The Joint Commission: Understanding the Basics

Today, The Joint Commission accredits more than 15,000 healthcare programs in organizations throughout the United States. It is currently one of three entities with “deemed status” from the Centers for Medicare & Medicaid Services (CMS) that a hospital may select for accreditation.

This chapter will help you understand how The Joint Commission has evolved over time, how some of the changes have led to frustrations among hospital personnel and medical staff, and will provide you, the accreditation coordinator, with some tips on how you might approach changes as they continue to occur. For those of you unfamiliar with the scope of The Joint Commission, an overview of its multiple accreditation and certification programs are also listed with a reference to each program’s Web site for obtaining additional information.

Some of the significant changes in the survey process, such as tracer methodology, will be described, as well as the “dos and donts” we have learned in the past few years. This chapter is focused on the basics of The Joint Commission and is intended to supplement or summarize the information found in standards manuals.

Why Seek Joint Commission Accreditation?

Although accreditation is not required by law, not having it puts healthcare facilities at a disadvantage in terms of public image, competitiveness, and the capability to borrow money or float bond issues. But perhaps one of the most important issues to hospital operations is the “deemed status” with CMS that allows facilities to participate in Medicaid and Medicare as a third-party payer.
Without acquiring accreditation from The Joint Commission; the Healthcare Facilities Accreditation Program (HFAP), operated by the American Osteopathic Association; or recently approved DNV Healthcare, Inc., hospitals would not be eligible to bill Medicare and Medicaid. Looking at the payer mix of many hospitals, Medicare and Medicaid compose the majority of patient care revenue; thus removal from those programs would be a major dent in the bottom line.

Note: If you are unfamiliar with HFAP, log onto the Web site www.hfap.org to learn more about their accreditation program. See the case study at the end of the chapter regarding DNV Healthcare, Inc.

Joint Commission accreditation benefits your hospital financially, but compliance with The Joint Commission’s standards also can help fulfill the most important objective of all: providing safe, quality patient care. As an accreditation coordinator, have you often wondered how many hospitals would actually seek accreditation if the financial component was not a pressing issue? Indeed, to comply with the Joint Commission standards, hospital leaders and staff must be knowledgeable of the requirements, integrate standards into daily operations, and be willing to revise processes as needed while continuing to provide high-quality and safe services.

Although continuously preparing for a Joint Commission survey can be time consuming, labor intensive, and expensive, hospitals should seek to recognize the value that accreditation brings to the organization. With a few exceptions, the Joint Commission standards are operationally sound and focused on the delivery of patient care that keeps the patient safe and improves the patient’s healthcare experience. People who cannot support such objectives might want to seriously ask themselves why they are working in healthcare.

**Accreditation Services**

In addition to general hospitals, The Joint Commission currently provides accreditation services to a multitude of other healthcare organizations listed here.

Complex hospitals may elect to have separate surveys for their ambulatory, home care, long-term care or behavioral services. In this scenario, each service stands alone for the count of findings (requirements for improvement) and meeting the program-specific threshold for avoiding adverse accreditation decisions.
Each Web site listed in parentheses in the following sections takes you to a Web page with information specific to that program. We are providing this list in the event you are a new accreditation coordinator and are not aware of the extent of accreditation services provided by The Joint Commission.

**Ambulatory care services**

This includes outpatient surgery centers, rehabilitation facilities, infusion centers, group practices, and other outpatient services. As of 2004, the Accreditation Council for Graduate Medical Education requires university medical schools that provide clinical services to obtain ambulatory accreditation. ([www.jointcommission.org/AccreditationPrograms/AmbulatoryCare](http://www.jointcommission.org/AccreditationPrograms/AmbulatoryCare))

**Behavioral healthcare organizations**

This includes organizations offering the following services for patients: mental health services, treatment for chemical dependency, and mental retardation/developmental disabilities services. Acute care hospitals with a behavioral health unit may choose to use this accreditation program in addition to the hospital standards. ([www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare](http://www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare))

**Clinical laboratories**

Nearly 2,000 organizations with laboratory services, including freestanding laboratories and those connected with other healthcare organizations, are accredited by The Joint Commission. Many of you may only be familiar with CAP accreditation from the College of American Pathologists, but this is an alternative. ([www.jointcommission.org/AccreditationPrograms/LaboratoryServices](http://www.jointcommission.org/AccreditationPrograms/LaboratoryServices))

**Critical access hospitals**

These are hospitals that have a census of less than 25 patients and are located more than 35 miles from a hospital or another critical access hospital. A hospital certified by its state as necessary to provide healthcare services to residents in the area is also considered a critical access hospital. The critical access standards do vary somewhat from the hospital standards, so read carefully to identify those nuances. ([www.jointcommission.org/AccreditationPrograms/CriticalAccessHospitals](http://www.jointcommission.org/AccreditationPrograms/CriticalAccessHospitals))

**Home care organizations**

This includes organizations offering home health services, personal care and support services, home infusion and pharmacy services, durable medical equipment, and hospice services. ([www.jointcommission.org/AccreditationPrograms/HomeCare](http://www.jointcommission.org/AccreditationPrograms/HomeCare))
**Long-term care**
This includes nursing home facilities, including dementia programs, subacute programs, and long-term care pharmacies. The Joint Commission has been accrediting these organizations—more than 1,300 of them—for 40 years. ([www.jointcommission.org/AccreditationPrograms/LongTermCare](http://www.jointcommission.org/AccreditationPrograms/LongTermCare))

