Joint Commission Survey Activity Guide for Hospitals

Do the 2010 changes foreshadow a different focus for surveys?

Did you happen to note that the Survey Activity Guide (SAG) was last updated by The Joint Commission February 11? We believe the subtle changes in the survey guide reflect potential changes in survey focus, driven in part by the commission’s ongoing effort to align with the CMS survey process. The best guidance for preparing for survey is provided within the SAG, which is on your extranet site. But the SAG has a lot of information. Our intent is to help you identify a few nuances within these changes to be better prepared for the day the Joint Commission survey team arrives at your door.

Survey activity list vs. survey agenda

A specific survey agenda is no longer predetermined. Instead, the survey team has a list of required activities. It will be your job to help them mold this list into a practical agenda. Start developing skeleton agendas and establish a process to collaborate with the survey team leader soon after arrival.

Documents

You may have only an hour’s notice that the survey team is on its way. After you greet them, you will take them immediately to an administrative conference room to be used as the “survey workroom” for the rest of your survey adventure. The room should be intimate but with enough space for ad hoc meetings in various sections of the room. Ideally, the room should be secured (i.e., supervised or locked) to safeguard surveyor materials and belongings. Imagine you are the host of the party and the surveyors are your guests.

The documents on the survey team’s list of required activities should arrive as soon as the surveyors do. Remember, less is more. Provide only the documentation specifically requested so the surveyor can easily find it. Then check—early and often—to respond to requests for more information. The worst thing you can do is bury the few documents the surveyor really needs in a mountain of unrequested support material. Keep the support material handy, but out of the survey workroom until requested.

Most of the material is completely described in the SAG. We’ve highlighted a few nuances below. To understand some of the items, you should check the Medicare Conditions of Participation (CoP). The current version is available at www.cms.hhs.gov/manuals/downloads/som107 AppendicesToC.pdf.

The worst thing you can do is bury the few documents the surveyor really needs in a mountain of unrequested support material.

Keep the following in mind:

p. 3 Anesthesia guidelines
Sue Dill Calloway, RN, MSN, JD, offers guidance on the latest CMS standards for anesthesia.

p. 5 Greeley survey solutions
Each month, an expert with The Greeley Company offers advice on a hot accreditation topic. This month we look at PPR.

p. 6 Medication Management standards
Guest columnist Gayle Cotchen, PharmD, MBA, looks at how the 2010 standards apply to ectopic pregnancy.

p. 11 Salary survey results
The Association for Healthcare Accreditation Professionals recently conducted a survey coordinator salary survey. See the initial results.

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12 months of performance improvement data are still requested (nothing new), but CMS surveyors also want to know about performance improvement projects, why they were chosen, and measurable progress achieved. This is straight out of the Medicare Quality Assessment and Performance Improvement (QAPI) CoP, and we believe this may foreshadow a deeper dive into the Medicare performance improvement requirements. Medicare is quite specific about QAPI, so make sure you know the CoP requirements and can demonstrate how you comply with them (A-0263 482.21).

The infection control plan and 12 months of surveillance data are still requested. Just remember to clearly show data in support of the National Patient Safety Goals (7.2–7.4): multidrug-resistant organisms, central line–associated bacterial infections, and surgical infections.

The “analysis from a high-risk process” means your Failure Modes and Effects Analysis or the equivalent. Remember, you now only have to have one within the past 18 months (LD.04.04.05 EP.10).

The activities guide still asks for measure of success (MOS) data from your PPR. This, too, is not a change, but note that you should not share your PPR and action plan, only the results of any measures of success you’ve been collecting as a result of the PPR. Many hospitals will have no MOS data to share. If so, simply state that “no MOS data were collected as the result of our most recent PPR.”

Remember the CoP when preparing your list of contracted services. This is not just a list of contracts for clinical services, but rather all contracts for services Medicare pays for. Don’t confuse a “purchase agreement” for supplies with a “contract for services.” For example, a purchase agreement for syringes or beds is not covered; a contract for elevator maintenance is covered (A-083 482.12[e]).

