The Joint Commission: An Overview

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

Some of the activities within the survey process, such as the tracer methodology and system tracers, will be described, as well as survey “dos and don’ts” that I have learned in the past few years. This chapter provides you with an overview of the basics of The Joint Commission and is intended to supplement or summarize the information found in standards manuals.

Why Seek Joint Commission Accreditation?

Today, The Joint Commission accredits more than 16,000 healthcare programs in organizations throughout the United States. Of those programs, 4,245 are hospitals. This means that The Joint Commission has accredited approximately 88% of the nation’s hospitals. The Joint Commission is currently one of three entities with “deemed status” from the Centers for Medicare & Medicaid Services (CMS) that a hospital may select for accreditation.
Although accreditation is not required by law, not having accreditation 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.

**Key Concept**
Even though your facility is accredited by The Joint Commission, this does not mean your state surveyors will not arrive at your facility to conduct a CMS survey, follow up on a complaint, or evaluate state licensing regulations. And although this book is focused on The Joint Commission, the principles it outlines are applicable to both CMS and state licensing surveys.

Without acquiring accreditation from The Joint Commission or from the Healthcare Facilities Accreditation Program (HFAP) operated by the American Osteopathic Association (AOA) or, most recently, approved by DNV Healthcare, Inc., hospitals would not be eligible to bill Medicare and Medicaid. According to the payer mix of many hospitals, most patient care revenue comes from Medicare and Medicaid payments. Thus, removal from those programs would have a major negative effect on a hospital’s bottom line.
Washington Hospital Switches to DNV Accreditation

For one Washington hospital, making the move from Joint Commission accreditation to DNV Healthcare, Inc.'s NIAHO accreditation was a matter of research, timing ... and moving at a lightning pace.

Group Health Central Hospital is part of Group Health Cooperative, an integrated delivery and financing system providing care to approximately 400,000 residents of Washington and Northern Idaho. The organization operates 26 primary care centers, three specialty centers, and one hospital.

“It all started out at the annual Institute for Healthcare Improvement National Forum,” says Elizabeth Rosen, RN, BSN, director of quality and regulatory compliance for Central Hospital. “DNV was there, and I discussed the situation with them and came back to share my interest with our leadership.”

The hospital’s chief of hospital medical staff, director of clinical operations, and Rosen met with DNV to determine whether the change was worth pursuing. Next, they brought in hospital administration, the chief nursing officer, the vice president of acute care, and legal counsel.

“I had outlined a proposal with a comparison of the Joint Commission and NIAHO standards,” says Rosen. “People were all positive, though there was some concern about the time frame.”

And what a time frame it was. The hospital was due anytime after January 1 for a Joint Commission survey. Regardless of whether it was changing accrediting organizations, Group Health was subject to the survey and could not change accrediting organizations if it had any outstanding requirements for improvement with the old accrediting organization.

The decision went from hospital leadership to the CEO of the overall organization.

“The CEO, in consultation with the board of trustees, made the final decision,” says Rosen. “At the same time this decision-making process was going on, we did a high-level gap analysis to look at the differences between DNV and The Joint Commission, to understand where our focus areas would be.”
Washington Hospital Switches to DNV Accreditation (Cont.)

The hospital’s legal counsel reviewed the contract template, and the application was filled out during the decision-making process because everyone involved knew the change would have to happen fast.

“We made the final decision to withdraw from The Joint Commission, and immediately following withdrawal sent our application to DNV,” says Rosen.

After signing the contract, the hospital began working with DNV to establish a timeline for the survey process—all in all, about a month elapsed between the signing of the contract and the arrival of DNV surveyors.

“We had to move very quickly,” says Mary Lou Calise, RN, BS, MSQA, CPHQ, quality consultant for Group Health. “We needed to be very compliant in a very short time period.”

Given how closely aligned the NIAHO standards are to CMS regulations, Calise says they were “pleasantly surprised during this process.”

Because there would be a time gap between Joint Commission and DNV accreditation, Rosen worked with the state Department of Health and the local CMS office to keep it up to speed regarding the hospital’s accreditation status.

Pros and Cons

Group Health made its decision after weighing the upsides and downsides to both accrediting bodies.

“We went over the pros and cons,” says Rosen. “Central Hospital is a very limited hospital—we’d previously had two hospitals [in the system], but closed one in 2008 as part of an affiliation with an existing tertiary community hospital, so we went from a hospital system with a number of regular inpatient/acute care units to having obstetrics inpatient with all other hospital-based outpatient units.”

One of the issues Group Health was having concerned the inpatient-oriented approach of the Joint Commission’s standards, which no longer made sense based on how Group Health’s services had changed with the closing of the second hospital.
Washington Hospital Switches to DNV Accreditation (Cont.)

“This was the biggest reason for changing,” says Rosen. “Another was that, especially in 2008 and 2009, the Joint Commission standards were becoming so prescriptive that it wasn’t fitting with our services and population.”

The frequency and volume of the Joint Commission’s changes were difficult on small hospitals, says Rosen.

“Some of the standards wouldn’t apply to us or [would] have [a] limited result on our population,” says Rosen. “Instead, [now] we’re able to focus our energies with more applicability.”

For example, the hospital has only a very small number of overnight patients requiring anticoagulant management. A process for managing these patients has been put into place and the hospital stands behind it, but it might not have been a priority focus area given the hospital’s patient needs.

“What I looked at was the NIAHO standards in comparison with what was currently being done at our facility for compliance,” says Calise.

She worked to marry the two sets of requirements, looking for weaknesses and for areas where the facility needed to change course or stay on course. It was very site-specific.

“For example, CMS has extended their restraints standards,” says Calise. “We were in compliance, but we don’t have a psychiatric unit. We use restraints very infrequently. We had to take a closer look at what we were doing and where we needed to go.”

Timing of Surveys
Also in the plus column: annual surveys.