**Office-based surgery centers**
The Joint Commission accredits more than 40 outpatient settings, including oral surgeons, endoscopy suites, plastic surgery practices, and laser surgery clinics. ([www.jointcommission.org/AccreditationPrograms/Office-BasedSurgery](http://www.jointcommission.org/AccreditationPrograms/Office-BasedSurgery))

**Certification Services and Disease-Specific Care**
More recently, The Joint Commission began offering a variety of certification programs, listed below. An organization does not have to be Joint Commission–accredited to apply for a certification, but many Joint Commission–accredited organizations opt for certification in service areas, such as stroke. Following are the certification programs:

- Acute coronary syndrome
- Alzheimer’s disease
- Arthritis
- Asthma
- Cancer
- Chronic kidney disease (in partnership with the National Kidney Foundation, [www.jointcommission.org/CertificationPrograms/ChronicKidneyDisease](http://www.jointcommission.org/CertificationPrograms/ChronicKidneyDisease))
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Depression
- Diabetes
- Emphysema
• Epilepsy
• Healthcare staffing services (an evaluation of an organization’s staffing practices, such as verifying credentials and competencies of healthcare staff, www.jointcommission.org/CertificationPrograms/HealthCareStaffingServices)
• Hemophilia
• High-risk pregnancy
• HIV/AIDS
• Hypertension
• Inpatient diabetes (new in 2006, applies to organizations with patients who have a medical history of diabetes diagnosed and acknowledged by a treating physician, www.jointcommission.org/CertificationPrograms/Inpatient+Diabetes)
• Ischemic heart disease
• Low back pain
• Lung volume reduction surgery (for hospitals performing this procedure, www.jointcommission.org/CertificationPrograms/LungVolumeReductionSurgery)
• Migraines
• Multiple sclerosis
• Obesity/bariatric surgery
• Osteoporosis
• Parkinson’s disease
• Primary stroke (in partnership with the American Stroke Association, www.jointcommission.org/CertificationPrograms/PrimaryStrokeCenters)
• Sickle cell disease
• Transplant center (www.jointcommission.org/CertificationPrograms/TransplantCenterCertification)
• Ventricular assist device (VAD) (for hospitals performing VAD as a destination therapy, www.jointcommission.org/CertificationPrograms/LeftVentricularAssistDevice)
Joint Commission International

Launched in 1999, The Joint Commission’s international accreditation program has been growing over the past several years, accrediting dozens of organizations in more than 20 countries. This program accredits international healthcare organizations, including hospitals, ambulatory facilities, laboratories, medical transport agencies, public health agencies, and health ministries.

The Joint Commission’s international standards are based on international consensus standards, and the process is designed to meet legal, religious, and cultural factors. As part of building a more global presence, in recent years the organization developed The Joint Commission International Center for Patient Safety, a Web resource with links to a best-practices database and other helpful information for domestic or international organizations to maintain their accreditation.

For more information, visit www.patientsafety.org.

History of The Joint Commission

It is important that accreditation coordinators understand the evolution of The Joint Commission. It didn’t just spring up to make us struggle with compliance issues. It really began almost a hundred years ago and was based on the assessment of patient care. If nothing else, you will see that it was initially started by physicians and surgeons!

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 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. 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.”
Dr. Codman’s original documents remain stored in a vault, and a replica of his recommended processes are on display in the Center for Quality and Patient Safety at, ironically, Massachusetts General Hospital. Today, The Joint Commission continues to annually present the Ernest Amory Codman Award to recognize excellence in performance measurement.

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 on Accreditation of Hospitals (JCAH). In 1959, the CMA withdrew to form its own Canadian accreditation organization. An independent, nonprofit organization, the JCAH provided voluntary accreditation to hospitals beginning in January 1953.

The JCAH received its “deemed status” soon after, in the 1960s, when the federal government created the Medicare program. The government decided that if it was going to pay hospitals for the care given to 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 realized that it did not have the resources, personnel, or expertise to conduct evaluations.

In response to this dilemma, in 1965 Congress passed the Medicare Act. The legislation states that hospitals accredited by the JCAH would be “deemed” to be in compliance with most of the Medicare Conditions of Participation (CoP) for hospitals.

As previously stated, CoP are the minimum requirements hospitals still have to meet today to qualify for reimbursement from Medicare and Medicaid. With the passage of this act, the JCAH, a private organization, became an official inspection agency, and a Joint Commission survey was more like an audit than the educational experience it is today. Surveyors reviewed documents to determine whether policies and procedures were acceptable, whether people attended meetings, whether the organization addressed clinical problems, and whether top managers were competent. They also focused heavily on the safety and physical structure of hospital facilities.

In 1987, the JCAH changed its name to The Joint Commission on the Accreditation of Healthcare Organizations, or JCAHO, to better reflect the changing scope of its services and the organizations that it surveyed. The standards were department-specific, rather than cross-disciplinary, and organized by clinical department in the Accreditation Manual for Hospitals (AMH), which listed Joint Commission standards.
but not their meanings or intents. For example, the AMH included standard chapters that were specific to physical rehabilitation and radiation oncology departments.

A survey consisted of surveyors arriving at the hospital after months’ notice, spending lots of time in conversations with administration and subsequently burying themselves in paperwork. At hospitals, procedure manuals were removed from shelves, dusted off, and cover sheets were signed and readied for review. The “best” medical records were hand-picked and ready for the types of care that surveyors were most likely to inspect. If the surveyors traveled to your unit, it was more in the format of a tour and perhaps to engage in minimal conversation in an effort to impress upon staff that they really did matter when it came to patient care.

