New accrediting body

CIHQ receives deeming authority

A new player has entered the field for hospital accreditation: The Center for Improvement in Healthcare Quality (CIHQ) has received deeming authority from CMS for acute care hospitals. CIHQ joins The Joint Commission, DNV, Inc., and the Healthcare Facilities Accreditation Program (HFAP) in this arena.

Deeming authority allows an organization to accredit healthcare facilities, thus providing the hospital or healthcare organization an alternative to working directly with CMS or its home state to be accredited.

CIHQ announced its intention to pursue deeming authority two years ago.

“We believe that the fundamental purpose of a deemed-status agency is to assure that an accredited organization is in compliance with the Medicare Conditions of Participation (CoP),” CIHQ executive director Richard Curtis, RN, MS, HACP, said in the organization’s official announcement. “We have the tools and resources to do so! The core of a deemed-status accreditation process should be to assure that patients receive care in a safe environment by an organization that complies with the minimum standards set forth by the federal government. Your deemed-status provider should assure this; provide you with the tools and support you need, engage with you in a collegial, respectful, and educational manner, and perform these services at a reasonable cost.”

For decades, the only accreditation options for hospitals outside of working directly with CMS had been The Joint Commission or HFAP, with The Joint Commission holding the lion’s share of the market.

In addition to acute care hospital accreditation, CIHQ also received approval for three disease-specific certification programs:

- Heart failure
- Hip and knee replacement surgery
- Primary stroke center

Standards based on CoPs

According to the organization’s FAQs, CIHQ has joined the growing trend in hospital accreditation of staying very close to the requirements set forth in the CMS CoPs.

According to the official FAQs page, “since the fundamental responsibility of a deeming authority is to assure that a hospital meets the Medicare COP’s, it makes sense to assure that our standards are consistent with those regulations.”

CIHQ has also developed what it calls a “reasonable and modest set of additional standards” to address gaps in the CoPs and CMS Interpretive Guidelines.

Similar to other accrediting bodies, CIHQ has stated it will conduct full surveys on a three-year cycle, with a focused, mid-cycle survey occurring around the 18-month mark. CIHQ anticipates a full survey will take three or four days and involve two to four surveyors, including a facilities specialist, which once again brings the organization in line with the arrangements of other accreditors. Mid-cycle focused surveys, meanwhile, are expected to be one day in length with a single surveyor.

CIHQ will not require reporting of core measure or quality measure data, though hospitals will need to comply with CMS requirements for data reporting. CIHQ will
also not require reporting of sentinel events or root cause analyses for sentinel events.

Additionally, the organization will not require internal self-assessments of standards compliance.

And finally, while ISO certification has become more and more common among accrediting organizations,

CIHQ has elected not to require ISO or additional certifications, nor will it “mandate adoption of a particular performance measure or improvement program,” according to the FAQs.

More information on the new program can be found on the official CIHQ website, www.cihq.org.

Meet a member

A different route into the accreditation arena

More often than not, accreditation specialists find their way into their role through another area of healthcare—this is frequently nursing, but can also be administrative or other in-house responsibilities. AHAP member Tom Salamone, director of regulatory compliance with Gannet Fleming, entered the accreditation world through an unexpected route: the property insurance industry.

“I started out basically as the healthcare guru for a property insurance company,” says Salamone. “I managed the fire, life safety, and loss prevention for the entire healthcare book of the business.”

The company wanted to find an edge on its competition. At the time, it was the only carrier with an eye to fire prevention and loss control specifically, but the company wanted to get creative with the services it was able to offer, so Salamone’s boss posed him a question: What else could the company provide that would make it the insurance carrier for healthcare organizations?

Salamone responded by identifying the concerns about The Joint Commission that he heard time and time again as a consultant in the field, and so he was told, "Go out and become our expert."

“I attended seminars by The Joint Commission and then basically went to hospitals and networked, evaluating the activities of regulatory compliance directors, directors of safety and life safety,” says Salamone. “To tell you the truth, I learned most of my knowledge through osmosis. That’s how I became knowledgeable, and I’ve been doing it for 30 years!”