The agreement with the outside blood supplier is a remnant of ongoing discussions with CMS. At one point, the proposed Joint Commission standards required proof of an adequate blood supply (PC.05.01.01 removed from the final amendments). Although this requirement was removed, this item in the survey guide remains and can only be cross-referenced to the general adequacy of hospital services and the rather complex CMS standard addressing potentially infectious blood products (A-0592 482.27[b]).
The request for **governing body minutes** refers to the Medicare institutional planning requirements (A-073 482.12[d]).

Three specific credentials files are mentioned because CMS requires that **anesthesia** (A-1000 482.52), **emergency services** (if provided) (A-1102 482.55[a]), and **respiratory care** (if organized as a service) (A-1153 482.57[a][1]) be under the direction of a “qualified” physician.

Finally, the requirement for medical staff bylaws and executive committee minutes reminds us of when physician surveyors would spend a lot of time poring through these documents for evidence of various requirements, usually finding something they didn’t like. We hope we’re not seeing a return to those days.

So, like many of the requirements modified in the past 12 months, the documents requested in the **SAG** reveal a much closer alignment between Joint Commission and CMS survey processes.

**Editor’s note:** Bud Pate, REHS, is vice president of content and development at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

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**A look at CMS’ newest anesthesia standards**

**Continuing Education | Learning Objectives**

After reading this article, you will be able to:

- Identify who should be aware of the new CMS anesthesia standards guidelines
- Discuss who, according to CMS guidelines, is allowed to perform deep sedation
- Identify how to find CMS anesthesia guidelines in the published standards
- Discuss which patients must be seen by an anesthesia professional before leaving the hospital, according to CMS guidelines

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**Editor’s note:** Sue Dill Calloway, RN, MSN, JD, director of hospital risk management at The Doctor’s Company in Columbus, OH, is the CMS Corner lead contributor. **Submit a topic idea to her by contacting BOJ Senior Managing Editor Matt Phillion at mphillion@hcpro.com. This is part one of a two-part series.**

CMS published revised interpretive guidelines for hospitals on December 11, 2009, which was again revised February 5. Any hospital that accepts Medicare and Medicaid reimbursement must follow these guidelines for all patients, including commercial payer and no-pay patients, and not just Medicare and Medicaid patients. The guidelines do not apply to critical access hospitals, which have their own manual.

The most current hospital manual is dated June 5, 2009, but it is expected that a new manual will be issued soon to include the new anesthesia interpretive guidelines.

The final memo was 17 pages long and completely rewrites the CMS anesthesia section standards. Every anesthesiologist, certified RN anesthetist (CRNA), or anesthesiology assistant who practices in a hospital, including surgery, postanesthesia care unit, outpatient department, and OB unit, should be aware of these new guidelines, along with all prospective payment system hospitals. These standards are also of interest to places where moderate sedation may be given, such as in the emergency department or endoscopy unit. It is important to note that deep sedation is anesthesia, which can only be performed by an anesthesiologist, qualified physician (MD or DO), CRNA, or anesthesiology assistant.

A dentist, oral surgeon, or podiatrist who is qualified under state law may also administer anesthesia. The hospital’s policy must address the circumstances under which an MD or DO who is not an anesthesiologist is permitted...
to administer anesthesia, and hospitals must follow accepted standards of anesthesia care when establishing their policy and procedure. The American Society of Anesthesiology has a number of position statements and guidelines.

**Anesthesia tags**

The anesthesia standards start at tag number 1,000. The CMS hospital manual is 370 pages long and has 1,163 tag or section numbers. The new standards go into detail on the differences between anesthesia and analgesia. In analgesia, the patient does not lose consciousness and is given medication for pain relief by blocking pain receptors. Anesthesia is the administration of a medication to produce blunting or loss of pain perception, voluntary and involuntary movement, autonomic function, and memory or consciousness.

The anesthesia standards apply to general, regional, and monitored anesthesia care (MAC), and deep sedation can be performed by an anesthesiologist, qualified physician, CRNA, or anesthesiology assistant.

Topicals, locals, minimal sedation, and moderate sedation can be done by an appropriately trained medical practitioner within his or her scope of practice, such as an emergency department physician or gastroenterologist. In addition, these four services (minimal, local, minimal sedation, and moderate sedation) are not subject to the anesthesia administration and supervision requirement. Often these are administered by an RN. The hospital must have a policy detailing who can administer these that is consistent with the state scope of practice.