For those of us who worked in the hospitals during this era, a Joint Commission survey was considered more of a bother than useful to improving care. Deficiencies we were hoping would be exposed were not discovered or only discussed behind closed doors. The medical staff interview consisted of an extravagant lunch and discussions most generally centered on the attendees’ most recent golf game. Even if a hospital didn’t meet Joint Commission standards, it could continue to attract business, treat patients, and receive payment in full for its services.

But then things began to change. Between 1987 and 1994, The Joint Commission continued to survey healthcare organizations by reviewing documentation, with an emphasis on retrospective assessment. Behind the scenes, however, The Joint Commission had embraced ideas based on total quality management, put forth by W. Edwards Deming, and the concept of quality improvement. The accreditor started to rewrite its standards along those lines and called this process its “Agenda for Change.”

**Change in approach**

In 1994, The Joint Commission unveiled its Agenda for Change and overhauled the AMH, renaming it the Comprehensive Accreditation Manual for Hospitals (CAMH), and did away with the department-specific standards. The new standards were cross-functional and affected every department and staff member within an organization. The Agenda for Change placed a new emphasis on actual outcomes and results, rather than relying solely on measures of structure or process.

It also placed new demands on hospital staff. Before the changes, 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 the requirements of the Human Resources chapter, Infection Control, Performance Improvement, and so forth, as processes affecting their departments were now dispersed throughout the manual.

Unfortunately, the mindset of some line managers has not transitioned from the “departmental think” of the early ’90s into the cross-functional approach required today. For example, the Medication Management chapter is not applicable to only the pharmacy. Medication Management standards apply to any location where medications are stored or administered. (Because of this factor, consider asking a nonpharmacist to lead the Medication Management chapter team and staff the team with a pharmacist and representatives from other applicable departments, such as interventional radiology, materials management, operating room, and of course, nursing.)

Hospitals started to be surveyed on actual performance as well as on the quality of their plans or policies and how well 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 “gear up” for surveys by spending the year prior to the survey visit getting policies and procedures in shape and even painting and cleaning floors to create a good impression for surveyors. This system still didn’t seem the best way to measure what was really occurring in patient care.

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 this country.

The IOM report revealed that as many as 98,000 patients a year die 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 following five years and recommended that The Joint Commission focus greater attention on safety.

When these reports were published, the public lost its confidence in The Joint Commission and in healthcare institutions. Hospitals felt pressure from patients, and The Joint Commission felt it from patient
safety groups, 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 in healthcare organizations across the United States, the accredditor announced in the fall of 2002 that it would make significant changes to the accreditation process.

**An Overview of Shared Visions–New Pathways®**

On January 1, 2004, The Joint Commission took the Agenda for Change one step further and introduced a new initiative it called Shared Visions–New Pathways, now more simply and commonly referred to as “the new survey process.” The initiative focused on patient safety and quality and encouraged physicians to participate in the survey process. It also introduced healthcare organizations to a new set of consolidated standards and rules and new Joint Commission lingo, such as elements of performance (EPs); A, B, and C category types; the periodic performance review (PPR); the priority focus process (PFP); measures of success (MOS); evidence of standards compliance (ESC); clarification; and the centerpiece of the survey process, the tracer methodology.

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 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 staff in the hospital. The survey process today involves 10% documentation review and 90% interaction with staff and patients at the “point of care” or at each patient care unit. 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.

Surveyors observe direct care, the medication process, and the care planning process; interview individual patients or families; review additional 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 your facility’s compliance with standards and National Patient Safety Goals (NPSGs).
Initially, hospital personnel were leery of the tracer methodology and were concerned that personnel would be unjustly subjected to questions that were outside of their scope of practice. This did not hold true. In fact, just the opposite occurred. Based on our clients’ feedback, personnel involved in tracer activities were excited that finally individuals caring for the patients were included in the survey and that concurrent patient care was evaluated in place of retrospective chart review.

The Joint Commission expects an organization to be continuously ready for a survey. This is interpreted as meaning 100% compliance with all of The Joint Commission’s standards, 100% of the time. In effect, if a surveyor unexpectedly shows up at your facility’s door tomorrow, The Joint Commission expects that the organization would have all policies and procedures implemented and that staff members could answer questions a surveyor posed to them. In 2006, the survey process changed over to an unannounced format to operationalize the expectation of continuous readiness.

New Joint Commission President

Mark R. Chassin, MD, MPP, MPH, began his appointment as The Joint Commission’s president on January 1, 2008.

According to The Joint Commission’s official announcement, Chassin’s accomplishments include building a nationally recognized quality improvement (QI) program with Mount Sinai Medical Center in New York City, as well as successful efforts to bring Six Sigma QI methods to the center’s hospital and medical school. His research at Mount Sinai has focused on developing and using QI measures, as well as studying the relationship between QI and improvement to health policy.

During presentations during his first year with The Joint Commission, Chassin highlighted the initiation of Six Sigma improvement efforts within the internal operations of The Joint Commission. A major focus will be on customer service, having listened to the feedback of the customers engaged in accreditation activities and their less than complimentary comments about some of The Joint Commission’s processes, particularly surveyor variation regarding standards interpretation.

During the September 2008 National Association of Healthcare Quality conference, Chassin shared with the audience the fact that five improvement team activities were underway, one being consistency of surveyor findings, and that the first group of employees was receiving training on Six Sigma methodologies.
Unannounced survey process

The last group of hospitals that underwent the announced survey process in 2005 experienced their first unannounced survey in 2008, following the introduction of unannounced surveys for organizations due for survey in 2006. Organizations no longer know months in advance when surveyors will conduct their on-site visit for regular accreditation surveys.