This learning method sounds a lot like the current practice of tracer usage, he notes, though at the time the preferred term was “mock survey,” and the focuses were on the environment of care, life safety, and emergency management.

“A lot of companies do this, and everyone is good at telling you what you’re doing wrong. What separates me from my competition is that I identify the issues and then work with the facilities to address all avenues for compliance while working a team,” says Salamone.

In this role, he also assisted in the development of environment of care and life safety dashboards that were user-friendly enough to be adoptable by—and adaptable to—other organizations. Things went so well, in fact, that Salamone found himself in need of a transition into the next stage of his career.

“I was educating them and giving them the tools, so they didn’t need me anymore!” he says.

From there, Salamone left the insurance industry and branched out into the consulting world, working directly with hospitals, nursing homes, and ambulatory surgery centers.

“I always got a kick out of helping hospitals do well,” he says.

But Salamone observed something between his work with the insurance world and as an independent consultant: When surveys would go well, the hospitals
he had worked with would be celebratory, and there was a sense of camaraderie and teamwork that he, as an outsider, wasn’t directly a part of.

“It was great because I’d helped them, but I said, ‘You know, I would love to be more involved in that. I want to be part of the team,’ ” he says.

So he went, Salamone says with a laugh, “to work for the good guys,” working with hospitals directly. He started out as a director of safety and eventually became a director of safety, security, emergency management, fire safety, life safety, and clinical (biomedical) engineering by the end of his time in this role.

“I oversaw all of environment of care, life safety, and emergency management as director,” he says. These days, Salamone is working with an architectural engineering firm.

“When I was working within healthcare, I did a lot of public speaking. I like to think those seminars were educational, informative, and enjoyable,” says Salamone. “I think the architectural and engineering firms saw my expertise value as well as respect, results, knowledge, and passion.”

And when those firms wanted to become players in the healthcare realm, they brought Salamone on board for access to his insider knowledge to increase their know-how and visibility.

**Observations over the years**

Having a few decades to observe the role of accreditation from various viewpoints inside and outside of hospitals, Salamone notes that differentiating between The Joint Commission and CMS remains a persistent challenge.

“Joint Commission is a survey—what they put in place is a proactive approach,” he says. “If you identify the issue before they do and have an acceptable and effective plan improvement, all sins are forgiven.”

But CMS is more of a “snapshot in time,” he observes. “You are either compliant or you’re not. CMS doesn’t particularly care about your plan for improvement—they’ll say, ‘That’s wonderful, but you are not compliant today.’ ”

He finds CMS to be much more thorough, with more eyes looking at more areas of the hospital—it really is an inspection versus a survey, he says.

Over the years, Salamone has also noticed a remarkable tonal shift in The Joint Commission.

“They have become more consultative and user-friendly,” he says. “It’s a much more fair and thorough Joint Commission.”

Meanwhile, CMS has increased its visibility and become much more present than in years past.

“People are more concerned now. CMS is more out there, more visible,” he says.

Because of this, Salamone cautions hospitals to be even more thorough than before in their ongoing preparedness.

“I think we need to be more diligent,” he says. “If your facility is a couple million square feet and you have no findings [in a Joint Commission survey], CMS might ask, ‘Are they really that good, or was the survey not that thorough?’ We need to keep up a full court press to stay prepared.”

He has also seen firsthand a particularly unusual survey incident: The Joint Commission and CMS arriving on the same day.

“I’ve lived in what I call Pandora’s box,” Salamone says, referring to that event. “We put them in a conference room and put a curtain between them. It was interesting to see how they played off each other.”

The organizations watched CMS actually recheck areas that The Joint Commission checked during that survey—giving a sense that CMS was able to kill two birds with one stone by inspecting both the hospital itself and The Joint Commission’s survey.

“The Joint Commission is now spending more time focusing on temperature, humidity, pressure relationships, air changes, HVAC cleanliness, all in addition to compliant sealing of penetrations of UL systems,” says Salamone.

He also notes a change in the people he speaks to in his education and consultative presentations.
“I used to speak only to engineers or safety people,” says Salamone. “Now I do a lot more presenting and educating to administrators and healthcare executives.”

