Primary Stroke program, developed with the American Stroke Association, and the Advanced Heart Failure program, developed with the American Heart Association.

Many organizations struggle to decide whether to move forward with disease-specific certification. To make that decision, develop guiding principles to help measure the return on investment. See Figure 1.4 for a sample set of guiding principles.

Organizations that provide lung volume reduction surgery or implant ventricular assist devices for destination therapy must be certified to receive reimbursement. CMS recognizes Joint Commission certification as a condition of payment by Medicare. It is likely that this trend to require certification for reimbursement will continue for other conditions and diagnoses as the federal healthcare reform initiatives and attention to outcomes evolve.

Primary and Comprehensive Stroke Center certification

It is worth saying a few words regarding the Primary Stroke Center (PSC) certification program, as it is the largest of the disease-specific care programs in sheer numbers, representing more than 50% of all disease programs certified at the time of this writing. The challenges of this certification include consistent implementation of Clinical Practice Guidelines (CPG), evaluation of patient perception of care quality for stroke, and ongoing data collection on performance measures.

The Brain Attack Coalition consists of a group of associations, including the American Academy of Neurology, the American Association of Neurological Surgeons, and the American College of Emergency Physicians, that work together to reduce the number of strokes and their associated disabilities

Figure 1.4 | Guiding Principles/Determination Criteria for Participation in Accreditation/Certification Programs

Guiding Principle
Foundational Requirement: Accountable Leadership Structure • Aligned quality process supported by internal/programmatic resources to support initiative
Guiding Principle/Determination Criteria
Government/payer standard or regulation
Market-share/growth opportunity that advances mission, vision, and strategic plan
Establishes foundational set of standards, criteria to improve and sustain care
Establishes process for periodic objective reviews to ensure sustained performance
Provides for learning and/or improvement opportunities that advance mission, vision, and strategic plan

in the United States. They also generate the guidelines used by hospitals for the treatment of acute and chronic strokes. Visit the Brain Attack Coalition website for more details: *www.stroke-site.org*.

Disease-Specific Advanced Certification for Comprehensive Stroke Centers (CSC) was implemented in 2012. The CSC requirements are more rigorous and require additional technology and resources in comparison to the advanced certification for primary stroke centers. As of this writing, HFAP and The Joint Commission are introducing stroke certifications as well. Programs considering this certification must be located in a Joint Commission–accredited organization.

Healthcare staffing

Firms that provide temporary clinical staff to hospitals and other healthcare agencies have been eligible for certification since 2004. This includes staffing agencies that provide nurses who work on either a per-diem or a multiweek traveling basis, physicians providing care under a locum tenens contract, or other clinical staff members placed temporarily. Both the corporate entity and individual offices of staffing agencies can be certified. The benefit of hospitals in using certified staffing agency personnel is that the same requirements apply to these firms, such as human resources standards, data collection, and review for PI activities, to name a few. These staffing firms must undergo a rigorous process to be certified. When you consider that the temporary staffing industry is basically unregulated, it makes sense to use vendors that have been externally evaluated when needed. Approximately 360 staffing firms are certified.

Palliative care

The advanced disease-specific certifications continue to expand. The Advanced Certification Program for Palliative Care, which was launched in 2011, recognizes hospital inpatient programs that demonstrate exceptional patient- and family-centered care and optimize the quality of life for patients (both adult and pediatric) with serious illness.

Primary-care medical homes

With a focus on the coordination of care, access to care, and the connection and collaboration of the primary care physician and team working with the patient and their family, this certification was launched in 2011. As we move deeper into federal healthcare reform efforts, this certification helps to provide a consistent focus on the continuum of care, as well as efficient, effective, and quality care.

Integrated care

The voluntary Integrated Care Certification (ICC) introduced in 2015 recognizes organizations across the healthcare continuum that strive to provide seamlessly coordinated patient care, no matter what kind of treatment the patient receives or where. To pursue certification, only one component that is going to be reviewed as part of your integrated care program has to be accredited by The Joint Commission. The ICC standards focus on functions and processes supporting integration, an established set of risk-screening criteria though the program, care coordination and case management that is not duplicative, and collection measurement, and analysis of data to drive improvement across the continuum. While all other certifications are valid for a two-year or 24-month cycle, this certification is valid for three years or 36 months, similar to hospital accreditation.

As government payers are focusing on value-based payment models, CMS is pushing for bundled payments and accountable care organizations. We are seeing commercial payers also moving to create incentives. In 2016, Anthem Blue Cross and Blue Shield in Ohio and affiliated health plans in 13 other states introduced incentive payment to providers that receive ICC. The hope is these financial incentives linked to evidence-based medicine and best practices will ultimately improve outcomes.