The Joint Commission says it implemented unannounced surveys to:

- Enhance the credibility of the accreditation process by ensuring that surveyors observe organization performance under everyday circumstances.
• Reduce the costs that organizations incur to prepare for a survey

• Address public concern that The Joint Commission should receive an accurate reflection of the quality and safety of care

• Help organizations focus on providing safe, high-quality care at all times, not just when preparing for a survey

Of course, The Joint Commission was also influenced to make this change because of a critical report by the U.S. Government Accountability Office in 2004 titled *CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals*.

All organizations are surveyed under the unannounced survey process, with the following exceptions (in which case surveys are announced):

• Department of Defense

• Bureau of Prisons

• Immigration facilities

• Office-based surgery practices

• Foster care

• Very small organizations

• Initial surveys

• Disease-specific care

• PPR option 2 and option 3 surveys

The Joint Commission considers the following to be the value of unannounced surveys:

• Greater focus on the changes that The Joint Commission makes throughout the year

• An end to “preparing to be surveyed” and a beginning for “preparing to embed the standards”

• Implementation of ongoing mock tracer activity to maintain continuous readiness
Can an unannounced survey be predicted?
Not at all. When unannounced surveys began in 2006, hospitals were told they would be surveyed any time in the calendar year in which they were due for their triennial survey. However, this also has changed. As announced in the April 2008 Perspectives, The Joint Commission’s monthly publication, beginning as early as July, 1, 2008, the survey window for hospitals could be as short as 18 months or as long as 39 months. See Figure 1.1.

According to The Joint Commission, the timing of surveys is to be based on preestablished criteria generated from priority focus processes data and from other data sources. In situations where the data suggests that patient safety and quality are potentially at risk, an organization will be scheduled for an earlier survey. The methods for calculating survey intervals are known by The Joint Commission and not fully disclosed to accredited organizations. Read on and learn how the strategic surveillance system score may have an impact on your next survey.
Strategic surveillance system

In July 2007, access to an “S3” score on the redesigned Joint Commission Connect extranet site was initiated for the hospital accreditation program. This score is generated from a data management tool that operates as a dashboard, providing reports of comparative measures using data from:

- Past survey findings
- Core measures
- Complaints and non-self-reported sentinel events
- An organization’s e-App
- Medicare Provider and Analysis Review (MedPAR)

Updated reports are posted quarterly on approximately the first of the month in April, July, and October. The S3 reports are only for use by hospitals via the secure, password-protected extranet site and are not available to the public.

Even though the S3 score has been available for some time, it is not unusual for a hospital’s leadership team to be unaware of the organization’s score. Not only does the report provide your facility’s individual score, it also lists your state and the national scores as well as comparison scores from the following groups:

- Top 10% of hospitals
- Top 25% of hospitals
- Thomson 100 Top Hospitals
- U.S. News & World Report America’s Best Hospitals
- Magnet® hospitals
- Hospitals undergoing for-cause surveys
- Hospitals receiving conditional accreditation
- Hospitals receiving preliminary denial of accreditation

As the survey coordinator, ensure that every quarter you share the S3 score with your readiness teams, the performance improvement committee, the Medical Executive Committee, and hospital leaders, including the board.
If we expect the leaders to be involved in promoting continuous standards compliance, measurement data such as the S3 score may be the impetus to push them into action or to keep the pressure on to maintain the best score possible.

This is one situation where the lower the score, the better. If your organization’s score is climbing toward that of organizations who received conditional accreditation, the readiness team needs to take a closer look at what components may be affecting the higher score.

One of the reports available to organizations displays the percentage of the types of data used to calculate the S3 score. This provides you with a heads-up of which data set to review to analyze what is contributing to a higher score and can point you in the right direction for implementing corrective actions. For example, if MedPAR data contributed to 70% of your score, it is time to drill down on the individual indicators that may be worse than the goal line. Are the facility’s mortality rates higher than expected? What about length of stay? How about complication rates? Consider enlisting the assistance of performance improvement personnel in drilling down and analyzing data.

Don’t try to take on the burden of analyzing your organization’s S3 score alone; it is not a one-person endeavor. Continuous standards compliance is a team effort, and this is a multifaceted measurement that will require team analysis.

Use of the S3 score in managing continuous standards compliance will be further explored in Chapter 8 of this book. Remember, the extranet includes a user guide and tutorial for familiarizing yourself with this data management tool.

**Standards Improvement Initiative**

In October 2006, The Joint Commission launched the Standards Improvement Initiative (SII), aimed at:

- Clarifying standards language
- Ensuring standards are program specific
- Deleting redundant and nonessential standards
- Consolidating standards
In phase I, the project looked first at the hospital, ambulatory, critical access hospital, home care, and office-based surgery standards. In July 2008, revised standards were posted to The Joint Commission’s Web site.

Shortly afterward, in August 2008, the scoring information was added to the posted standards. The hard-copy manuals were available to accredited organizations in September 2008 and the E-dition, the electronic manual, in November 2008.

So what does this mean to the accreditation coordinator? As a result of SII, the 11 standards chapters have increased to 16. The chapters of Record of Care, Life Safety, Waived Testing, Transplant Services, and Emergency Management were created.