“We saw a benefit to an annual survey,” which DNV requires, says Rosen. The upside of this frequency would be “having some sense of when you can anticipate when the survey would be and also keeping on top of everything all the time,” she says.

Calise agrees.
Washington Hospital Switches to DNV Accreditation (Cont.)

“Coming once a year ... those of us working in quality are all for it,” she says. DNV offers to train one person in the facility to be a surveyor—the facility pays for travel expenses, and this designee must survey three other facilities each year. He or she is also trained in ISO 9001 compliance.

“We liked the idea of a collaborative approach,” says Rosen. “We liked the idea of having one of our own internal quality folks become a DNV surveyor and becoming our in-house expert.”

That person, in Group Health’s case, will be Calise.

“I used to be a surveyor for the Commission on Accreditation of Rehabilitation Facilities,” says Calise. “When I’d see a different way of doing something well, I’d bring that knowledge back to my facility. You’re always learning, finding different ways to accomplish your goals.”

Calise is looking forward to the challenges NIAHO certification will provide.

“I’m very pro-data, and this is looking at your data, doing an analysis of it, and looking for where the faults are [and] tweaking it to get your system where it needs to be,” says Calise.

Another selling point for Group Health was the concept of “no tipping point” for findings, says Rosen. Hospitals are instead required to have a corrective action plan in place and meet the time frames established for that plan.

“I can’t deny [that] I didn’t understand the scoring system for The Joint Commission,” says Rosen. “You didn’t really know if there was a tipping point with the new [2009] scoring.”

Leaving The Joint Commission

After submitting the withdrawal notice, the Group Health hospital administrator received a call from the Joint Commission account representative to schedule an exit interview.

“Toward the end of the interview, they wanted to know the actual date of withdrawal,” says Rosen. The letter had said “immediately.” Whatever date is specified for the withdrawal, The Joint Commission sends a notification to CMS to say the facility is no longer subject to Joint Commission accreditation. It was unclear what implications, if any, the notice to CMS might have concerning the hospital’s continuing Medicare certification.
Washington Hospital Switches to DNV Accreditation (Cont.)

“Our understanding was that our [Joint Commission accreditation] certificate was effective through mid-March 2009,” says Rosen.

According to the Joint Commission representative, however, the minute you withdraw you go into nonaccreditation status, Rosen says. This left the hospital in a quandary: If you do not withdraw immediately, you are still subject to a Joint Commission survey at any time, even if the hospital is in the process of changing to a different accreditation body.

“We were a little surprised at that,” says Rosen. “So we reviewed the situation with our attorney and with our accreditation consultant at The Greeley Company and were assured it was not a significant issue.”

Coincidentally, a week after the DNV survey is scheduled, the hospital will undergo its regular state licensing survey. Under current Washington state law, the state’s Department of Health is required to conduct periodic hospital surveys, but may forego conducting a survey during a year in which a hospital is surveyed by The Joint Commission or by the AOA. The law reflects the fact that for more than 30 years, The Joint Commission and the AOA had been the only hospital accreditation entities approved by CMS. This changed in fall 2008, when CMS approved DNV Healthcare as another option for achieving deemed status under Medicare.

“Because the state of Washington has not yet added DNV as an option, we still need to have a licensing survey,” says Rosen. Group Health is working closely with the Washington State Hospital Association and the Department of Health to change the law and recognize DNV for purposes of future state surveys.

Once NIAHO accreditation has been achieved, the next step will be to implement the second component to DNV accreditation: use of ISO 9001.

“ISO 9001 is centered [on] quality,” says Calise. “Industry has been doing it for a long time. It’s looking at processes, making sure you’re meeting the standards you’re reaching for, and if not, adjusting them to make sure you do.”

Source: *Briefings on The Joint Commission*, April 2009.
Note: If you are unfamiliar with HFAP, log on to www.hfap.org to learn more about its accreditation program. The Web site for DNV is www.dnv.com/focus/hospital_accreditation.

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 specialist, 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 members 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 in this section.

A complex hospital, defined as a hospital that uses more than one manual in its survey process and is governed by the Tailored Survey Policy, may elect to have separate surveys for its ambulatory, home care, long-term care, or behavioral services. In this scenario, each service stands alone for the count of Requirements for Improvement (RFI) findings and meeting the program-specific “bands” to determine the number of noncompliant direct impacts an organization may receive before being reviewed by the Joint Commission’s central office.

Each Web site listed in parentheses in the following sections takes you to a Web page with information specific to that program. I am providing this list in case you are a new accreditation specialist and are not aware of the extent of accreditation services that The Joint Commission provides.
**Ambulatory care services**

This includes outpatient surgery centers, rehabilitation facilities, infusion centers, group practices, sleep labs, imaging centers, community health centers, 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. If your organization is utilizing a radiology group for telemedicine, perhaps it is accredited by The Joint Commission. If so, this would be the accreditation for that type of service.

[www.jointcommission.org/AccreditationPrograms/AmbulatoryCare](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. More than 1,800 behavioral health organizations have sought this accreditation.

*Note:* 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](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 be familiar only with CAP accreditation from the College of American Pathologists, but The Joint Commission is an alternative.

[www.jointcommission.org/AccreditationPrograms/LaboratoryServices](www.jointcommission.org/AccreditationPrograms/LaboratoryServices)

**Critical access hospitals**

These are hospitals that have a census of fewer 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 vary somewhat from the hospital standards, so read carefully to identify those nuances.

[www.jointcommission.org/AccreditationPrograms/CriticalAccessHospitals](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. More than 4,000 entities are accredited by The Joint Commission.
(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 1,100 of them—for more than 40 years.
(www.jointcommission.org/AccreditationPrograms/LongTermCare)

Office-based surgery centers
The Joint Commission accredits more than 400 outpatient settings, including oral surgeons, endoscopy suites, plastic surgery practices, and laser surgery clinics.
(www.jointcommission.org/AccreditationPrograms/Office-BasedSurgery)

International accreditation
Launched in 1999, The Joint Commission’s international accreditation program has been growing over the past several years and, at the time of this writing, accredits 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 a way to help build 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.

