The Survey Coordinator’s Handbook
16th Edition

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

The Survey Coordinator’s Handbook is the trusted resource thousands of accreditation professionals have relied on for years. This annual guide is the one-stop shop for new and experienced accreditation professionals. Updated to reflect the growing importance of CMS survey preparation, the book not only provides 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.

This book will give you:

- The core information every new and returning survey coordinator needs to get up to speed on accreditation survey preparation, including CMS and Joint Commission processes
- Chapter-by-chapter tips for survey readiness and compliance
- Advice from industry veterans on what to do before, during, and after your survey visit
- Overviews of problematic survey components
- Follow-up tips for post-survey actions
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About the Author

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

Jodi L. Eisenberg, MHA, CPHQ, CPMSM, CSHA, was recently appointed the principal consultant accreditation and clinical compliance services for University Health Consortium (UHC). UHC is an alliance of academic medical centers and their affiliated hospitals, representing majority of the nation’s academic medical centers. In this role, she will lead the efforts at UHC to evaluate the current state across the healthcare environment and make recommendations for effective future state orientation, transformation and process development. The primary function of this role is to help members develop their continuous survey readiness process, improve their accreditation survey outcomes and ultimately ensure a focus on quality and patient safety.

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 is the programmatic direction for the design, development, and oversight of the hospital and departmental policy and procedure-management system. She has served as faculty to the HCPro Accreditation Boot Camp as well as faculty to the University Health Consortium Accreditation Specialist Orientation Program.
Additionally, Eisenberg serves as an editorial advisor for *Briefings on The Joint Commission*, published by HCPro, a division of BLR. She is the original author of the *Survey Coordinator's Handbook*. She is the co-author of *Performance Improvement: Winning Strategies for Quality and Joint Commission Compliance*—published by HCPro, Inc.—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, Inc., 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, professional in medical staff management, and a specialist in healthcare accreditation.
Acknowledgments

It is hard to believe this is the 16th edition of the *Survey Coordinator’s Handbook*. I can remember working on the first edition early in my career with the hopes that it would help others that were new to accreditation. I would like to acknowledge a few people who had the vision and the ability to create the accreditation coordinator role at Northwestern Memorial Hospital twenty-one years ago: Cynthia Barnard, director of quality at Northwestern Medicine and Larry Goldberg, Loyola University Health System President and CEO. And to the leadership at Northwestern Medicine who have challenged me to grow and supported me over the years: Dean Harrison, chief executive officer for the System; Dennis Murphy, former chief operating officer; Julie Creamer, senior vice president of operations; Jay Anderson, vice president and chief information officer; Gary Fennessy, vice president operations; Maureen Slade, associate chief nurse executive and Kristin Ramsey, associate chief nurse executive and vice president of surgical services and my partners in crime Amy Galat, director of emergency management and Dan Zahorik, project director of property operations. There are countless others who have provided collaboration and advise over the years.

Having recently left my role at Northwestern Medicine after a 20-plus year tenure, I rounded on the units one last time before I bid them farewell. Working with the front line staff has always been the highlight of my days at NM. Too often we get caught up in the business of healthcare but what truly has made my time at NM valuable is the people and the care they provide. I am thankful for the care they have provided to me and to my family over the years. The relationships that I have had the pleasure of encountering have helped me to grow professionally and personally. For that I will be eternally grateful.

As my tenure at NM comes to a close, it is hard for me to imagine not having my leader, my mentor, my friend Cindy at my side. She has taught me well and I will always be indebted to her for the opportunities, the challenges and the faith she has had in me over the years.

As in past editions, we would like to thank those experts who have contributed to the content and whose input continues to be part of the building blocks of this handbook: Brad Keyes, CHSP; Elizabeth
Di Giacomo-Geffers, RN, MPH, CSHA, CNAAR(r); Gayle Bielanski, RN, BSN, CPHQ; Maureen Connors Potter, RN, BSN, MSN; and Donna Woodkey-Dinsmore, RN, MBA: Thank you for the tools, comments, and information you have provided in previous editions, which still appear as a part of the structure of this book.

And past handbook authors Laure L. Dudley, RN, MSN, CSHA, Patricia Pejakovich, RN, BSN, MPA, CPHQ, CSHA, and Jean Clark, RHIA, CHSA: Your efforts laid the groundwork for this series and should not go unnoted. Thank you both for your work on earlier editions of this book. To Jean Clark, my coauthor in previous editions, my partner in the Accreditation Boot Camp, and my friend... thank you for your friendship and mentorship over the years.