Before this recent growth in interest from the executive level, he found that middle management understood the process and the need to ensure a successful survey, but getting support at the upper tiers was difficult due to a lack of understanding. Obtaining the budget, staff, or assistance needed to make improvements was difficult when leadership did not see the pivotal importance of compliance.

“Now when you talk to leaders, they are interested. They go back to their facilities and call in the department directors and managers,” says Salamone. “They ask, ‘Are we compliant? Do we have the capability to ensure compliance? How comfortable are you with the necessary existing resources?’ And leadership is now leading the talk. They’re in the room and they need to know that they’re not out of the woods.”

The Joint Commission’s decision to cite the leadership standards for noncompliance has been a game changer in this area.

Despite economic downturns in recent years, Salamone still sees a focus on survey readiness, particularly in the engineering/facilities side of healthcare.

“The economy is hurting, but healthcare is still growing,” says Salamone. “More renovations, more construction, more design work.”

And that means more of the tactics we as accreditation professionals have become accustomed to.

“I think facilities need to not only be proactive but to really keep that full court press on,” says Salamone. “Just because the survey is over doesn’t mean everything goes back to normal. We can’t get complacent, and I think that is our goal in healthcare and the message that we’ve needed to get to leadership.”

**FPPE, OPPE, and physician involvement**

*Communication key to developing optimal practices*

Every hospital faces unique challenges, and devises unique solutions, when looking for the best way to manage focused professional practice evaluation (FPPE). For example, Longmont (Colo.) United Hospital has implemented a singularly effective form for tracking FPPE within its radiology unit. In describing how that form was developed, AHAP Insider’s sister publication Medical Staff Briefing had the chance to hear about the bigger picture of not only the organization’s FPPE policy development and improvement, but also how it maximized physician involvement in the ongoing professional practice evaluation (OPPE) process.

“When we implemented FPPE in our facility, we involved the physicians in that process,” says Dana Crowell, CPMSM, director of medical staff services for Longmont United Hospital. Crowell is also president of the Colorado Association for Medical Staff Services.

Getting active participation from physicians wasn’t just a matter of rubber-stamp involvement, Crowell points out. “You can say you involved them if they approve certain things, but that doesn’t mean they were involved in the development phase. We wanted them to have ownership in the process,” she says, adding that any time a new requirement is handed down from an accrediting or regulatory agency, physicians appreciate being asked to help rather than having policy forced on them without their input.

When it came time to create the radiology form, for example, the organization reached out to its exclusively contracted group of radiologists.

“When we needed this to happen, we sat down with the president of that group and said, ‘Here is what we need—can you help us determine what appropriate things we would want to have reviewed?’ ” says Crowell.

The lead physician drafted a set of key components, and the form was created based on those.

“It was all rather painless,” says Crowell. “Had we had multiple groups, it might not have been so easy to accomplish.”
Longmont United Hospital has always had a radiologist as a member of its medical executive committee—radiology being one of its clinical service areas. Chairmanship of the committee rotates between radiology and pathology, with the representative from the other unit acting as a vice chair. Longmont also almost always has a radiologist on the credentials committee to keep that specialty directly involved in its decisions.

Crowell notes that this kind of direct physician involvement has been applied across the board.

“They know they have a key stake in what you’re trying to develop,” she says.

In addition to FPPE and OPPE, this physician involvement has been useful for focused chart reviews when the peer review committee identifies potential issues.

**OPPE by any other name**
While the healthcare community still struggles with the requirements of OPPE and FPPE, the former really is not a new concept.

“I’ve been here six years, and this facility has been doing OPPE for a long time—they were not necessarily calling it OPPE, but prior to the Joint Commission requirement a lot of facilities could probably say the same thing, doing the equivalent by gathering and evaluating performance data.”

That being said, when she first arrived Crowell found the forms in use somewhat generic.

“A generic form is okay if you’re looking at a medicine specialty. We had a generic medicine form, a generic surgery form, but nothing for pathology or radiology, radiation oncology, or emergency services,” she says.

The existing forms weren't really appropriate to evaluate those areas because they weren't asking the right questions to drill down into physician performance.

“We met with the leaders of those specialties to create forms specifically for them,” says Crowell. They worked on all the forms simultaneously, with Crowell explaining why it was important for each one to include specialty-specific data requirements.