Certification services and disease-specific care
More recently, The Joint Commission began offering a variety of certification programs. At the time of this writing, the Joint Commission Web site listed seven advance certifications and 29 disease-specific certifications. 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)
- Chronic obstructive pulmonary disease (COPD)
- 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 the healthcare staff)
- Hemophilia
- High-risk pregnancy
- HIV/AIDS
- Hypertension
- Inpatient diabetes (new in 2006, this applies to organizations with patients who have a medical history of diabetes diagnosed and acknowledged by a treating physician)
- Ischemic heart disease
- Low back pain
- Lung volume reduction surgery (for hospitals performing this procedure)
• Migraines
• Multiple sclerosis
• Obesity/bariatric surgery
• Osteoporosis
• Parkinson’s disease
• Primary stroke (in partnership with the American Stroke Association)
• Sickle cell disease
• Transplant center (this program was under development in 2006)
• Ventricular assist device or VAD (for hospitals performing VAD as a destination therapy)

When Multiple Disease-Specific Care Surveys Arrive

On the upside, disease-specific care (DSC) certification surveys provide a little more notice for hospitals than triennials, because The Joint Commission announces surveys six to eight weeks in advance rather than arriving unannounced. On the downside, in a six-hospital system with multiple DSC programs, those surveys can arrive uncomfortably close together.

“Disease-specific care has been functioning for many years, and it acts as a mark of excellence,” says Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, a healthcare consultant in Trabuco Canyon, CA, and former Joint Commission surveyor.

For Main Line Health, a six-hospital system outside Bryn Mawr, PA, this meant four surveys in three hospitals from February 2009 through August 2009. With the right prep work, however, four surveys in a six-month period did not necessitate wide-scale panic, says Mary McKay, RN, MS, CPHQ, system director of regulatory affairs and nursing quality. The system weathered a VAD destination therapy program, primary stroke center certification, and two knee and hip programs successfully in a matter of weeks.

The prep work for a DSC survey is similar to preparations for The Joint Commission’s triennial survey, says McKay.
When Multiple Disease-Specific Care Surveys Arrive (Cont.)

“It’s very similar—you do your annual periodic performance review (PPR) and take your action plan from that,” says McKay.

Main Line Health is also part of the Continual Survey Readiness program, which provides a self-assessment similar to the PPR. Each program underwent a self-assessment, devised action plans, and brought in clinical leaders to help push for improvements.

“With these certifications, the closer you get to the clinical area, the more robust the program is going to be—you’ll have a better sustainability and compliance,” says McKay.

In the weeks leading into the surveys, mock surveys were conducted either internally or through a consultant.

“Six to eight weeks before the survey we have our own internal tracers we conduct, focusing on those areas impacted by the program,” says McKay.

Stay vigilant in all areas before the surveyors arrive, she says.

“One caution—don’t ignore the rest of the patients or the rest of the unit,” says McKay. “You know they’re coming in to survey you for stroke or knee and hip, but it’s still important that all of your admission assessments are complete. Nutritional, pain screening, falls ... they want to know you’re addressing patient safety. Don’t lose sight of those.”

Surprises

McKay found that surveyors were very interested in education during DSC surveys.

“One quote all of the surveyors used [was] ‘What makes you different?’ ” she says. “ ‘What sets you apart from the hospital down the street?’ That’s a message we hadn’t seen in print before, and it really drove the message home, to refine the program and give it a unique look.”

In addition, McKay found that the education component is more prescriptive in some programs than others.
When Multiple Disease-Specific Care Surveys Arrive (Cont.)

“With stroke, there’s a big education requirement,” says McKay. “Each staff [member] was asked, whether they were nursing or therapy or anyone else, what additional training [they] had in this area. And whether you’re looking at stroke, or knee and hip, or VAD, that education sets you apart.”

Staff education also reflects on the hospital as a whole.

“From the surveyor’s point of view, they also want to know that having this additional education shows leadership’s commitment to the program. Education is part of the organization’s goals,” says McKay.

For its knee and hip certification program, the healthcare organization had developed an individual care plan for patient education.

“Folks come in with a preop visit, and that education follows them through their hospital stay,” says McKay. “Post-discharge there’s a chance to participate in further education.”

The organization was able to demonstrate the content and initial education to the knee and hip patient and document the patient’s understanding, which reflected well on the program during the survey.

Patient education was one area in which the stroke program received an RFI—in this case, it wasn’t that the education was not being provided, but simply had to do with documentation of such education.

“We use nursing pathways, and we haven’t gone fully electronic yet,” says McKay. “Because we use prepopulated pathways, they were not specific enough for stroke education.”

Although the surveyor saw and believed that the facility was performing the appropriate level of education, the generic template for documenting this education will be improved.

That being said, the programs performed remarkably well during the surveys. Two of the four programs came away without a single RFI, and the other two programs had only two findings each.
When Multiple Disease-Specific Care Surveys Arrive (Cont.)

A lot of the success of these surveys came from the excellence of Main Line’s staff education component.

“I have to give kudos to our nursing staff educators,” says McKay. “I think the challenge will be in sustaining this going forward, always remembering [that] this population of the staff needs more than the mandatory training sessions. We need to give them refreshers in joints, VAD, [and] stroke.”

Recertification

The second time around should be a very different experience, says McKay. “I’m looking forward to the recertifications,” she says. “I think in some ways, as we know now what to expect, they’ll be easier.”

Main Line has already begun to identify areas that will be a challenge prior to the next round of surveys. First will be tracking standards as they change—the “unknown” factor between surveys, McKay says.

Also, tracking new staff members and the necessary education will be pivotal.