### Standard Chapters in the CAMH

- Emergency Management (EM)
- Environment of Care (EC)
- Human Resources (HR)
- Infection Prevention and Control (IC)
- Information Management (IM)
- Leadership (LD)
- Life Safety (LS)
- Medication Management (MM)
- Medical Staff (MS)
- Nursing (NR)
- Provision of Care, Treatment, and Services (PC)
- Performance Improvement (PI)
- Record of Care, Treatment, and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Transplant Safety (TS)
- Waived Testing (WT)
Standards were relocated from other chapters and in some cases, additional standards were formulated by breaking original standards into multiples. One such example is the 2008 standard IM.6.10 that contained 18 elements of performance. In the 2009 standards, RC.01.01.01, RC.01.02.01, RC.01.03.01, RC.01.04.01, and RC.01.05.01 contain the EPs from the 2008 standard. (For more examples of changes, see Chapter 2.)

The hardcopy 2009 standards manual will finally be alphabetized by the standards chapters and the ancillary information moved to the back of the manual.

EP type B was eliminated. That means the A EPs are those that require a defined structure or process and the C EPs are to be the implementation or action items. This should make it easier to focus on the interventions needed when noncompliance is identified.

There was a question posed during the August 2008 session of The Joint Commission’s Executive Briefings about why some of the A EPs contained a measure of success if they were based on structure, as it would be impossible to conduct a four-month measurement. Unfortunately, this was not clarified before the hardcopy standards were distributed to hospitals, so it will be a “wait and see” as to whether corrections will be made via frequently asked questions or Perspectives.

In the reformatted standards, as applicable to the individual EPs, the following icons were added:

- “Circle D”: required documentation, which may be in the form of a document or the act of documentation
- “Triangle 2”: indicates situational decisional rules (those listed in the ACC chapter of the standards manual that apply to conditional and preliminary denial of accreditation
- “Triangle 3”: indicates direct impact on patient safety and quality of care
- “Circle M”: a measure of success would be required if this element of performance was found to be noncompliant during the PPR or actual survey

According to The Joint Commission, phase II of the SSI project is underway now, with the behavioral, long-term care, and laboratory standards being evaluated. Feedback from organizations is currently being encouraged.
Standards, EPs, and scoring guidelines

In 2004 the fact that The Joint Commission based scoring on an aggregation of an organization’s compliance with all EPs caused some concern. After all, Shared Visions—New Pathways was just as new to the surveyors as it was to organizations.

In the first part of 2004, some surveyors arrived on-site at clients’ institutions and announced that they would not be doing tracers and the survey would still be the “old method.” In actuality, it was a hybrid with some tracers being performed and perhaps document review being a larger part of the survey than it is today. Even though we talk about standards being compliant or noncompliant, it is important to remember that scoring takes place at the level of the EP.

Category A EPs

These EPs are scored according to the presence (2 points) or absence (0 points) of the requirements (e.g., a policy, guidelines, etc.). An easy way to remember this category for both yourselves and organizational personnel is this: “You either have it, or you don’t.” There isn’t any wiggle room.

Category C EPs

These EPs address issues that can be quantified or counted. During the survey, they are scored based on the number of occurrences of noncompliance identified. No occurrences or even one occurrence is scored as compliant and is given 2 points. Two occurrences will yield a score of 1, which is partial compliance, and three occurrences equals noncompliance, scored as a 0. Another way to remember this is: “Three strikes and you’re out.”

Category C EPs are frequency-based during your survey but are rate-based when conducting an internal PPR. Ninety percent compliance is considered full compliance, 80% is partial, and 79% or lower is scored as noncompliant. Remember: frequency-based during the survey, rate-based during PPR.

Track record

In addition to meeting the expectations of the EPs, surveyors will evaluate if the process has been implemented for at least 12 months prior to survey. This is a requirement if the EP is to be scored in full compliance.

Critical results reporting is an example of how the track record requirement affected the scoring of EPs for many organizations during 2008 surveys. For several years now, organizations have been required to
collect data regarding the timeliness of reporting critical results to the responsible licensed caregiver (NPSG 02.03.01, EP 5 in 2009) Unfortunately, medical staffs could not always agree on what constituted a critical result, and it was unclear which hospital personnel were accountable for the notification.

If your hospital was surveyed in November 2008 and 12 months of data regarding critical results notification could not be produced for the surveyor, the EP would be scored as noncompliant. Because of the track record requirement, organizations need to act promptly on implementing process changes following the issuance of new standards.

**Scoring the standard**

A standard is scored as either compliant or noncompliant. During a survey, standards determined to be noncompliant are tagged as such and a requirement for improvement (RFI) is generated. It is the RFI count that determines whether an organization will reach the threshold set for conditional accreditation or preliminary denial of accreditation. Hospitals are anxiously awaiting The Joint Commission’s response as to whether 2009 will include a change in the threshold or even if thresholds will be utilized.

As stated before, the EPs are where the initial scoring actually occurs. Any time a single EP of scored as noncompliant, the standard is deemed noncompliant. The number of EPs is immaterial. It only takes one.

This is a concept that not all hospital leaders have grasped. If a noncompliant EP is identified and if for some reason the leaders do not push for compliance, leaders need to be aware of the vulnerability that exists during a survey. The single noncompliant EP could lose the entire standard and up the RFI count.

In 2008, standards could be scored as partially compliant and were considered as supplemental findings. As part of the Standards Improvement Initiative, supplemental findings will no longer exist. A standard that is not fully compliant will be considered a finding in which an RFI will be issued.