To the guy who pulls the details all together to produce a great book, Matt Phillion, HCPro editor, who has kept me on track with many projects over the years. His patience, sense of humor, and expertise has proved invaluable in creating solid and informative resources for both new and experienced accreditation coordinators.

Finally, to all of you who are reading this book, remember, the next visit will happen... whether it is The Joint Commission, CMS, DPH, or another regulatory body with an acronym... just take a deep breath... you are doing great work at the bedside and that will shine through!
Accrediting organizations, including the federal government, have come under continuing pressure to ensure ongoing oversight of healthcare organizations, beginning with the Institute of Medicine’s report published in 1999 “To Err Is Human,” in addition to negative media reports, complaints from patients, and increased scrutiny of the Centers for Medicare & Medicaid Services (CMS). Increased oversight of the surveillance process has increased the probability of the number and frequency of unannounced surveys, whether by CMS or by one of the accrediting bodies with deemed status.

This book is intended for the person or persons in the facility who will be the primary point of contact and liaison between their healthcare organization and the regulatory agency. An overview of the history and evolution of the accreditation process is provided 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. The survey coordinator can make a positive impact on patient care daily through partnership with operational leaders and effective management of time, resources, and staff. The goal is to move the organization from the mentality of complying because CMS or the accrediting body says so to providing effective, efficient, and safe patient care and, as a byproduct of that, complying with the rules and regulations. This involves keen listening skills, knowledge of the sources of truth, collaboration with frontline staff members and operational leaders, and an ability to be open to continuously learning and improving.
Introduction

This handbook not only provides an overview of the regulations and the process, it contains suggestions for managing the process prior to, during, and after regulatory visits. Also contained in the handbook are many helpful figures and forms, many of which are currently in use by survey coordinators across the country. While these are merely illustrations from selected settings, we believe that they will provide clarity around the recommendations and provide you with a running start to establishing a continuous readiness program within your healthcare organization.
CHAPTER 1

Accreditation at a Glance

Accreditation evolved from a minimum set of healthcare standards developed by a group of surgeons, to standards promoting optimal quality, and finally to an era focused on patient safety and outcome measurement and management. The evolution began in the early 1900s and continues today.

The easiest answer to the question why accreditation matters is that most healthcare organizations need accreditation in order to be eligible for Medicare. Accreditation has become a symbol of credibility to insurers, health plans, and patients. The primary intent of accreditation is to ensure that the hospital adheres to basic standards and provides consistent quality care.

This chapter provides an overview of the accreditation process to help you understand the role it has played in influencing healthcare policy and practices. For those who are new to the field of accreditation, this chapter summarizes the types of services accrediting agencies provide and includes an overview of the accreditation and certification programs available. This review is also intended to provide you with a general scope of the issues facing most organizations every day in regards to integrating continuous survey 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.

History of Accreditation

The timeline in Figure 1.1 provides you with a glimpse of how healthcare standards came into formation. 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 these outcomes, hospitals could evaluate their processes and procedures to gauge whether they needed to make improvements.

His innovative thinking resulted in a forced separation of practice from 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 the methods 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. There were just five standards 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 JCAH. In 1952, ACS transferred its standardized program to JCAH, which began to provide voluntary accreditation to hospitals beginning 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. The federal legislation stated that hospitals accredited by JCAH would be “deemed” to be in compliance with most of the Medicare CoP for hospitals. This allowed The Joint Commission to bypass the routine renewal process for maintaining deeming authority. It was able to create and modify requirements outside the realm of the basic CoP.

These CoP are the minimum requirements 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 Joint Commission 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.

An evaluation 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 minimal review of the actual process of care on the patient care unit.

During this period, staff members usually considered the Joint Commission 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 issues.

Change in approach

In 1994, The Joint Commission unveiled its Agenda for Change and overhauled the Accreditation Manual for Hospitals or 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 emphasis of the standards and survey process pointed to actual outcomes and results, rather than relying solely on measures of structure, process, or documentation.

This approach also placed new demands on hospital staff members. Before the changes, many departments had to concern themselves with only 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, departments had to become familiar with requirements outside 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.