“As you acquire new staff [members], you have to have process(es) to capture their data, [and] put them into the pipeline for ongoing training and education,” says McKay.

A number of unexpected points came up before, during, and after the survey:

- **Clinical competencies:** “For these units, they need particular competencies that are going to speak to how they are competent; what sets them apart from nurses on an adjacent floor,” says McKay.

- **Older competency policies:** “Our competencies were age-specific, which are passé,” says McKay. “We are moving to population-based.” Although the system has done well on past surveys, they know that, having gone through four DSCs, the competencies will need to be updated for the next triennial survey and for DSC recertifications.
When Multiple Disease-Specific Care Surveys Arrive (Cont.)

- **HR files:** “We were surprised at the number of HR files they pulled,” says McKay. Or rather, the lack thereof: For each survey, fewer than five HR files were requested.

**How do they compare?**

The surveyors were extremely personable, says McKay, and they offered a great deal of guidance and education, leaving behind helpful tools for improving processes.

“We have that sort of back and forth during the triennial, but there’s a more personal aspect to the DSC surveys,” she says.

With a single surveyor, a professional bond forms more quickly, McKay says.

In terms of workload, the more focused nature of a DSC survey—although intense—is in many ways more manageable. Issues that arise tend to be program-specific and not systemwide.

Systemwide issues can occur, however. For instance, in 2008, The Joint Commission changed its standard for primary source verification. Even if a hospital changed its process, it needs to verify that such a change is implemented correctly and sustained. If even one clerk does not implement the change and continues to operate under the old standard, this can impact the whole system when it comes time for any survey, DSC or triennial.

**What’s next?**

Main Line Health is not done with its DSC surveys yet. The remaining facilities are still in the process of setting up initial certification for knee and hip programs, stroke, and COPD in the next six to nine months.

After that, they will be looking at the first rounds of recertifications.

“With recertification, they give you a window,” says McKay. “In the second year, you have five days’ advance notice of the survey. It’s enough to make sure people are there and to get the appropriate materials ready, but not enough to perfect everything if you’re not already ready for survey.”

Source: *Briefings on The Joint Commission*, June 2009.
History of The Joint Commission

It is important that accreditation specialists understand the evolution of The Joint Commission. It didn’t just spring up to make us struggle with compliance issues. It began almost 100 years ago and was based on the assessment of patient care. As you read the history, think about the impact on senior physicians and hospital staff members who have experienced the multitude of changes the accreditation process has gone through over the years.

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. 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. 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, the American Hospital Association, the American Medical Association, 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, CoPs 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.

To provide some insight on the impact of The Joint Commission to practicing physicians, please see the following excerpt from the HCPro publication The Greeley Guide to New Medical Staff Models:

During the 1970s, The Joint Commission began to require medical staffs to perform audits to measure the performance of their peers. Such a change was a direct threat to the clublike culture of most medical staffs, creating the potential for conflicts among physicians. Up to that point, even morbidity and mortality conferences had been confidential, undocumented discussions. Writing down the results of a case review, assigning it a score, and conducting other audit activities was anathema to most physicians. This created the first crack in the organized medical staff culture as it had developed.

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 they were 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 with notice, spending lots of time in conversations with administration and subsequently burying themselves in paperwork. At hospitals, procedure manuals were removed from shelves and 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 members 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 were discussed behind closed doors. The medical staff interview consisted of an extravagant lunch and discussions that generally centered on the attendee’s 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, renamed 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 members. 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 chapter, Performance Improvement
chapter, 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.

Key Concept

Because the standards are applicable to many departments, 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 work 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 (or in some cases, a couple of weeks before) the scheduled survey getting policies and procedures in shape and even painting and cleaning floors to create a good impression for surveyors. This system didn’t seem the best way to measure what was really occurring in patient care.

The IOM report revealed that as many as 98,000 patients per 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 of healthcare organizations across the United States, the accreditor 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 (EP); A, B, and C category types; the PPR; the priority focus process; 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 the staff in the hospital. The survey process today involves 10% documentation review and 90% interaction with staff members 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 a facility’s compliance with standards and National Patient Safety Goals (NPSG).

Initially, hospital personnel were leery of the tracer methodology and were concerned that personnel would be unjustly subjected to questions that were outside 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 will have all policies and procedures implemented and that staff members can answer questions a surveyor poses to them. In 2006, the survey process changed to an unannounced format to operationalize the expectation of continuous readiness.

**January 2008: New president of The Joint Commission**

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

During presentations in 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 was 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.

It is Chassin’s belief that a “near miss” holds much value to institutions and is often not given the attention that is needed to avoid a more serious event. Near misses should be considered a wakeup call, an alert that the process is not consistently being carried out and should be promptly evaluated.
Joint Commission Makes Changes in Culture, Performance in 2009

The Joint Commission has made significant steps to improve its performance and culture in 2009, the organization announced during its recent Executive Briefings in New York.

Ann Scott Blouin, PhD, RN, executive vice president of accreditation and certification operations, discussed at length major changes the healthcare accrediting body has taken in recent months to improve the way it works with hospitals, as well as its own internal processes. Among those improvements:

- **Refocusing surveyors:** Blouin told the audience that The Joint Commission has refocused its 500 hospital surveyors to balance their roles as both evaluators and educators/coaches/mentors. According to Blouin, this was received as an invigorating change by 95% of the surveyors.

- **Adaptation:** The Joint Commission is using Lean, Six Sigma, and “change acceleration” to change its own culture. According to Blouin, there is a new focus on customer service and simplification of processes. The Joint Commission has also changed its tactics on criticality; now, only direct-impact RFIs affect accreditation decisions.

- **Post-survey reports:** The Joint Commission has promised to improve the time frame in which hospitals receive their post-survey reports. A recent study within the organization found that, on average, hospitals were receiving their reports 16.4 days after survey, with massive fluctuations in that time frame—despite a requirement that hospitals receive their report within 10 days of their survey (not a 10-day average). A new process has been developed to reduce the time to develop the report from 38 hours to 4.4 hours and the average time frame to receive the report to 5.4 days.