**Monitored anesthesia care**

These classifications are important later in the discussion on postanesthesia evaluations since the latter outpatient surgery patients do not have to have a postanesthesia evaluation before they leave the hospital. Patients who have had general, spinal, epidural, MAC, or deep sedation must be seen by an anesthesia provider before leaving the hospital. This may be problematic for some hospitals because they will have to change their process to meet this requirement.

MAC is defined by CMS as anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia, such as a CRNA or anesthesiologist. Indications for MAC depend on the nature of the procedure, the patient’s clinical condition, and the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in the definition of MAC.

Analgesia via epidurals and spinals for labor and delivery is permitted to be administered by a CRNA without physician supervision. (Make sure that a mask is worn when inserting, according to the Centers for Disease Control and Prevention guidelines, in light of five patients who acquired a hospital-associated infection.) This is considered pain relief. However, if the operating physician decides that anesthesia is required for the safe operative delivery of a child, the CRNA supervision requirements would apply.

Anesthesia services must be organized into one anesthesia service no matter where they are furnished, such as the operating room, OB unit, emergency department, psychiatric department, gastroenterology unit, or outpatient surgery areas. Anesthesia services must be under the direction of a qualified physician, such as the director of anesthesiology. The medical staff determines the criteria for the qualifications for the anesthesia director. An anesthesia service is responsible to adopt the many policies required by CMS, including the minimum qualifications for each category of practitioners who can provide anesthesia services. Other required policies include informed consent, infection control measures, safety practices, documentation requirements, equipment testing, and delineation of pre- and postanesthesia staff responsibilities.

*Editor’s note: In our next issue, Dill Calloway will continue her analysis by looking at supervision of anesthesiology assistant guidelines.*
The Periodic Performance Review (PPR) is an annual self-assessment process aimed at supporting continual accreditation readiness and performance improvement activities required by The Joint Commission.

There are traps that many organizations can fall into when scoring the electronic assessment. One pitfall is to score too harshly and end up with a large number of non-compliant standards that must then have measures of success (MOS) demonstrated to show compliance. There have been organizations that have scored 30–40 standards non-compliant, which resulted in an extremely complex and difficult action plan with which to comply. This dilutes the performance improvement efforts and can lead to only partial compliance when completed. It can become an annual exercise in futility since success is difficult to obtain.

It is not necessary for an organization to go through the entire electronic PPR standard by standard each year. Use of the previous year’s PPR can act as a baseline and allow for review of compliance with new or changed standards. Focus efforts on the priority standards for compliance and MOS activities. You should narrow the focus for compliance to standards that put your organization at the highest risk.

Once an organization has determined the limited number of priority standards on which to focus for the year, the developed MOS should be realistic and attainable. Keep in mind that the MOS, and compliance with the MOS, can be used by the surveyor during the next triennial survey. Surveyors will use this information to determine whether the organization is truly working toward compliance or whether the PPR was submitted simply for paper compliance.

The PPR should be thought of as a process to stay current in standard compliance and not a burden that must be completed annually with little or no benefit to the organization. Each new standard should be reviewed to determine whether the organization is currently in compliance. If it is not, evaluate the process that is currently in practice to see whether it needs to be altered or can be utilized as is to demonstrate compliance.

Keep things simple, as elaborate new processes that are unattainable or unsustainable may set the facility up for failure. Simplifying the process usually means reducing efforts rather than adding to them. Look for ways that are part of the natural process of performing everyday tasks that can be used with minimal alteration to fit the standard requirements.

For facilities that use the on-site PPR instead of the electronic submission, embrace the survey as an opportunity to learn from the surveyor. Ask surveyors questions about ways that they have seen other facilities reach compliance in areas that you feel you are struggling.

Use this time to gauge the organization’s survey readiness and establish changes that may need to occur to have the triennial survey run smoothly in the future.