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 method of 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. Therefore, an evaluation of the overall process was undertaken.
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 highly recognized name in the healthcare market, this is not the case among the general public. The public understands that someone is overseeing hospitals, but it doesn’t really understand the process. When 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.

In addition to consolidating standards, The Joint Commission changed how it scored the standards and required hospitals to complete a PPR—a lengthy, mid-cycle 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.

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 same 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 the patient received.

Surveyors 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 were 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 became easy to support and adopt. To this day, the nursing industry tends to be very supportive of these efforts.

As the number of deemed agencies grows and the focused emphasis on quality and outcomes continues, accreditation agencies, the Centers for Medicare & Medicaid Services (CMS), and, most importantly, patients expect an organization to be continuously focused on the quality and safety of 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?**

It’s important to note that at the time of this writing, The Joint Commission is likely 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 currently one of four entities that have received hospital deeming authority from the 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 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 the 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.

CMS is the primary deeming authority and has granted deemed status to the organizations outlined in Figure 1.2.
Joint Commission remains the agency that accredits the largest number of healthcare organizations. All of these agencies conduct surveys as agents of CMS; although their standards may be written a bit differently, they are all linked to the CMS CoPs. Therefore, much of what is discussed crosses requirements in each accreditation program, and regardless of the agency chosen to accredit your organization, you will benefit from adopting the concept of continuous survey readiness or, better phrased, continuous readiness for patient care. Refer to the supplemental report by Elizabeth Di Giacomo-Geffers at the end of this chapter for a wealth of information on CMS and accrediting organizations and how they currently compare.
## Figure 1.3  |  Survey Planning Session Documents

### Survey Planning Session Documents

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<td>Survey confirmation and agenda</td>
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### Day of Survey Documents

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<td>Lists of scheduled surgeries</td>
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<td>Current ambulatory/dx testing list of patients</td>
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### Performance-Improvement (PI) Data

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### Accreditation at a Glance

#### Figure 1.3  |  Survey Planning Session Documents (cont.)

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<td>Quarterly</td>
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<td>Environment of Care meeting minutes (12 months)</td>
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<td>List of all contracted services to include nature/scope of services provided</td>
<td></td>
<td>As needed</td>
</tr>
<tr>
<td>!</td>
<td>Agreement with outside blood supplier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>!</td>
<td>Grievance policy (Patient-Care Policy 5.42)</td>
<td></td>
<td>Annual</td>
</tr>
<tr>
<td>!</td>
<td>Governing body minutes to verify compliance with budget requirements</td>
<td></td>
<td>Annual</td>
</tr>
<tr>
<td>!</td>
<td>Credential files to verify appropriate clinical leadership/oversight for anesthesia, respiratory, and emergency services</td>
<td></td>
<td>Reappointment interval</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Accreditation Survey Activity List</th>
<th>Suggested Schedule Time (minutes)</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyor arrival and preliminary planning</td>
<td>First day (60)</td>
<td></td>
</tr>
<tr>
<td>Opening conference and orientation</td>
<td>First day (60)</td>
<td></td>
</tr>
<tr>
<td>Surveyor planning initial</td>
<td>First day (60)</td>
<td></td>
</tr>
<tr>
<td>Individual tracer (one per surveyor)</td>
<td>Each day (60–120 minutes each tracer)</td>
<td>Units/visits to be determined day of survey</td>
</tr>
<tr>
<td>Lunch</td>
<td>Each day (30)</td>
<td>Surveyors only</td>
</tr>
<tr>
<td>Issue resolution</td>
<td>End of day as necessary (30)</td>
<td>Surveyors and organization participants as applicable</td>
</tr>
<tr>
<td>Team meeting/surveyor planning</td>
<td>End of day except first/last day (30)</td>
<td>Surveyors only</td>
</tr>
<tr>
<td>Organization meeting</td>
<td>End of day (30)</td>
<td>Hospital participants only</td>
</tr>
<tr>
<td>Daily briefing</td>
<td>Each day/start of day (30)</td>
<td></td>
</tr>
</tbody>
</table>
Note that being accredited by any of the agencies with deeming authority doesn’t eliminate the possibility of a CMS survey. CMS can opt to conduct a post-accreditation validation survey at any time. CMS may also 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 they can ensure standards compliance at virtually any time. Therefore, it is essential to move beyond being compliant for any particular regulatory agency and to focus instead on being compliant in providing efficient, effective, and safe patient care.