- **PPR:** The Joint Commission is examining changes and enhancements to the PPR based on feedback from the field that the dates of submission are not working.

And, as we discussed earlier this year, there are no more automatic thresholds—there is “no magic tipping point,” says Blouin. The Joint Commission has also made a concerted effort to reduce costs.
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.

All organizations are surveyed under the unannounced survey process with the following exceptions provided in the March 2009 edition of Perspectives, The Joint Commission's monthly publication (in which case surveys are announced):

Ambulatory care program

- All office-based surgical practices
- An organization that either provides nondeemed ambulatory surgery or telehealth, or is a sleep center

Behavioral health care program

- All methadone programs, if not part of a hospital
- All in-home behavioral health, case management, or Assertive Community Treatment programs, if not part of a hospital
- All freestanding organizations with 10 or fewer staff members or a total average daily census (ADC) of less than 100
- All community-based, freestanding programs

Home care program

- Small, nondeemed health and hospice organizations, if not part of a hospital

Medicare/Medicaid certification-based

- Long-term care program
- All one-day freestanding Medicare/Medicaid certification-based long-term care surveys, if not part of a hospital
• DCS certification programs
• All recertification reviews for lung volume reduction surgery and VAD

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 to “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 anytime in the calendar year in which they were due for their triennial survey. However, this also has changed. As announced in the April 2008 issue of Perspectives, 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.

Field Experience

Undo energy is being spent to try to second-guess survey dates. The listservs are full of “creative research” highlighting ways you might be able to predict your survey date. In 2009, an organization was studying the time survey agendas posted on the Joint Commission Connect extranet and hypothesized that a survey would occur within two months of the posting. The question is: so what? What can we improve or correct within two months? Do we really want to revert to the game-playing of the early ’90s? We would be far better off if we used our time to conduct tracers and continue to work our action plans for long-term fixes that improve standards compliance.

According to The Joint Commission, the timing of surveys is to be 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 will 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. Read on and learn how the strategic surveillance system score was thought to have an impact on your next survey.

**Strategic surveillance system**

In July 2007, access to a Strategic Surveillance System (S3) score on the redesigned Joint Commission Connect extranet 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 electronic application (e-App)
- Medicare Provider and Analysis Review (MedPAR)

At The Joint Commission’s Executive Briefings held September 25, 2009, attendees were informed that scores from the Hospital Consumer Assessment of Healthcare Providers and Systems were added to the data used to formulate each hospital’s S3 score. The Joint Commission also notified attendees that it was discussing the removal of MedPAR data but that no decision had been reached at that time.

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 its organization’s score. Not only does the report provide your facility’s individual score, but it also lists your state scores 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’s America’s Best Hospitals
• Magnet hospitals
• Hospitals undergoing for-cause surveys
• Hospitals receiving conditional accreditation
• Hospitals receiving preliminary denial of accreditation (PDA)

As the accreditation specialist, 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. The S3 score is one situation where the lower the score, the better.

One of the reports available to organizations displays the percentage of the types of data used to calculate the S3 score. Unfortunately, data such as MedPAR results have such lag times that the information is considered outdated before it hits the S3 score. It is difficult to drill down into data which physicians and other staff members consider to be off the radar screen. It would take several years for implemented interventions to show an improvement. (Hence, this is a very good reason you should remove MedPAR results from the calculation of the S3 score.) In addition, it appears that hospitals with very high S3 scores have not been surveyed any earlier than those with lower scores.

**Standards improvement initiative**

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

- Clarifying standards language
- Ensuring that standards are program-specific
- Deleting redundant and nonessential standards
- Consolidating standards

In August 2008, revised standards with scoring information were posted to The Joint Commission’s Web site.
As a result of Phase I of the SII, the 2009 CAMH was published with five new chapters—Record of Care, Life Safety, Waived Testing, Transplant Services, and Emergency Management—for a total of 16 chapters. Type B EPs were eliminated, and we were introduced to new icons as highlighted in the following box:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Circle D”:</td>
<td>Required documentation, which may be in the form of a document or the act of documentation</td>
</tr>
<tr>
<td>“Triangle 2”:</td>
<td>Indicates situational decisional rules (those listed in the ACC chapter of the standards manual that apply to conditional and predenial of accreditation)</td>
</tr>
<tr>
<td>“Triangle 3”:</td>
<td>Indicates direct impact on patient safety and quality of care</td>
</tr>
<tr>
<td>“Triangle 4”:</td>
<td>Indicates indirect impact on patient safety and quality of care (added in October 2009)</td>
</tr>
<tr>
<td>“Circle M”:</td>
<td>Indicates an MOS is required if this EP was found to be noncompliant during the PPR or actual survey</td>
</tr>
</tbody>
</table>

In addition, a decimal system of standards numbering that leaves the reader confused as to how to locate a standard they knew well from the 2008 manual. The numbering system may help The Joint Commission, but it has caused confusion and persistent searching for the reader, also known as the customer.

**EPs, standards, and scoring guidelines**

In 2004, the fact that The Joint Commission initiated scoring based on an aggregation of an organization’s compliance with all EPs caused some concern to hospitals undergoing survey. After all, Shared Visions–New Pathways was just as new to the surveyors as it was to organizations, and they feared the surveyors would overinterpret the EPs and put the hospital in accreditation jeopardy.

Even though we talk about standards being compliant or noncompliant, it is important to remember that scoring takes place at the EP level. As a result of the SSI, the EPs increased from approximately 1,200 to 1,700 in the hospital accreditation manual.
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 is “Either you 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.