As an aside, at the fall 2009 Executive Briefings, The Joint Commission announced that it was looking at a complete revision of the PPR process. However, this revision appears to have been put on the back burner, so the current PPR process remains in effect for now. ■
Applying standards to pharmaceutical management of ectopic pregnancy

Editor’s note: Gayle Cotchen, PharmD, MBA, is lead pharmacist at Magee-Womens Hospital of the University of Pittsburgh Medical Center (UPMC). Cotchen is a graduate of Duquesne University School of Pharmacy. She has more than 25 years of pharmacy practice experience and a background in women’s health, regulatory compliance, and patient safety. Below, she discusses the institutional experience complying with Joint Commission standards when treating a patient who has an ectopic pregnancy that is unruptured.

Ectopic pregnancy will be used throughout this article to illustrate some of the 2010 standards, highlighting The Joint Commission’s addition of hazardous medications to several standards in 2009. The purpose of this article is to illustrate the application of several standards to a health condition.

A detailed procedure for diagnosing and treating patients with unruptured ectopic pregnancy is not provided and is beyond the scope of this article. This health condition is a good choice for the purpose of this illustration because it is the leading cause of maternal death in the first trimester of pregnancy, and The Joint Commission’s most recent Sentinel Event Alert specifically addresses maternal death (see Issue 44: Preventing Maternal Death, released January 26).

Complying with recent changes to several standards may become clearer by applying them to a health condition, such as ectopic pregnancy. Topics included in this article are ordering methotrexate (MM.04.01.01), managing this high-alert and hazardous medication (MM.01.01.03), and disposing of it (EC.01.01.01).

➤ Medication Management standard MM.04.01.01: Medication orders are clear and accurate. At Magee’s emergency department, patients experiencing symptoms from an unruptured ectopic pregnancy are often ordered methotrexate. Instead of using computerized prescriber order entry or the general antineoplastic order form, Magee’s Pharmacy and Therapeutics Committee approved a policy requiring use of the Methotrexate Intramuscular for Ectopic Pregnancy order sheet. The order sheet increases the likelihood that the order is clear and accurate, because it does the following:

- Prompts the practitioner for necessary information, such as patient identification, height, weight, and allergies.
- Lists baseline laboratory tests to consider prior to methotrexate administration, which are b-hCG level, AST, serum creatinine (AST and serum creatinine only for patients with a history of liver or renal disease, respectively), hemoglobin, and blood type/Rh status. Serum creatinine or AST greater than twice the upper limit of normal are among methotrexate’s contraindications.
- Provides instructions for calculating the body surface area. As part of the pharmacist review, calculations are double-checked prior to order entry.
- Information that is incomplete, such as the physician’s printed name, signature, and date/time, is more noticeable since the field on the order sheet is empty. This is shown by viewing the bottom portion of the order form (see p. 8). Incomplete, illegible, or unclear orders are clarified by the pharmacist prior to dispensing.

Magee’s Pharmacy and Therapeutics Committee requires use of the order sheet, which avoids the use of verbal and telephone medication orders as required by element of performance (EP) 6 and documents the indication for use. This preprinted order sheet mirrors the Methotrexate Intramuscular for Ectopic Pregnancy policy, which is reviewed at least annually by Magee’s Pharmacy and Therapeutics Committee and updated based on current evidence and practice (EP 7).

➤ Medication Management standard MM.01.01.03: The hospital safely manages high-alert and hazardous medications. Methotrexate is one of Magee’s
high-alert medications (as the medication class: chemotherapy). The table below lists processes Magee identified for the safe use of methotrexate.

In 2009, the requirement to manage hazardous medications was added to MM.01.01.03, which had previously only required managing high-alert medications. Magee’s Pharmacy and Therapeutics Committee had reviewed the medications on its hospital formulary and approved a hazardous medications list (EP 1). Based on information from the American Hospital Formulary Service, the material safety data sheet from Bedford Laboratories, and the corresponding package insert (http://tinyurl.com/ygyu89c), drug handling precautions were determined for Magee’s hazardous medications, including methotrexate injection.

The precautions for managing this hazardous medication (EP 2) include wearing two pairs of chemotherapy gloves and gown. In addition, if splashing is anticipated, a face shield is worn when handling the patient’s excretions. Excretion handling for patients receiving high doses, such as doses greater than 500 mg per meter squared, necessitates following excretion precautions for seven days versus three days for low doses. Staff members audit this EP quarterly by observing processes involving Magee’s high-alert and/or hazardous medications for compliance with the EPs for this standard.