“I think physicians were not aware that this data was being collected on them for years,” says Crowell. “They didn’t understand the importance of this data, that the data is relevant and will speak to whether your privileges are maintained, modified, or reduced.” Because of those facts, she explained, the information provided on the form has to be pertinent to physicians’ specialties.

Having exclusive contracts for some of these specialties made it easier to establish data requirements and get everyone on board.

“For other specialties like surgical and medical subspecialties, we have what I would call a generic form—we have a diagnostic and a procedural form, and although I call them generic, they are pertinent to any procedure,” she says. “Depending on what is being evaluated, we choose an appropriate physician to perform the analysis.”

This settled the issue of updating OPPE processes, but FPPE—as many organizations find—was a slightly more difficult challenge.

“It’s more difficult because it’s harder to understand,” says Crowell. “It’s one of those standards you can read the language and try to wrap your brain around, but it’s a tough sell to physicians because they feel we do our job at the credentialing and privileging process with the data we collect.”

FPPE from the standpoint of peer review might seem like a normal part of a facility’s practice, but it can be more difficult to gain acceptance for when done elsewhere—such as when it’s part of adding new privileges.

“I’ve actually had this conversation with a Joint Commission surveyor,” says Crowell. “It is sometimes perceived as a slap in the face to do FPPE for adding privileges, because we have a very strenuous credentialing and privileging process—we feel we go above and beyond the requirements to do best practices.”

FPPE’s requirement to collect additional data and evaluate every procedure performed, especially in an area like family medicine or general surgery, can seem an impossible burden.

“Fortunately, they said we could bundle procedures,” says Crowell. “But that’s why so many hospitals are still struggling. The expectation in the standards are very difficult to meet if you take them literally.”

Would it be more beneficial if The Joint Commission were more prescriptive? “Part of me would love it if they would
be more prescriptive and say, 'Here's the requirement, here is how we want you to do it.' But by the same token they want to give us the freedom to manage the hospital the way we see fit,” says Crowell. “That's part of the struggle, particularly for newer MSPs, as they work their way through Joint Commission and CMS requirements.”

In any event, Crowell and her organization have done something right with FPPE—at their last survey, the Joint Commission surveyors asked to take copies of Longmont's FPPE documents with them to pass along as best practices for other facilities.

“That makes you feel good at the end of the day,” she says. “When the people who really count want to share your story with other hospitals, that’s when you want to give kudos to everyone involved in the development process.”

Age makes a difference
Among the struggles to implement FPPE and the ongoing difficulties related to getting physicians on board with the concept, there has been a very noticeable pattern of which physicians are having an easier time.

“I've found that younger doctors who are coming out of training or recent graduates have much less trouble embracing FPPE and OPPE than those who have been practicing for many years,” says Crowell. “The residency and fellowship training programs are talking to them more and more about how you are not the captain of the ship, but rather part of a team.” When she works with younger physicians in an orientation setting, they are much more likely to make immediate sense out of the organization's FPPE processes. More worrisome, she finds, is a particular trend with physicians who have been practicing at other organizations.

“It's a bit disturbing—a lot of physicians who have been practicing in other facilities for a number of years, whether it was a practice in another area or a locum tenens, I get the deer in the headlights look,” says Crowell. “It appears that there are hospitals out there that are collecting this data without the physicians knowing!”

In some cases, it seems that the only time the data is made available to the physician is when there is an outlier. In other cases, physicians may actually be receiving the data but are simply too busy to notice its arrival. Regardless, the physicians have a right to this data, Crowell notes. “How will you hold them accountable for data they don't know about?”

In cases where the data is being provided but possibly overlooked, how can you ensure physicians will review the information your department gives them? The answer is physician involvement, says Crowell.

“There are a number of ways to involve your physicians—the standards require involvement, but there are different levels to meet that standard,” she says.

Best practice would involve the specialties in the process, giving them a say in how the data is used and ensuring the data arrives in a useful format. “This data needs to be useful and meaningful,” says Crowell. “I'm not a believer in gathering data just because we have to. It's not just the physician, but the hospital you're affecting!”