Key Concept
During the survey, category C EPs are scored based on the number of occurrences of noncompliance. No occurrences or even one occurrence is scored as compliant and is given two points. Two occurrences will yield a score of 1, which is partial compliance, and three or more occurrences equal 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 or greater compliance is considered full compliance, 80%–89% is partial compliance, and 79% or lower is scored as noncompliant. Remember: frequency-based during the survey, rate-based during PPR.

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

Key Concept
Not all hospital leaders have grasped this concept. If a noncompliant EP is identified and, if for some reason the leaders do not push for compliance, they need to be aware of the vulnerability that exists during a survey. The single noncompliant EP could lose the entire standard and increase the RFI count.
Based on the EP scores, a standard is scored as either compliant or noncompliant. At the conclusion of the survey, standards determined to be noncompliant are tagged as such and an RFI is generated.

Beginning in 2009, standards could no longer be scored as partially compliant as supplemental findings were discontinued. A standard that is not fully compliant will be considered a finding in which an RFI will be issued.

**The introduction of criticality**

The following four levels of criticality were introduced in 2009 as a method for focusing on EPs that have a greater impact on patient care and safety:

- Immediate Threat to Health and Safety
- Situational Decision Rules
- Direct Impact Requirements
- Indirect Impact Requirements

If you are experienced with CMS surveys, the term *immediate jeopardy* should be familiar. The concepts here are similar to Immediate Threat to Health and Safety as there is not a specific listing of causes that can result in this finding, but the following examples were listed in the 2009 *CAMH*:

- Inoperable fire alarm
- Adult-strength medications on pediatric crash cart
- Lack of master alarms for medical gas systems
- Patients with known antibodies receiving transfusions without the units being typed for the corresponding antigen

The seriousness of this determination yields an expedited decision of PDA. A follow-up survey is required to clear the PDA decision. Even after the immediate threat has been corrected, the organization receives conditional accreditation until a follow-up survey is performed within four to six months.
The next level of criticality, Situational Decision Rules, is based on specific situations identified during the survey. The following examples were provided in the 2009 CAMH:

- A facility without a license
- An individual without a license when a license is required
- Failure to implement Life Safety Code® (LSC) corrective actions

EPs that are subject to this level of criticality are labeled with a black triangle that has a “2” in it. Depending on the finding, a decision of either PDA or conditional accreditation could be rendered. During this year, Perspectives addressed this topic as it tends to be overwhelming to hospitals. In the CAMH, the tab labeled “ACC” provides a lengthy listing of accreditation decisions known as “Rules” that provide the reader with a more thorough explanation that is beyond the scope of this publication.

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**New Accreditation Decision**

**What Will This Mean for Your Facility?**

The Joint Commission has announced it will adopt a new accreditation decision for 2010. This decision, “Medicare Condition-Level Deficiency Follow-Up Survey,” is intended when surveyors assess a facility with one or more condition-level deficiencies out of compliance.

These condition-level deficiencies refer specifically to the CMS CoPs. This new accreditation decision is based in part on the Joint Commission’s application for hospital deeming authority through CMS.

According to The Joint Commission, if and when an organization has received this decision following a survey, the organization must address the identified deficient CoPs. After this, a follow-up survey will be conducted on-site. The Joint Commission has specifically stated that this accreditation decision is not to be confused with conditional accreditation decisions.

“I’m sure this is the result of continuing dialogue between The Joint Commission and CMS regarding the Joint Commission’s pending deeming application decision,” says Joe Cappiello, chair of Cappiello & Associates in Elmhurst, IL. “What CMS probably said was, ‘If you have a condition out, it has to be fixed right away, and you’ll have to go back in there and validate that it was fixed.’ ” This initial announcement did not address what scenarios will cause this type of accreditation decision.
New Accreditation Decision (Cont.)

What Will Trigger a Visit?
A number of events could trigger a post-survey on-site visit, says Cappiello. Here are a few possible examples:

- **Post-survey random unannounced survey:** “This is the 5% random sample pool that everyone is put in,” says Cappiello. “If you require submission of an MOS, you are out of the pool until your MOS is submitted.”

- **Post-submission of clarifying data:** “If the initial decision was conditional or [a] preliminary denial of accreditation,” says Cappiello, “[an] on-site clarification validation survey [CVS] will be scheduled if [the] clarification changed the accreditation decision.”

Other hypothetical causes for this survey include:

- Conditional decision follow-up survey
- ESC survey
- MOS survey
- Sentinel event follow-up survey
- CoP follow-up survey

“With the exception of the CoP follow-up survey, these are just [a] part of the previously published accreditation process,” says Cappiello. As another example, say your hospital does not exceed the bandwidth but receives a few RFIs. If you have a CoP out, that will require a follow-up visit.

What The Joint Commission didn’t reveal, says Cappiello, was the time frame. Historically, CMS requires correction and verification by on-site follow-up within 90 days. “I would imagine that CMS will require The Joint Commission to follow that timeline,” says Cappiello.

As yet another example, say you’ve exceeded your bandwidth, you have gone to conditional accreditation, and you have a CoP out. This means you’ll get a follow-up conditional survey by The Joint Commission following your acceptable submission of ESC and you’ll have a follow-up by The Joint Commission based on the CoPs.
New Accreditation Decision (Cont.)

“We don’t know if those two are combined,” says Cappiello. “Would they do them at the same time? Come back and take a look at direct impact standards and CoPs in the same visit? But what if the timelines are not compatible? I would hope that if the timelines match, The Joint Commission would combine the two into a single visit.” If, however, the timelines turn out to be incompatible, this could result in two visits—both of which the hospital pays for.

This may also have an effect on the size of the team sent for the follow-up survey. A follow-up survey frequently comprises one surveyor for one day. If a number of standards and a number of CoPs are out, this may result in a larger review team. “I would think that The Joint Commission would review the timeline and the size/composition of the survey team on an individual basis,” says Cappiello. Also unclear at this point are the number of post-survey processes.