➤ **Environment of Care standard EC.02.02.01:**

The hospital manages risks related to hazardous materials and waste. To minimize the risks associated with disposing of methotrexate (EP 8), pharmacy and nursing place the hazardous medication waste (e.g., the syringes after the methotrexate injections have been given) in designated containers that are segregated from regular waste, sealed, and transported to a specific holding area for subsequent pickup by the vendor for disposal in accordance with applicable federal, state, and local laws.

Compliance with selected Joint Commission standards has been illustrated using ectopic pregnancy in the setting of Magee-Womens Hospital of UPMC. For safe and effective treatment of ectopic pregnancy, orders for methotrexate are carefully prepared following Joint Commission standards as well as state laws and regulations.

### Examples of high-alert medication processes

<table>
<thead>
<tr>
<th>Process category</th>
<th>Specific processes for handling methotrexate injection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Storage</strong></td>
<td>Do not store the vials above 5 ft. on shelves. Enclose shelves used for storing the vials or use shelves that contain a lip on the front to prevent products from falling from the shelf.¹</td>
</tr>
<tr>
<td><strong>Ordering</strong></td>
<td>Do not accept verbal orders for methotrexate. Attending physician will sign orders for methotrexate prior to agents being dispensed.</td>
</tr>
<tr>
<td><strong>Dispensing</strong></td>
<td>The syringes of methotrexate IM are drawn up in the chemotherapy laminar flow hood. Satellite pharmacist will routinely monitor chemotherapy preparation. Use chemotherapy baggie over the amber bags to transport drug.</td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td>Double-check that a spill kit, chemotherapy gloves and gown, and a yellow chemotherapy disposal container are readily available where administration will occur. Wash hands before donning two pairs of chemotherapy gloves (a protective gown is also recommended). Visually examine the transport bag for evidence of breakage; remove the syringe from the transport and amber bags if it appears intact.</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Access Methotrexate Intramuscular for Ectopic Pregnancy order sheet. Monitor patient according to established parameters, such as hCG to a nonpregnant level².</td>
</tr>
</tbody>
</table>


Sample order form

MAGEE-WOMENS HOSPITAL

Methotrexate Intramuscular for Ectopic Pregnancy

Authorization is given to the Pharmacy to dispense and to the Nurse to administer the generic or chemical equivalent of the above described drug. Unless the product name is enclosed in parentheses, the generic equivalent will be dispensed.

No Known Allergies

Allergies (indicate medication and reaction)

PATIENT INFORMATION:
Enter value if test was obtained.

LABS

HCG: Date drawn: 

Height ______ inches / cm

Weight (actual) ______ lb / kg

PATIENT INFORMATION:
Enter value if test was obtained.

LABS

HCG: Date drawn: 

Height ______ inches / cm

Weight (actual) ______ lb / kg

AST: 

Serum Creatinine: 

Hemoglobin: 

Body Surface Area (BSA) = m^2
to calculate BSA, go to www.medcalc.com/body.html and use Mesteller formula or use the Clinical Calculation in PowerChart

Printed: 

LABS/TESTS (order as needed or indicated)

- β-HCG
- Hemoglobin
- WBC
- Platelets
- Type and Screen
- Prochlorperazine (Compazine) 10 mg po once
- Other:

DIAGNOSIS

METHOTREXATE REGIMEN

- SINGLE-DOSE REGIMEN* 50 mg/m^2 = ______ mg IM x 1 dose on ______
- PERSISTENT TROPHOBLAST (date)
- POST-SALPINGOSTOMY 1 mg/kg = ______ mg IM x 1 dose on ______ (date)
- PROPHYLACTIC DOSE
- HIGH-DOSE REGIMEN* 1 mg/kg = ______ mg IM x 1 dose on ______
- CYCLE #: (date)

NOTE: Provide Rx for Leucovorin 0.1 mg/kg (round to nearest 5 mg tablet size) PO on next day

* Requires hospital-approved, treatment-specific consent

DISCHARGE INSTRUCTIONS

- Return for blood test on ______ (date); lab orders to be arranged by ordering physician
- Other:

Physician Printed Name: ____________________________ Pager #: ____________________________

Physician Signature: ____________________________ Date/Time: ____________________________

RN Signature: ____________________________ Date / Time: ____________________________

Source: University of Pittsburgh Medical Center. Reprinted with permission.
Using Lean and Six Sigma for change management

Hospitals are sick and need our help. That is the message process improvement concepts such as Lean and Six Sigma hope to address as they become more commonly used in healthcare.