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. Most hospitals note that they 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.

Although there are multiple deeming authorities in the hospital market, The Joint Commission remains the largest. 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 NPSGs. 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 beginning in 2003. This focus on high-risk, problem-prone areas with a spotlight on transparency has made an 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 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 a mandatory consideration, as they are linked directly to reimbursement by CMS and some third-party payers.

To determine whether a service falls within the tailored survey option, organizational and functional integration criteria are provided. 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, among them 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 take note: The Joint Commission still maintains a cooperative agreement with both the College of American Pathologists and the Commission on Office Laboratory Accreditation 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 back adverse findings to the designated accrediting body for follow-up consideration. Refer back 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 new (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 sub-acute 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 the government’s estimate that there are more than 16,000 nursing homes in the United States.

It is important to note that 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; as well as 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.
Chapter 1

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 affect the quality and safety of care, such as disease-management programs. 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 with the American Heart Association.

Many organizations struggle with whether to move forward with disease-specific certification. It is beneficial to develop guiding principles to gauge the return on investment. A sample set of guiding principles is included in Figure 1.4.

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

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

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 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 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.

Important note: Programs considering certification must be located in a Joint Commission–accredited organization.

**Healthcare staffing**

Firms providing temporary clinical staff to hospitals and other healthcare agencies have been eligible for certification since 2004. This includes staffing agencies that provide nurses who are 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 go through a rigorous process to be certified. When you think about the fact 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.
Chapter 1

**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.

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**

Based on 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 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 surveys or a decrease in the time between survey.
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 then gather all dates that 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 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.

Supplemental information

CMS and accrediting organizations: a look at how different accrediting organizations stack up

Editor’s note: Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, is a healthcare consultant in Trabuco Canyon, Calif., and a former Joint Commission surveyor.

Each fiscal year, the CMS releases a financial report, and included in this tome-like document is an interesting bit of information for hospitals who use accrediting organizations—CMS performs a side-by-side comparison of what each organization does and how they stack up to each other in terms of survey processes and procedures, training, oversight, and enforcement.

This review involves not only hospitals but all accrediting organization (AO) programs covered by CMS, including critical-access hospitals (CAH), home health agencies, hospices, ambulatory care centers, psychiatric hospitals, outpatient physical therapy and speech language pathology services, and rural health clinics.

CMS reviews all of these organizations to determine whether the organization can adequately ensure compliance with Medicare requirements by:

- Implementing necessary reporting requirements, including electronic reporting methods
- Expanding the validation survey program, which is intended to ensure the effectiveness of AOs and identify areas of risk and noncompliance
- Providing ongoing education for AO staff

One of these bullet points is of particular importance for healthcare organizations: expanding the validation survey program. Tangential evidence over the past few years has indicated that hospitals are seeing more and more validation surveys by CMS post-survey by their own AO, and these validation surveys are checking up on the AO’s compliance as much as on the hospital’s.
The Joint Commission Survey Coordinator’s Handbook, 16th Edition

Chapter 1

The CMS report, available online at http://tinyurl.com/bc6qbpg, examines:

- The scope of AO activities
- CMS approval of accreditation programs
- AO survey activities and assessment of compliance
- State Survey Agency (SA) validation of AO surveys
- Validation surveys for long-term care hospitals
- Program improvements reported by the AOs
- CMS management and oversight of AOs
- The first of the accompanying charts is a who’s who of AOs and the CMS programs for which they accredit.

**Number of surveys**

Although more and more competition arises, The Joint Commission maintains the lion’s share of accredited facilities in the programs for which it accredits. The second accompanying chart is a breakdown of the number of surveys conducted across the board in each program, both new and renewal. The Joint Commission still accredits 3,410 hospitals, for example, and conducted 36 new surveys and 1,143 renewal surveys in 2012. By comparison, the Healthcare Facilities Accreditation Program (HFAP) accredits 184 organizations, conducting 14 initial surveys and 74 renewals. The third major player in the hospital accreditation field, Det Norske Veritas (DNV), Inc., deems 174 hospitals, with 63 initial surveys and four renewals.

According to CMS, all AOs experienced growth between fiscal years 2008 and 2011. This is largely due to increases in the number of home health, hospice, and ambulatory care center facilities.