“Let’s say the report has been issued and the decision has been rendered,” says Cappiello. “How soon after the organization receives the report is this new condition-level deficiency follow-up done? Do they need to submit to The Joint Commission just like they do to [CMS] a plan of correction? What are they requiring to be submitted prior to the follow-up, and how far out will that be scheduled?”

Source: Briefings on The Joint Commission, September 2009.

The third criticality level, Direct Impact Requirements, is the icon that we tend to watch for more often. EPs labeled with a white triangle with a “3” inside are based on implementation of care processes, and if noncompliance exits there are few or no protective defenses to prevent an impact on patient quality and safety. It is the number of noncompliant standards determined by noncompliant direct impact EPs that may cause the surveyors to look for patterns or trends in their findings.

The concept of program-specific bands for determining screening thresholds for more intense evaluation of findings for the number of noncompliant direct impact standards was introduced with surveys beginning in 2009. Determining your organization’s screening threshold is a two-step process. First, you must calculate the number of surveyor days, by simply adding the number of surveyors and the
number of days they were on-site for your most recent survey or as described in your survey agenda posted on the Joint Commission’s Connect extranet.

For example, say that three surveyors were on-site for three days, plus another surveyor was there for two days: $3 \times 3 = 9 + 2 = 11$. For a hospital with 11 surveyor days, the organization is placed in Band 4 based on Table 1 found in the “HB” section of the CAMH updated in June 2009.

In Table 2, Band 4 depicts 11 noncompliant direct impact standards as the screening level for a review by the central office of The Joint Commission.

Do the bands still exist?

At the same September Executive Briefings presentation mentioned earlier in this chapter, additional information was provided to the audience regarding direct impact bands. Here is a summary of the topic:

There are no “magic numbers” that result in adverse action, even though the surveyor days/bands have been published. According to all three speakers at the presentation, never have specific numbers rendered an organization immediately into adverse action. That concept (according to all three speakers) has been a misconception by the industry since the publication of the bands. The issue with the number of RFIs apparently is to evaluate for trends or for significance of the RFIs. Adverse action should occur only if there was a negative trend or pattern with the types of standards scored as noncompliant. For example, if several RFIs trended in life safety and leadership (because leadership wasn’t performing its oversight function), adverse action may occur. Each report would be reviewed individually. A member of the Joint Commission staff was asked this question: “If a small hospital had 20 direct impact RFIs and none of them were related and did not roll up into a trend of any kind, would there be no adverse action?” The spokesperson replied, “No. There would not.” The next question: “How, then, in this scenario, would the hospital’s accreditation status read?” The reply: “Simply, accredited with RFIs.”

With this new information, the organization should perhaps consider that its number of direct impact RFIs would be a trigger for the surveyors to look more carefully at the type and patterns of the RFIs. Stay tuned for more clarification from The Joint Commission.
Direct impact noncompliant standards are to be corrected within 45 days following survey. This was a change effective in 2009 to have different time frames for achieving standards compliance.

The final criticality level is Indirect Impact Requirements. New information provided on page 12 of Perspectives announces that a symbol for the indirect impact findings is a triangle with a 4 inside. EPs considered to be indirect have to do with planning and evaluation of care processes. If noncompliance is not resolved, there is still a risk to the patient’s quality and safety, but initially, not at the level of the direct impact EPs.

If no direct impact EPs are found to be noncompliant (partials included), noncompliant indirect EPs would result in a noncompliant indirect standard. The organization will have up to 60 days to correct this finding following survey.

**And the changes continued**

Just a little more than three months after hospitals received their 2009 edition of CAMH, The Joint Commission released a document on its Web site titled “New & Revised 2009 Accreditation Requirements in Response to CMS Deeming Application.” Hospitals were stunned: 46 pages of approximately 165 EPs in addition to the previous changes in the 2009 standards scoring; numbering; more chapters; NPSGs; and now this. To make things worse, a July 1, 2009, implementation was expected.

Accreditation specialists scrambled to meet these new requirements. Valuable resources were being expended when, on March 26, 2009, yet another revision was posted! This document decreased the EP changes to 87 and eliminated some of the EPs that hospitals had already implemented. Sound familiar? It should. And one of the most damaging fallouts to the accreditation specialists was that staff members, including physicians, were beginning to question the credibility of the messenger and The Joint Commission.

Damage control began as well as the review of the March 26 revisions. To ensure that you are on target, Chapter 2 will focus on these changes and offer suggestions for compliance. Even though hospitals received the updates in June, some seem to have slipped by without adequate attention; hence, the reason for Chapter 2.
The Joint Commission has not announced any changes to the actual on-site survey process for 2010. You can find a full description of the components of a survey in The Joint Commission’s *Survey Activity Guide*, last published in January 2009 and available on the Joint Commission Connect extranet. We will discuss additional recommendations for preparing and managing survey readiness in Chapter 7 of this book.

**Individual tracers**

If you were to ask hospital staff members about the most significant change in the survey process in recent years, they would likely respond that it is the implementation of tracers. Subsequent to their introduction in 2004, tracers make up most survey activities; the actual number depends 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; otherwise, the medical record is too extensive and time-consuming for performing a thorough tracer. 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.

The tracer activity 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 was admitted via the emergency department, may have been a patient in the intensive care unit, and may have undergone diagnostic testing with a subsequent admission. Surveyors expect that caregivers can locate information from all aspects of the medical record. Otherwise, continuity of care is broken and nonexistent.
Examples of dos and don’ts to follow

Do:
Preselect a location for conducting tracers in each patient care unit. Staff members do not need the added stress of juggling records while surveyors are becoming agitated as they wait for a review site to be selected. If your medical record is electronic, be sure to plan for a computer to be available in the selected review location.

Once you’ve been notified that the surveyors have arrived to conduct your unannounced survey, ensure that the selected location is clear of debris and that adequate seating exists for the surveyor, the caregiver, the surveyor escort, and perhaps one additional person. Test the computer to be used for tracers to 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, and so forth.