Like any sick patient, there is a process to help make hospitals better. **David Marshall**, Lean Six Sigma healthcare consultant at Magari Consulting Services, said during a recent HCPro audio conference titled “Healthcare and Lean Six Sigma: Implement Process Improvements and Maximize Resources.” That process is:

- Assess
- Diagnose
- Treat
- Prevent

The symptoms, like waste and blame, pile on like any human illness.

“Blame is like a virus,” said Marshall. “But there are no bad people, only bad processes.”

As for waste, people adjust and get used to it. It takes “new eyes”—another common concept in Lean and Six Sigma—to spot waste we may have become so used to living with we no longer even notice it.

**Lean management**

Lean management is intended to eliminate waste, and that means leading by example. Management is not top down—but it must be supportive, said **Sarah Cottington, BS, RHIT, CPHQ**, performance improvement/RAC coordinator at Pella (IA) Regional Health Center.

- Identify the process for diagnosing a problem with Six Sigma
- Identify key concepts of Lean
- Discuss key components of Six Sigma
- Describe the DMAIC cycle

The people doing the work are the resident experts, and they must be integral when redesigning that work. Other Lean concepts include:

- A culture built on the scientific method
- Problem solving done during the course of work
- Departments that self-manage improvement efforts
- Taking care of small problems so larger problems go away
- All problems stated as they relate to the patient

“No change is made until there is a deep understanding of the way work happens,” said Cottington. “This deep understanding is achieved through direct observation of the work.”

And that understanding means naturally coming to recognize inefficiencies. “You want to learn to ‘see’ and recognize waste,” said Cottington.

Make it a part of new employee orientation, she said. Look at your existing processes with fresh eyes. Also, make Lean part of employee training: offer a course each quarter and provide coaching as needed.

“Learn by doing,” said Cottington.

Ask what you have done each day that is Lean. And make Lean part of all areas of your life—begin to model what you have learned, she said.

**Six Sigma**

Six Sigma is a distinct concept from Lean, but the two work very well together to create process change. Some view Six Sigma as a silver bullet, Marshall said, adding that “there is no one method” for fixing everything.

Other misconceptions about Six Sigma are that it works only in the manufacturing setting, that it is simply a fad, or that it is just about crunching numbers. It is a combination of vision, philosophy, metrics, goals, methodology, and more to evoke process change intended to reduce waste and variation, Marshall explained.

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Change management

The key components to Six Sigma are:

➤ Evidence-based
➤ Process focus, management, and improvement
➤ Preventive vs. corrective
➤ Boundaryless communication and collaboration
➤ Relentless pursuit of perfection with zero defects

Change management can certainly be done incorrectly, however. Poor change management can have many variations of negative results, including:

➤ Confusion
➤ Anxiety
➤ Anger
➤ False starts
➤ Chaos
➤ Resentment
➤ Burnout

A major component of making change management work is meeting management. Leaner processes involve fewer meetings, but meetings are still necessary—so do them right, said Marshall.

Consider the following tips for effective meeting management:

➤ Communicate the agenda at the beginning of the meeting
➤ Develop and enforce meeting rules

“Parking-lot ideas that are not within the scope of the project or the meeting agenda,” Marshall suggested.

Avoid interrupting when someone else is talking, and maintain a level of respect among participants.

Roles are important. Know who is:

➤ Leader
➤ Facilitator
➤ Timekeeper
➤ Note taker

And know how precious time is. End every meeting five to 10 minutes early to allow people time to get to their next meeting, Marshall said.

Editor’s note: Want to know more about Lean Six Sigma, process improvement, and change management? You can purchase this audio conference online at www.hcmarketplace.com.

prod-8412.
Slow year for wage increases for survey coordinators

Editor’s note: The following is an excerpt from the Association for Healthcare Accreditation Professionals (AHAP) annual salary survey. The survey polls accreditation specialists and survey coordinators nationwide.