Crowell's organization does OPPE reports every six months, although her office works on those reports on a daily basis. “I have almost 400 reports to do, and one of the things we have been sensing is that perhaps the physicians are not getting as much out of them as we'd like,” says Crowell. In working with the medical executive committee, she and her office have tried to avoid making OPPE “busy work”—which brings us back to meaningful data collection. To get a better handle on how the physicians were perceiving and using the OPPE reports, Crowell's office issued a series of questions to gauge their involvement.

“We had some preconceived notions of what the answers would be. We were right on some and wrong on others,” says Crowell. “We thought based on previous feedback that we'd have a large number of practitioners who had no idea what OPPE was, but the majority knew exactly what we were talking about.”

Unsurprisingly, though, there was some confusion about what was being done with the data. “A fairly large percentage didn't know what we were doing with this information, so we needed to include more information on the cover letter for their reports,” says Crowell. They also received a fair amount of feedback asking for a different, more usable data format.

“I would encourage other hospitals who have been doing OPPE to take the time to do a self-check, and the best way to do a self-check is to ask your physicians!” says Crowell.

It's easy once the process is in place and functioning well to overlook the necessity of self-diagnosis. “It's human nature,
with so many plates spinning in the air at the same time, but unfortunately most of these processes are living, breathing, growing processes, and you have to adapt as you go,” says Crowell. “It’s always worth asking what can we do better.”

It is perfectly acceptable to put parameters on the suggestions you are asking for, she notes. For example, her organization specifies that requests for indicators should be electronically collectible, lest they be unusable with the current system. They also request that suggestions have a big-picture feel to them.

“We need things to be useful and meaningful not just to you, but to the entire group or specialty, and it needs to be measurable,” Crowell says. “We need to be able to put a numerator or denominator to it, and need to be able to measure compliance. This helps structure the conversation.”

**Survey your physicians**

To ensure the data you are collecting for OPPE reports is of value to your medical staff, be sure to check in with them. The following are the questions Longmont United Hospital presented to its medical staff as a check-in on the effectiveness of the hospital’s OPPE process:

1. Are you aware of the OPPE measures that are being used to evaluate your practice at Longmont?
2. Are you aware of how the data collected is used by the credentials committee, medical executive committee, and board?
3. Is the data provided in the OPPE reports useful to you in guiding practice improvement?
4. Do you feel the OPPE measures used are an effective tool to measure the quality of your hospital practice?
5. Are the OPPE reports easy to read and interpret?
6. What measures would you suggest be added or removed from the OPPE reports?
7. What other OPPE process changes would you suggest?
8. If you would like to discuss your suggestions with the credentials committee chair, please provide your name and preferred contact.

**Salary growth still limited for survey coordinators**

*Accreditation specialists see low or no increases to pay in past 12 months*

In the 2012 AHAP Salary Survey, just over a third (34%) of respondents reported receiving no pay increase in the previous 12 months, and of those who did, 31% received 2% or less. How did the profession fare in the 2013 survey? It could be argued accreditation professionals had an even worse year, according to the results, as the most significant responses still come from the low- to no-increase categories.

Respondents to this year’s survey reported a small uptick in going a year without a salary increase (35%), with a heavy 39% reporting a small increase of 2% or less. This number clocked in at 31% last year, so there has been some improvement there.

However, for the more respectable 3%–4% raise category, we saw a decrease from 27% in 2012 to 21% in 2013.

Increases higher than 4% this year were almost non-existent, according to respondents:

- 5%–6%: 1%, compared to 3% last year
- 7%–8%: Unchanged at 1%
- 9%–10%: No responses, compared to 2% last year
- Over 10%: 1%, a slight drop from 2% last year

But salary increases are not the only form of compensation, so we asked our respondents whether they received bonuses as part of their pay. The numbers barely moved from last year’s survey, showing that bonuses remain uncommon among accreditation specialists:

- An annual bonus based on performance of organization: 23%, up from 22% last year
- An annual bonus based on individual performance: 11%, up from 10% last year
- A bonus based on achieving department goals of efficiency or productivity: 9%, down from 11% last year
- No bonuses: 65% receive no bonuses (compared to 69% last year)
Only 1% of the survey takers answered that they had some other form of bonus this year. Because the number was so low, we looked at our archives for additional types of bonuses AHAP members have typically encountered in the past. These included:

- Longevity bonuses
- Bonuses based on quarterly financial achievements by the organization
- Combinations of personal and organizational goals

### Annual salaries
As in years past, accreditation specialist salaries hover in the mid to high five-figure range. The largest percentages this year (16%) reported salaries between $70,000 and $79,999, followed closely by those closer to six figures ($90,000 to $99,999) at 14%.