Verbiage used in the presentation of the 2009 standards to state hospital associations referenced the “criticality” of standards:

- The accreditation decision focuses on critical standards and EPs
- Accreditation decisions will be based on the criticality of findings and the number of RFIs
- Elements of performance considered critical to patient care are those noted with the icon of a triangle 3
Chassin reiterated the focus on critical elements of performance during a recent National Association for Healthcare Quality (NAHQ) conference when he closed his presentation by stating that accreditation decisions should be based on standards that directly affect the patient. Other standards need to corrected, but patient care is the focus. At this time, the quantification of these statements is not available in terms of what level of RFIs is acceptable to remain fully accredited.

The Survey Process

The Joint Commission has not announced any changes to the actual on-site survey process for 2009. A full description of the components of a survey can be found in The Joint Commission’s Survey Activity Guide, last published in 2008 and available on the Joint Commission Connect extranet. Additional recommendations for preparing and managing survey readiness will be discussed in Chapter 6 of this book.

*Individual tracers*

If you were to ask hospital staff about the most significant change in the survey process, they would most likely respond that it is the implementation of tracers. Subsequent to their introduction in 2004, tracers make up the majority of the survey activities, the actual number being dependent on the length of your organization’s survey.

Patients are selected for tracers from the census provided each morning to the surveyors. An “ideal” patient is one who has been in the hospital several days but not much longer than seven days, or the medical record is too extensive and time consuming for performing a thorough tracer. Most generally, patients with diagnoses from the organization’s clinical service groups will be selected.

Upon arrival to the patient care unit, the surveyor will ask to meet with the caregiver assigned to the patient.

At this point, the surveyor begins the assessment process. As the caregiver prepares to meet with the surveyor, the process of handoff communication will be closely observed.
Do’s and Don’ts Drug Survey

Do:

- Preselect a location for conducting tracers in each patient care unit.
- Ensure that, upon notification that the unannounced survey is underway, the selected location is clear of debris and that adequate seating exists for the surveyor, the patient, the caregiver, the surveyor escort, and perhaps an additional person.
- Locate a computer, if needed; place it in the selected area; and ensure that it is functional.
- Collect all components of the hardcopy medical record, including those that might be stored separately from the primary medical record such as medication administration records, care plans, etc.

Don’t:

- Attempt to answer for staff or provide prompts. The tracer is an activity between the surveyor and the assigned caregiver. Managers should not be involved, as this could spur an invitation to exit the activity.
- Expound too much on answers. Doing so will often reveal information that exposes deficiencies in care that were outside of the scope of the surveyor’s question.
- Be defensive. Defensiveness has no place in tracer activity; if a deficiency in documentation is identified and it is from a previous unit or caregiver, accept the fact of the deficiency and answer questions as asked.
- Never attempt to answer a question by assuming what the documentation was intended to mean; let the record speak for itself.

The record review of the tracer begins at the point that the patient entered your organization. If the tracer is being conducted in the medical unit, it is possible that the patient may have been admitted via the emergency department, may have been a patient in the intensive care unit, and may have undergone diagnostic testing. It is an expectation that caregivers can locate information from all aspects of the medical record. Otherwise, continuity of care is broken and nonexistent.
Using the example above, if medical unit staff members are unable to locate the pain assessment performed in the emergency department, for example, it becomes obvious to the surveyor that the receiving unit does not utilize this information and that caregivers may be practicing within their own silo of care.

As the surveyor questions the caregiver, notes will be taken about the other units in which the patient received care. Expect to travel to those units next. This will continue until the surveyor has exhausted the patient care locations or time has lapsed for the selected patient tracer.

In addition to individual patient tracers, system tracers were introduced in 2004, others added in 2006, and program-specific tracers were added in 2008.

**System tracers**

**Medication management (MM)**

This session is designed to explore the organization’s MM practices and to identify any potential risks. The specific medication processes that surveyors will look at include medication storage, order transcription, administration, and monitoring. Following a group discussion, it is likely that a patient receiving either complex medications or a medication listed on the organization’s list of high-alert medications will be selected for a review of medication practices. This may begin in either the pharmacy or on the patient care unit and will involve tracing the medications from the time of order through to administration.

**Infection control (IC)**

Discussions of the hospital’s IC program will usually begin with a review of the annual risk analysis, prioritization of risks, strategies for reducing the risks, and measurements of progress. Surveillance data should be readily available for this discussion. Surveyors may subsequently request a name of a patient currently in isolation and conduct a review of the record within the patient care unit. In the Survey Activity Guide, IC data is listed as the document to have ready for the surveyors to review. Be prepared with a listing of patients currently in isolation, the most current risk analysis, the prioritized strategies, and recent measurement data of the strategies.

**Data use**

Based on the comments of Dr. Chassin, the participants in this session should be well prepared to discuss initial data, data analysis, selection of appropriate interventions and the subsequent measurement data to assess effectiveness. Surveyors generally focus on data used to improve the safety and quality of care, such
as medication errors, patient falls, use of restraints and seclusion, organ procurement conversion rate, staffing effectiveness indicators, and perhaps any of the other topics listed in PI.01.01.01.

**Emergency management (EM)**

This tracer was added in 2006 for hospitals with greater than 200 licensed beds and changed in 2008 to include all hospitals. During this tracer, surveyors will review your hazard vulnerability analysis, your role in relation to the community’s EM plan, your processes for sharing information, the “all hazards” command structure linked to the community, and improvements made in response to findings during any EM exercises. This tracer was added because of the inadequate emergency preparedness capabilities of hospitals affected by the Gulf Coast hurricanes, including Katrina, in 2005. In addition, surveyors have been known to travel to a specific patient care unit and pose an emergency scenario and then interview staff within the unit on their role in EM. Consider adding a brief EM tracer to environmental rounds as a method to practice spontaneous questioning with staff who may not be expecting to participate in EM survey activities.