In a year that saw budgets cut, travel expenses slashed, and jobs lost, it is unsurprising to report that 2009 did not see major increases in salary for accreditation specialists and survey coordinators across the country. What the 2010 AHAP Salary Survey discovered, however, is that increases did happen—but not in significant amounts.

According to the 83 AHAP members participating in this year’s survey, 40% saw no increase in the past 12 months. The remaining 60% saw at least a small increase, although 22% saw 2% or less, and 33% saw a rise of 3% to 4%. A small amount (4%) saw an increase of 5% to 6%, and only one respondent saw an increase above that (10%).

Members were also asked whether they are eligible for an annual bonus. The majority (59%) were not eligible for any kind of bonus, although a fair percentage (30%) were eligible for an annual bonus based on the performance of the organization, and another 18% had bonuses contingent on individual performance. Two percent received bonuses based on goals of efficiency or productivity in their department.

What are survey coordinators earning annually? The largest percentage (20%) make between $70,000 and $79,999 per year, according to our survey. In fact, most survey coordinators make within a range of $60,000 to $99,999 per year, with double-digit figures represented in each bracket of tens of thousands—17% receiving $80,000–$89,999, and 12% each making $60,000–$69,999 or $90,000–$99,999. Another 11% of respondents make between $100,000 and $109,999.

There are, as in every year, significant outliers. Two percent of respondents reported salaries of $30,000 to $39,999; another 9% made $40,000–$49,999 and 9% from $50,000 to $59,999. In the upper echelon of salaries, 5% of respondents reported making more than $150,000 per year. Another 2% reported salaries between $130,000 and $139,999.

In total, 24% of respondents reported making more than $100,000 per year. Only 6% reported making less than $50,000.

Education and certification

AHAP members are a well-educated group, according to this year’s survey. A whopping 44% of respondents reported achieving a master’s degree, and another 17% have performed at least some graduate-level work.

Another 20% hold bachelor’s degrees, and 12% hold associate’s degrees. Only 7% reported high school degrees as their highest form of education.

It is always an interesting activity looking at the alphabet soup of certifications our members hold, and this year’s survey is no different. The majority (62%) of respondents are RNs, and 33% are BSNs. As usual, Certified Professional in Healthcare Quality certification is well represented (23%).

The Certified Specialist in Healthcare Accreditation certification saw significant growth from previous years, with 19% of respondents holding this certification.

AHAP members are a widely varied group, as reflected by their certifications. Fifty-two percent of respondents reported additional certifications on top of those registered above. These included:

- MSN
- MBA
- BUAD
- RHIT
- MSHA
- MPH
- HACP
- CNOR
- M.Ed
- MHA

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**Wage increases**  
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**Who is a survey coordinator?**

The survey coordinator role continues to be overwhelmingly female. As usual, this year’s survey showed 94% of respondents were women.

The majority of respondents are experienced but still relatively new to the role—56% reported they have been in the survey coordinator position for two to five years.

A strong percentage (18%) say they have been in the role less than two years, and another 17% have been survey coordinator for six to 10 years. Only 9% have been at the job for more than a decade.

The age range for survey coordinators has remained consistent from year to year. The majority of respondents are between 51 and 60 years of age (52%) with the second largest contingency (27%) between ages 41 and 50. There were more respondents over age 60 (10%) than under 30 (2%).

**Where are survey coordinators?**

The survey respondents ranged across the country in relatively even numbers, although the three areas of the country that responded with 20% or more were North Central, Southeast, and Pacific states. The smallest percentage of respondents hailed from the Northeast (9%).

The urban/suburban/rural split was remarkably even—35% of respondents each from suburban and rural, 34% from urban. Larger hospitals (more than 300 beds) responded in larger numbers than either those with 150–300 beds (28%) and those with fewer than 150 beds (31%).

More than two-thirds of respondents reported that they oversee other hospital functions besides survey coordination. Most commonly (61%), this was quality improvement, but 30% of respondents said they also handled risk management or safety management.

Members of AHAP can access the complete report at http://tinyurl.com/ygc6mu6. If you aren’t a member, you can find out more about AHAP at www.accreditationprofessional.org.

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Get ‘talking’

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