<table>
<thead>
<tr>
<th>Approved Accreditation Organization Programs (F Y 2011)</th>
<th>Hospital</th>
<th>Psych Hospital</th>
<th>Critical Access Hospital</th>
<th>Home Health Agency</th>
<th>Hospice</th>
<th>Ambulatory Surgery Center</th>
<th>OPT*</th>
<th>Rural Health Clinic</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAAHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAAAS F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AOA-HFAP</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNVHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>JC</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>19</td>
</tr>
</tbody>
</table>
Survey results

Now we know the number of surveys the field saw last year—but what came from those surveys? Our third accompanying chart delves into that question, comparing the findings in 60-day validations surveys by the number of condition-level deficiencies found by the AO, by the state agency during the validation survey, and the disparity rate.
### 60-Day Validation Survey Results for Each Facility Type (FYs 2008 Through 2011)

<table>
<thead>
<tr>
<th>Facility</th>
<th>60-day Validation Surveys</th>
<th>SA: Condition-level Deficiencies</th>
<th>Missed by AO</th>
<th>Disparity Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FY 2008</td>
<td>FY 2009</td>
<td>FY 2010</td>
<td>FY 2011</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>92</td>
<td>89</td>
<td>104</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>43</td>
<td>39</td>
<td>47</td>
<td>36</td>
</tr>
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<td></td>
<td>30</td>
<td>32</td>
<td>40</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>36%</td>
<td>38%</td>
<td>44%</td>
</tr>
<tr>
<td>CAH</td>
<td>17</td>
<td>22</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>16</td>
<td>16</td>
<td>11</td>
</tr>
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<td></td>
<td>7</td>
<td>15</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>41%</td>
<td>68%</td>
<td>65%</td>
<td>45%</td>
</tr>
<tr>
<td>HHA</td>
<td>21</td>
<td>51</td>
<td>76</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>9</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>8</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>14%</td>
<td>18%</td>
<td>14%</td>
<td>18%</td>
</tr>
<tr>
<td>Hospice</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>25%</td>
<td>5%</td>
</tr>
<tr>
<td>ASC</td>
<td>38</td>
<td>29</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>12</td>
<td>NA</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>12</td>
<td>NA</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>42%</td>
<td>41%</td>
<td>NA</td>
<td>45%</td>
</tr>
</tbody>
</table>

NA: Not applicable because 60-day validation surveys were not conducted.

---

### Hospital 30-Day Validation Survey Results by AO (FYs 2008 Through 2011)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>TJC</th>
<th>AOA/HFAP</th>
<th>DHCPSC*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Validation Sample</td>
<td>269</td>
<td>66</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>SA: Condition-level Deficiencies</td>
<td>118</td>
<td>33</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Missed by AO</td>
<td>91</td>
<td>29</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Disparity Rate</td>
<td>34%</td>
<td>44%</td>
<td>50%</td>
<td>NA</td>
</tr>
<tr>
<td>Sampling Fraction</td>
<td>.07</td>
<td>.06</td>
<td>.06</td>
<td>.03</td>
</tr>
</tbody>
</table>

NA: Not applicable due to sample size less than five or because SA cited no condition-level deficiencies.

* DHCPSC: hospital accreditation program received initial CMS approval September 2008.
Interestingly, according to CMS, the AOs missed at least a third of the condition-level deficiency findings. In 2008, there was a disparity rate in the hospital programs between findings of 33%; in 2011, that rate jumped to 44% (though with fewer validation surveys).

According to the CMS report, with the exception of home health agencies (and hospices in 2011), the disparity rate for the score for each facility type exceeds the 20% threshold established in the regulations. That 44% disparity rate means that AOs, for hospitals, did not cite comparable serious deficiencies as the stage agency did for almost half of the hospitals surveyed.

Both more and less telling is the breakdown between different AOs for these disparity rates. Note on our fourth accompanying chart how The Joint Commission stacks up against DNV and HFAP from 2008 to 2010. According to CMS data, all AOs were consistently over the 20% threshold for the time periods covered.

Although The Joint Commission appears to have the upper hand, with a 34% disparity rate versus 43% for DNV and 80% for HFAP, The Joint Commission also surveyed exponentially more hospitals: 268 for The Joint Commission versus 10 for HFAP and seven for DNV, with 91 missed deficiencies for The Joint Commission versus eight for HFAP and three for DNV. The percentages are clearly at the mercy of small sample sizes.