**Sentinel Events**

We should all know that a sentinel event is any unexpected death or serious physical or psychological injury (e.g., loss of limb or function) to a patient. The Joint Commission initiated this term and the investigation of such events in 1998.

An organization is not required to report a sentinel event to The Joint Commission, but it is required to conduct a thorough and credible root-cause analysis that includes an extensive action plan to reduce the risks of such an event occurring again. (See Figure 1.2 for the most recent sentinel event statistics released by The Joint Commission). Joint Commission surveyors are instructed not to inquire about the occurrence of sentinel events, but they may ask staff members about methods for reporting such events and the subsequent investigation process. Should The Joint Commission become aware of a sentinel event, its inquiry will be directed to the contact people listed on your facility’s e-App or, depending on the circumstances, a for-cause survey could be triggered. Consult your standards manual for more information on this topic.

The Joint Commission periodically releases *Sentinel Event Alerts*, with one of the most recent being *Behaviors That Undermine a Culture of Safety*, posted on its Web site July 9, 2008. These alerts include occurrence data, strategies for risk reduction, and recommendations for preventing the event.
**Figure 1.2 Sentinel Event Statistics**

The following are the most reported types of sentinel events. Organizations have been voluntarily reporting sentinel events to The Joint Commission since January 1995 for an all-time total of 5,208 events. In the following chart, you can see how the number of occurrences has increased from 2006 to 2008.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Inpatient suicides</td>
<td>501</td>
<td>641</td>
</tr>
<tr>
<td>Operative/postop complications</td>
<td>473</td>
<td>598</td>
</tr>
<tr>
<td>Wrong-site surgeries</td>
<td>496</td>
<td>691</td>
</tr>
<tr>
<td>Medication errors</td>
<td>369</td>
<td>470</td>
</tr>
<tr>
<td>Delays in treatment</td>
<td>286</td>
<td>390</td>
</tr>
<tr>
<td>Deaths/Injuries by restraints</td>
<td>147</td>
<td>183</td>
</tr>
<tr>
<td>Patient falls</td>
<td>207</td>
<td>307</td>
</tr>
<tr>
<td>Assaults/rapes/homicides</td>
<td>128</td>
<td>198</td>
</tr>
<tr>
<td>Transfusion-related events</td>
<td>97</td>
<td>119</td>
</tr>
<tr>
<td>Perinatal deaths/injuries</td>
<td>117</td>
<td>159</td>
</tr>
<tr>
<td>Elopement</td>
<td>71</td>
<td>82</td>
</tr>
<tr>
<td>Fires</td>
<td>66</td>
<td>77</td>
</tr>
<tr>
<td>Infection-related events</td>
<td>78</td>
<td>105</td>
</tr>
<tr>
<td>Anesthesia-related events</td>
<td>61</td>
<td>84</td>
</tr>
<tr>
<td>“Other”</td>
<td>n/a</td>
<td>652</td>
</tr>
</tbody>
</table>

Organizations are no longer required to assess the application of the recommendations and implement those that are appropriate. The question to you as an accreditation coordinator and promoter of patient safety is: Why would you not want to utilize this valuable information already packaged for your review? It is recommended that each SE Alert be assessed for implementation of recommendations as applicable to your hospital’s services and population.

**Electronic Application**

Hospitals have access to their electronic application (known as the e-App) that is available on the Joint Commission Connect extranet. Your assigned Joint Commission account representative is able to assist you in updating the application and answering content questions. Surveyors also are able to access the application via their laptops.
It is imperative that your organization’s e-App remains current. Any addition or deletion of a service is required to be reported to The Joint Commission within 30 days of the occurrence.

If you are questioning the necessity of reporting a change, contact your Joint Commission account representative for advice. Should you miss the 30-day deadline and the changes in service are adding significant patient volume, this could trigger an extension survey.

In addition, the application is utilized to plan the length of the on-site survey, the number of surveyors, and the specific qualifications of a surveyor should your facility include home care, behavioral health services, etc.

**Your Survey Team**

Generally, The Joint Commission sends a team composed of a physician, a nurse, and an administrator to survey a hospital, one of whom is the survey team leader. Surveys last for two to five days, depending on the number of beds in your hospital and the scope of your patient care activities.

For a hospital with fewer than 50 beds, for example, The Joint Commission typically sends a physician and nurse surveyor for two days. A survey at a facility with 500–750 beds would most likely involve four surveyors and last at least four to five days. Beginning in 2008, all hospitals had an additional *Life Safety Code* surveyor for one day and if the facility met specific square footage requirements, a second day was added.

The Joint Commission also may add more surveyors to a team if necessary. For example, if travel to a hospital’s outlying ambulatory campuses is necessary, The Joint Commission might send an additional surveyor for those sites.

Also, The Joint Commission might assign additional surveyors to review specialty areas, such as home health, long-term care, and nursing home facilities affiliated with a hospital. Check your survey agenda once it is posted to the extranet for hospital-specific information.
A New Player in the Hospital Accreditation World

The Centers for Medicare & Medicaid Services (CMS) announced in September 2008 the approval of DNV Healthcare, Inc., as a deeming authority for U.S. hospitals. DNV is the first new organization to receive deeming authority for hospitals in more than 30 years.