IMPORTANT NOTE

Unlike accreditation, certification is on a biennial cycle, so on-site reviews are conducted every two years at these organizations. Intracycle conference calls are held during the year in between to discuss progress and status of performance measures and improvement initiatives. This coincides with licensure, reappointments, etc.

Unannounced Survey Process

As the result of a CMS directive, unannounced surveys for organizations started in 2006. If you are undergoing a deemed status survey, your visit will be unannounced except in certain circumstances, such as for durable medical equipment or small-office practices. Organizations new to accreditation can state preferences for when they would like to have their initial survey conducted.

Once an initial survey has been completed, organizations can be resurveyed anywhere from 18 to 36 months later. You will hear a lot of discussion about whether your organization is in its "window for survey," meaning that the clock is ticking for your next on-site survey, because it has been more than 18 months since your last survey.

The timing of on-site surveys is based on preestablished criteria generated from priority-focused process data and other data sources. In situations where the data suggest that patient safety and quality are potentially at risk, an organization may be scheduled for an earlier survey.

The methods for calculating survey intervals are known by The Joint Commission and are not fully disclosed to accredited organizations. Many speculate that there is an internal process using a score generated from data collected by The Joint Commission on each organization similar to the Strategic Surveillance System (S3). It is thought that a hospital with multiple complaints, a for-cause survey, several sentinel events, high-profile news, or a downward trend in core measures might be the trigger for increased frequency of or a decrease in the time between surveys.

IMPORTANT NOTE

Scheduling surveys is a complex process. Most surveyors don't work full time, so they need to tell the central office staff when they can be available to travel in the near future. The survey scheduler in accreditation operations must gather all the dates when surveyors are available. Staff members then need to match the available types of surveyors to the specific survey complement that is needed for your organization. This sounds easier to execute than it is. When a surveyor gets sick or injured or is delayed out of a city, the scheduler must execute a backup plan. For example, the scheduler may try to find a specific replacement (such as a cross-trained surveyor), reroute an existing group, or, as a last resort, reschedule the survey. You won't know about any of this, because the survey date is unannounced to you, and all of the activity is happening behind the scenes. As mentioned, some surveyors are cross-trained to more than one program, so if a nurse is needed for a homecare survey, a nurse planned for a hospital survey may be reassigned to the homecare survey. Then a substitute needs to be assigned to the original hospital survey. So a number of factors are involved in getting just one survey scheduled, never mind 1,000 of them annually. You will know when your survey is to be conducted when the surveyors present on-site in your lobby. The survey event and the surveyors assigned will be viewable to you on your extranet site.

Chapter 1 Quiz

1. True or false: If your hospital wants reimbursement for Medicare and Medicaid, it must seek accreditation from a CMS deeming authority.

   Answer: False. Accreditation is voluntary. Should you choose not to seek accreditation voluntarily, you must undergo a CMS survey, typically conducted by state surveyors.

2. True or false: If your hospital wants reimbursement for ventricular assistive devices implanted in Medicare or Medicaid patients, it must seek certification from a CMS deeming authority.

   Answer: True.

3. If you are in your survey window, the most effective way to prepare for your on-site survey is to do what? Circle all that apply.

   a. Prepare a variety of agendas, taking into consideration your services and operational variances.

   b. Keep the e-app current with your organization's leader and services.

   c. Continue internal tracer activity to keep staff members engaged and prepared.

   d. Prepare the documents that are not time sensitive, such as your current emergency and PI plan.

   Answer: All of the above.

4. True or false: The Disease-Specific Care Certification Program runs on the same triennial cycle as the hospital, and its decision is not factored into the hospital's accreditation process.

   Answer: False (mostly). Although the certification decision does not affect the hospital's accreditation, the on-site visits occur more frequently—once every two years. However, if the reviewer identifies a serious issue on site, the Office of Quality Management will be notified for a decision as to whether further hospital follow-up is indicated at that time. The newly introduced ICC is on a triennial schedule.

5. True or false: Standards are scored at the Element of Performance level.

   Answer: True.

The Survey Coordinator's Handbook

18th Edition

Jodi L. Eisenberg, MHA, CPHQ, CPMSM, CSHA

The Survey Coordinator's Handbook, 18th Edition, is the ultimate resource in survey prep for all accreditation professionals no matter their experience! This handbook walks you through every step of preparation, explaining key problem areas and highlighting major focuses for surveyors. Not only does it provide insider information on how to prepare for, survive, and respond to a hospital survey, it also provides historical context about the accreditation process to help new and veteran survey coordinators understand the why as well as the how.

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