These figures represent 6% of surveys covered by The Joint Commission from 2008 to 2010 and 7% in 2011, and 6% for both HFAP and DNV during the entire time period.
### Chart Five

#### Number and Type of Condition-Level Deficiencies Cited on 60-Day Validation Surveys (FY 2011)

<table>
<thead>
<tr>
<th>MEDICARE CONDITIONS</th>
<th>CITED BY STATE AGENCY</th>
<th>MISSED BY ACCREDITATION ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong> Sample: 73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Environment</td>
<td>28</td>
<td>26</td>
</tr>
<tr>
<td>Governing Body</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Patient Rights</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Infection Controls</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>62</td>
<td>51</td>
</tr>
</tbody>
</table>

| **Home Health Agency** Sample: 77 |
| Skilled Nursing Services | 8                     | 4                                   |
| Acceptance of Patients, Plan of Care | 7                     | 2                                   |
| Comprehensive Patient Assessment | 7                     | 5                                   |
| Organization Services  | 5                      | 3                                   |
| Other Conditions      | 17                     | 10                                  |
| **TOTAL** | 44                     | 24                                  |

| **Critical Access Hospital** Sample: 20 |
| Physical Environment | 10                     | 8                                   |
| Other Conditions     | 3                      | 3                                   |
| **Total**            | 13                     | 11                                  |

### What is being missed?

Chart five is a comparison of the number of facilities cited by state agencies for specific condition-level deficiencies and the number of surveys where the AOs missed citing comparable deficiencies.

For those following the most-cited standards by their own AO, the list should come as no surprise. Physical environment topped the list, and despite being one of The Joint Commission’s own most-cited standards, CMS found that organizations missed 26 out of 28 condition-level deficiencies in this area. (This standard was the top cited in the previous three years as well.) In addition, 28 of 73 hospitals surveyed were found with condition-level deficiencies, compared to 39 out of 104 in 2010.
In FY 2010, CMS life-safety engineers completed an analysis of physical environment findings for 60-day validation surveys conducted in hospitals from 2006 though 2009. This information was presented in early 2011 as a means of improving CMS’ life safety survey processes.

The majority of the physical environment disparity consists of Life Safety Code® (LSC) deficiencies, and the CMS life-safety surveyors identified the top 10 disparate LSC deficiencies cited by stage agencies but not the AO. These top 10 deficiencies held true in 2011. Additionally, there was a gap in the average number of life-safety surveyor hours per survey provided by the AO versus the stage agency.

Recently, however, The Joint Commission has taken issue with the application of CMS standard citation practices when evaluating life safety compliance, CMS states in its financial report. The Joint Commission has also raised questions about what it believes is a disproportionate use of state resources for surveying life safety. The AO has suggested that a cost-effective survey process focuses on other areas more important to patient safety.

According to CMS, the organization considers fire safety requirements statutorily required for hospitals but will continue to work with The Joint Commission as well as with the other AOs to address their concerns.

Other areas of overlap with the most-cited list of Joint Commission standards include infection control, quality control, and governing body requirements. Infection control in particular appears to be improving, however, with only five condition-level deficiencies found and only one of those missed by the AO.

Simply put, all of the most commonly found deficiencies tied in very clearly with past years’ findings.

**Full, denial, pending**

It is always interesting each year to get a look at how the different organizations stack up to each other in terms of accreditation decisions. Denial of accreditation is, of course, the worst case possible, but how often does this actually happen?

CMS reports on all AOs and their accreditation decisions in this year’s report. For simplicity’s sake, let’s take a look first at the hospital program and its three AOs (The Joint Commission, DNV, and HFAP).

HFAP surveyed 88 hospitals in 2011 and awarded full accreditation to 98% of hospitals surveyed.

CMS notes that during 2010 and 2011, HFAP performed well in performance measures under the categories of timeliness, electronic submission of facility notification letters, and formatting survey schedule submissions. It also showed substantial improvement for timely triennial surveys and two notification letter measures. HFAP hit 100% compliance for four out of 10 compliance measures in 2011.
DNV, Inc., conducted a total of 66 surveys in 2011. DNV awarded full accreditation to 99% of hospitals surveyed and 100% of CAHs surveyed. One survey result was pending at the time of the CMS report.