According to the pre–Federal Register announcement, DNV was recognized “as a national accreditation program for hospitals seeking to participate in the Medicare or Medicaid programs” effective September 26, 2008, through September 26, 2012.

“We’re coming into this business not just as another option,” says Yehuda Dror, president of DNV Healthcare. “We want to take a leadership position.”

“I think a lot of people will explore the possibility,” says Bud Pate, REHS, vice president for content and development for The Greeley Company, a division of HCP, Inc., in Marblehead, MA. “There are some hurdles that people will need to jump over—since DNV is new they’re going to need to work through some residency issues, contract issues that may exist . . . but none of these are insurmountable.”

DNV has crafted a system intended to combine the CMS Conditions of Participation (CoP) with ISO-9001 quality management. This program, called the National Integrated Accreditation for Healthcare Organizations (NIAHO®), was created to make the accreditation process more streamlined as well as identify means for improving current standards and promoting continual improvement.

“The ISO-9001 certification seems to be a logical progression as the focus on patient care quality assurance moved toward performance improvement in healthcare, primarily in hospitals,” says Larry Poniatowski, RN, BSN, CSHA, principal consultant for Accreditation Compliance Services with The University HealthSystem Consortium in Oak Brook, IL. “The issue here now will be to see how well it’s embraced by hospitals as an alternative to Joint Commission accreditation.” So far, 27 U.S. hospitals in 22 states have been accredited by DNV Healthcare using the NIAHO® program in addition to other accreditation services.

In mid-2007, DNV Healthcare acquired Cincinnati-based TUV Healthcare Specialists with the belief that the acquisition would help cement DNV’s application to CMS. TUV had previously applied for deeming authority unsuccessfully in 2006.
DNV Healthcare is a division of Houston-based DNV USA, a subsidiary of the Norwegian company Det Norske Veritas. DNV focuses on risk management and training in several industries, including healthcare. DNV will survey annually rather than every three years.

“What we offer is something of a way of life,” says Dror. “It’s not a case where every three years we come in, do an audit, and leave. We’re coming in every year. This leaves no time to prepare. It’s not punitive, but you don’t have time to prepare, so instead it must be a way of life, making sure the core objectives are met.”

But it is the introduction of the ISO-9001 component to the healthcare setting that has many interested in the new accreditation organization’s process. “It’s the ISO piece that organizations are going to have to explore further, and look to see if they can fit within its mold,” says Poniatowski. “I think that hospitals that try to achieve that level of culture of safety may want to embrace something on this level. At this point in time, hospitals have been given a viable choice.”

Pate has observed growing frustration with National Patient Safety Goal changes and anticipates some initial problems with the rollout of the new Joint Commission standards in 2009. “Physicians have had it with” these things, says Pate. “This [DNV] looks like an attractive alternative to them.” Pate sees the introduction of competition to the accreditation world as a win-win for both the accrediting organizations and for hospitals.

“I see this potentially as a situation similar to Apple and Microsoft,” says Pate. “I think Joint Commission will continue to be the Microsoft [in this equation]. But I think Apple [or DNV] will keep Microsoft honest. Many people will explore it, and a few will go for it. And over the years they’ll find a niche in the healthcare industry.”

The emergence of a competitor in the accreditation world marries nicely with changes in leadership at the Joint Commission, Pate notes, as the organization has voiced a renewed commitment to improving customer service.

“It comes at an opportune time,” agrees Poniatowski. “With a new Joint Commission president who is dedicated to measurement and improvement and embracing Six Sigma for process improvement, I think it’s going to be good for the entire healthcare field. We’re all going to learn something.”

Source: BOJ, November 2008
TEST YOUR KNOWLEDGE

1. The Joint Commission accreditation must be obtained to participate in the Medicare and Medicaid programs.
   - True  - False

   **Answer: False.** The Joint Commission is only one option. An organization may select the HFAP accreditation of the American Osteopathic Association, have CMS conduct the survey, or now select the newly approved organization DNV Healthcare, Inc.

2. For hospitals seeking renewal of accreditation, which of the following items are true regarding an effect on the date of the survey?
   A. Strategic Surveillance System score of greater than 200 will result in an earlier survey
   B. Presence of The Joint Commission surveying nearby hospitals within the state will result in an earlier survey
   C. The Joint Commission recently requested submission of a root-cause analysis for a sentinel event which will result in an earlier survey
   D. Only The Joint Commission knows the date for the unannounced survey

   **Answer: D.** Much hearsay is present on listservs and among hospital personnel, but only The Joint Commission knows the date of your organization’s survey.

3. In 2009, what is the score of the standard based on the following EP findings?

<table>
<thead>
<tr>
<th>EP</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td>EP 1</td>
<td>2</td>
</tr>
<tr>
<td>EP 2</td>
<td>1</td>
</tr>
<tr>
<td>EP 3</td>
<td>0</td>
</tr>
<tr>
<td>EP 4</td>
<td>2</td>
</tr>
<tr>
<td>EP 5</td>
<td>2</td>
</tr>
<tr>
<td>EP 6</td>
<td>2</td>
</tr>
</tbody>
</table>

   A. Compliant; at least two-thirds of the EPs were compliant
   B. Partial compliance; becomes a supplemental finding
   C. Noncompliant; due to one noncompliant EP
   D. Compliant; majority of EPs are compliant

   **Answer: C.** Once an EP is found noncompliant, the standard is deemed noncompliant. Also, supplemental standards no longer exist in 2009.