Remind the patient caregiver of the patient selected for the tracer to hand off to another caregiver. Surveyors tend to watch this practice very carefully.

Don’t:
Attempt to answer for staff members participating in the tracer or try to provide prompts when answers are not readily articulated. 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 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. Comments such as “Oh, this field should have contained the pain assessment” may seem minor, but in our state of nervousness, we might let such a comment slip. The solution is to practice the survey process with another department manager to ensure that your conduct remains appropriate.

Attempt to answer a question by assuming what the documentation was intended to mean; let the record speak for itself.
Using the preceding example, if medical unit staff members are unable to locate the pain assessment performed in the emergency department, for instance, 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.

**Success Story**

The transition to electronic records is not an easy conversion, and it becomes particularly troublesome during a tracer when staff members are under the gun to locate specific information. One organization developed a road map for nursing staff members who were still struggling with computer documentation. Snapshots of key screens and highlighted fields were printed in small tiles with step-by-step instructions detailing how to open the screens. Based on this information, the emergency department triage form and the pain assessment field were identified. The road maps were laminated and were used in daily work to increase their computer expertise.

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 were added in 2006, and program-specific tracers were added in 2008. System tracers include the following:

**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, ordering, transcribing, 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 either in 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 risks, and measurements of progress. Surveillance data should be readily available for this discussion. Surveyors may subsequently request the 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 are listed as the document to have ready for the surveyor’s review. Be prepared with a list of patients currently in isolation, the most current risk analysis, the prioritized strategies, and recent measurement data of the strategies.

Data use

The participants in this session should be well prepared to discuss data collection, data analysis, selection of appropriate interventions, and subsequent measurement 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, and perhaps any of the other topics listed in PI.01.01.01.
Emergency management (EM)

The EM tracer was established in 2006 for hospitals with more than 200 licensed beds, and in 2008, it was expanded to include all hospitals, regardless of size. This tracer was added in the aftermath of a review of the challenges hospitals faced during events such as the Gulf Coast hurricanes, including Katrina; the floods in Houston; and other catastrophic events in which response capabilities were quickly reduced to the point of evacuation.

During this tracer, surveyors will review and assess your hazard vulnerability analysis; your organization’s role in relation to the community’s EM planning; your preparations relative to the key response functions (communications, resources and assets, safety and security, staff, utility systems, patient care); practical implementation of the “all hazards” incident command structure (including linkages with the community); your organization’s capabilities during long-term events with no support from the community; and improvements made in response to opportunities identified during EM exercises.

In some instances, surveyors have been known to travel to specific patient care unit(s) and pose an emergency scenario (nominally based on your hazard vulnerability analysis), and then interview staff members within the unit on their role in EM. Consider adding a brief EM tracer to environmental rounds as a method to practice spontaneous questioning to staff members who may not be expecting to participate in EM survey activities.
Typically, record review has occurred during individual and system tracers, but the numbers of reviews depended on the length of the survey and number of surveyors. Agendas are packed with multiple activities now, so the first question is how the additional record review will occur. And think about this: If you have recently changed a process to comply with a standard, retrospective chart review might include those who received care prior to the change. Yikes, the olden days have returned with the influence from CMS. The good news is that the Joint Commission survey process will certainly prepare you for the dreaded CMS arrival because it appears that the two organizations’ survey processes are becoming increasingly similar.

What is the possible effect on your organization? For a medium-size hospital with an ADC of 130, 10% would be 13 records. An additional 17 records will need to be included in the review process to reach 30 records. Historically, your on-site survey has been scheduled for three days with three surveyors for clinical activities, not counting the life safety surveyor. Based on the typical three-day agenda, there are 19 opportunities for chart reviews during tracers. An additional 11 records, either open or closed, would need to be requested for review.

**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. 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; alternatively, 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. One of the most recent such alerts is Leadership Committed to Safety, which The Joint Commission posted on its Web site on August 27, 2009, and revised on September 8, 2009. These alerts include occurrence data, strategies for risk reduction, and recommendations for preventing the event. As a component of accreditation, 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 specialist and promoter of patient safety is why you would not want to utilize this valuable information already packaged for your review. It is recommended that each Sentinel Event Alert be assessed for implementation of recommendations as applicable to your hospital’s services and population. Also consider using the analysis of the alert and application to your organization as your required 18-month proactive risk assessment, formerly known as a Failure Modes and Effects Analysis.

**Electronic application**

Hospitals have access to their e-App that is available on the Joint Commission Connect extranet. Your assigned Joint Commission account executive 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. You must report any addition or deletion of a service 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 executive 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, and so forth.

**Your Survey Team**

Generally, The Joint Commission sends a team comprising a physician, a nurse, and an administrator to survey a hospital, and one of these three people acts as 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 to 750 beds would likely involve four surveyors and last at least four to five days. Beginning in 2008, all hospitals had an additional LSC 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.
TEST YOUR KNOWLEDGE

1. True or false: If your organization is accredited by The Joint Commission, you will be exempt from full surveys conducted by CMS.

Answer: False. The Joint Commission accreditation grants your organization “deemed status” to bill Medicare and Medicaid for services provided. CMS still provides oversight to all entities with deemed status. Validation surveys, follow-ups on complaints, and so forth may still be performed by CMS.

2. Which of the following is true regarding scoring of standards?
   A. Partial compliance will result in a supplemental finding
   B. Indirect impact requirements scored as noncompliant must be resolved within 45 days
   C. Immediate Threat to Health and Safety may result in either a preliminary denial of accreditation or conditional accreditation
   D. Conditional accreditation due to a situational decision rule must be corrected within 45 days

Answer: D. Evidence of standards compliance must be submitted to The Joint Commission within 45 days. A follow-up validation survey will also be conducted.