For 2010 and 2011, DNV performed well on timeliness and accuracy, electronic submission of facility notification letters, and several survey schedule submissions. It achieved 100% level for timely triennial survey and two facility notification letters measures. In total, DNV achieved 100% level for eight of 10 categories.

The Joint Commission had by far the most hospital surveys in FY 2011, with 1,179 hospitals surveyed (mostly reaccreditation surveys—just 36 of these surveys were initial). Most (82%) of the hospitals received full accreditation.

According to the CMS report, The Joint Commission performed well on accuracy of submissions, electronic submission notification letters, and formatting survey schedules. The accreditor saw substantial improvement into 2011 in the areas of timeliness of submissions, timely triennial surveys, and timeliness of survey schedules reaching 100% for all of these measures. The Joint Commission also saw substantial improvement for facility notification letters (where there is still opportunity for improvement). In total, The Joint Commission received 100% scores in six of 10 CMS measures.

**Increased validation surveys**

Although it has been noted for some time that CMS is conducting more frequent validation surveys for all AOs, it is interesting to note that this year’s financial report directly addresses and confirms this.

According to the financial report, over the last few years CMS has increased the number of validation surveys it conducts. Until recently, budget constraints have significantly limited the number of sample validation surveys the organization could afford to conduct.

In recent years, more federal dollars have been made available for validation surveys. Interestingly, according to the financial report, although validation surveys have increased in total—and there has been a marked increase in surveys conducted at hospitals—those total survey numbers are now spread out among all programs, not just hospital accreditation.

There has been a 221% increase in validation surveys from 2007 to 2011 (just 90 surveys in 2007, 289 surveys in 2011). During that same time frame, validation surveys for nonhospital programs has increased a staggering 423%—35 surveys in 2007 and 183 surveys in 2011. Hospitals specifically did see almost double the amount of surveys (a 93% increase in that same time frame).
AAAHC to Launch Hospital Accreditation Program

The Accreditation Association for Ambulatory Health Care (AAAHC)—a longtime accrediting body for ambulatory facilities—has announced that it will enter the hospital accreditation space with its new hospital systems program.

The program will be offered through the Accreditation Association for Hospital/Health Systems (AAHHS) and operate separately from the ambulatory accreditation body under an umbrella organization, the Accreditation Association.

According to AAAHC president and CEO John Burke, PhD, the initial spark for this move was the trend toward accountable care organizations (ACO) and other factors that have pushed more primary care and freestanding ambulatory care settings back into hospital settings.

This new board will oversee the development of an accreditation program by and for hospitals. The Accreditation Association will also be formed, with its own board of trustees to link this new hospital body with the parent organization, the AAAHC.

The new hospital program will be developed by hospital professionals for hospitals, using the knowledge, culture, and philosophy developed over 33 years of ambulatory accreditation experience.

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**Key points: Readiness and sustained compliance or proactive preparation for sustained compliance**

1. Review top compliance issues with CMS and the accrediting organization or agency, as applicable to your organization
2. Develop a sustained compliance model (plan, implement, and evaluate)
3. Assign responsibilities to process owners
4. Educate and train process owners and team members
5. Present results to leadership and staff at least quarterly
6. Keep direct and indirect staff and physicians informed of progress
7. Share your excellence by publishing, presenting poster session(s), and/or public speaking.
8. Celebrate your success.
Chapter 1

Moving parts

Burke took a few moments to sit down with Briefings on The Joint Commission to discuss the development of this new program.

“It’s early in the process, but we’ve made significant progress already,” he says.

The first step was, of course, creating the already-mentioned hospital board.

“It had become clear to us that modern hospitals and growing health systems are now exploring new models to better coordinate care,” says Burke. “That includes clinical integration, and it’s having an impact on ambulatory care.”

What this means for AAAHC and its new umbrella organization is that there is a need to develop a clear and well-developed strategy before launching the new program.

The Accreditation Association will be a small board of trustees with limited powers—the organization wants to leave the development process to the operating bodies, the AAAHC and AAHHS.

AAHHS will focus specifically on small and rural hospitals early on in order to play to the existing expertise of the organization.

“An awful lot of what goes on in ambulatory care is going on in small and rural hospitals,” says Burke. “That’s why we’ve chosen to focus early on hospitals with 200 beds or less, both in rural and suburban/small community settings. We’re best suited to move in that direction.”

The organization has been busy over the past two years working with a large number of hospital groups to recruit members to the new board.

“The whole plan has been developed over the past [several years] but it has been implemented internally,” says Burke. “That takes some doing because obviously the AAAHC is being very unselfish in moving into the hospital arena—they recognize that it shouldn’t be an extension of the ambulatory program, but rather it should be a system developed for modern hospitals and healthcare systems.”

By getting the right people involved early, building the right focus groups, and gathering the right research, says Burke, the organization hopes to be able to develop a program that will be the right fit and meet the needs of smaller hospitals nationally and internationally.

“We need the right internal strategy to make sure we’ve got AAAHC constituent organization buy-in, but we also need an external strategy for organizations looking for an alternative option,” says Burke.
“We’ve finally reached the stage where we believe AAAHC and the Accreditation Association need to look at the modern healthcare system in the U.S. to bring our mission to the whole industry.”

This grew out of early experiences internationally.

“We’ve gone into Central and South America—a lot of organizations in the international community have our accreditation based on our experience in ambulatory areas,” says Burke. “You could call it accreditation for the modern healthcare system in the U.S.”

**National developments**

The ACO initiative and Medicare’s proposed revisions power this decision.

“The whole move toward clinical and vertical integration in the hospital arena” is key, says Burke.

The boundaries between types of healthcare programs are thinning.

“We’ve been told by a lot of people in the critical access area and rural hospital arena that a lot of what they do is actually ambulatory care,” says Burke.

For this reason, the organization already has a number of hospitals that have voiced interest in the possibility of a sister program to AAAHC for their hospital system.

“Our area of expertise will be useful to them,” says Burke.

The organization has also received feedback that many of these smaller organizations are looking for a partner in accreditation, a program they can trust to provide assistance that is tailored to their needs.

“We want to hopefully be that organization that is there to help them improve their quality of care in respective areas over time,” Burke says.

The program is still in the development process and will evolve as it grows closer to going live.

“Ideas will be refined and fine-tuned,” says Burke. “We recognize that hospitals are very different from ambulatory care facilities. We need to become expert in those areas.”

AAHHS has already begun developing a surveyor pool, having recruited between 30 and 40 surveyors with recent hospital or health-system experience.
Chapter 1

The next step will be development of standards.

“We have to develop standards and have to develop them in cooperation with the hospital community,” says Burke.

In preparation, the organization itself has undergone restructuring, with the two entities—hospital operations and ambulatory operations—becoming two organizations under the aegis of the Accreditation Association.

“We’re already well under way with the development of a launch plan. We want to make sure we don’t move too fast—we want to keep in mind our mission and resist the temptation to overcomplicate our strategy,” says Burke. “I always believe in keeping things as simple as possible.”

What’s Next?

The Conditions for Coverage are not new, says Burke, and the organization is expected to meet the same stringent requirements of other organizations applying for deeming authority.

“Any organization that wants deemed status by AAHHS will have to meet those requirements,” says Burke. “Beyond that, we’re going to design standards we think best meet the needs for improving quality in these smaller hospitals.”

AAHHS has not ruled out providing accreditation services for larger organizations as well.

“Our initial focus will be on smaller organizations, but we’re obviously ultimately hopeful to move into the large hospital arena,” says Burke. “We want to take it one step at a time. It’s important that we understand the hospital environment even better than we do now before thinking about large teaching hospitals.”

Burke stresses that they have not forgotten their commitment to ambulatory accreditation.

“We are expanding programs there, patient-centered medical homes, putting a lot of new resources into our managed care program to expand that, building a new staff, and of course we can’t overlook our long-term commitment to the core areas of ambulatory surgery, office-based surgery, and other key elements of the ambulatory program,” he says. “We’ve grown dramatically over the last few years. The past 12 years have been years of unprecedented growth. We feel that in order to sustain that growth and expand our mission, we need to explore new opportunities and new markets.”

Organizations need to not only fulfill their existing mission but grow as well, he says.
“We think we’ve developed a strong and vibrant program, and I think we’re going to do the same with hospitals,” says Burke. “There’s a need out there, a desire for options. We may be a better fit for some hospitals.”

**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. 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 OQM will be notified for a decision as to whether further hospital follow-up is indicated at that time.

5. True or false: Standards are scored at the EP level.

   **Answer:** True.
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