The number of respondents reporting salaries over $100,000 went up this year (29%, up from 23%), but so did the number of respondents reportedly making under $60,000 a year (21%, up from 17%). Going to a further extreme, we saw a very significant jump in respondents making over $150,000 this year (10%, up from 3%) with those making under $50,000 remaining roughly the same (13%, with a variation +/- a tenth of a percent).

Here is a breakdown of salaries, with last year’s reported percentages for comparison:

- Over $150,000: 10% (up from 3%)
- $140,000–$149,000: 4% (up from 3%)
- $130,000–$139,000: 1% (unchanged)
- $120,000–$129,000: 1% (down from 2%)
- $110,000–$119,000: 4% (up from 3%)
- $100,000–$109,000: 9% (down from 11%)
- $90,000–$99,000: 14% (up from 12%)
- $80,000–$89,000: 11% (down from 19%)

![What Is Your Current Salary Range?](chart.png)
- $70,000–$79,000: 16% (unchanged)
- $60,000–$69,000: 9% (down from 14%)
- $50,000–$59,000: 9% (up from 4%)
- $40,000–$49,000: 11% (up from 7%)
- $30,000–$39,000: 1% (down from 3%)
- Under $30,000: 0% (down from 3%)

Demographics
Every year as part of the salary survey, AHAP asks demographic questions of the respondents to paint a better picture of survey coordinators. The questions target age, gender, experience, education, and more.

The accreditation specialist role is still most often held by women. While last year we saw an increase in the number of male respondents, we saw an upswing in female respondents this year from 91% to 95%.

Nearly half (47%) of respondents are between the ages of 51 and 60. The closest age range to this group is 27% between the ages of 41 and 50. Accreditation coordinators continue to go strong from 61 to 70 years of age (14%); in fact, they make up a larger percentage of respondents than those 40 or under (11% from 31 to 40, and only 1% from 26 to 30).

But what about seniority? Instead of age, let’s take a look at length of time in the role. The breakdown in percentages between groupings is pretty close, with a noticeable but not overwhelming number in favor of the two- to five-year experience range. The survey found that 25% of respondents had been in the role for more than 10 years, while 27% had held the role from six to 10 years. The largest group, with two to five years in their current position, was 34%, while those with less than two years in

HAVE YOU RECEIVED A RAISE WITHIN THE LAST 12 MONTHS? IF SO, APPROXIMATELY WHAT PERCENTAGE OF YOUR SALARY WAS THE INCREASE?
their current role made up 14% of respondents.

It is interesting to note that the last group has shrunk since 2012 (from 20%), but this may simply be due to rising levels of experience in the role. Veterans of 10 or more years, however, made up only 14% of respondents last year. Again, this might simply be due to the stability of the role, as rookies graduate to veterans and experienced coordinators graduate into the 10-years-and-up category, but it is worth noting in terms of the evolution of survey coordinator demographics.

It is an old accreditation adage that survey coordinators wear multiple hats. Well, the adage is apparently true, according to this latest survey. More than half (59%) of respondents said they oversee survey preparation in multiple settings (down from 68% last year). We asked respondents to identify what other settings they oversee (allowing the opportunity to check off all that apply), and they’re broken down below, with last year’s percentages for comparison:

- Multiple acute care settings: 62%, up from 45%
- Ambulatory surgery center: 31%, down from 32%
- Home health agencies: 31%, unchanged
- Physician office: 36%, up from 31%
- Behavioral health center: 26%, unchanged

We have seen in the field numerous mergers and acquisitions among hospitals and hospital systems, which may account for the increase in accreditation specialists working across multiple acute care settings. News reports indicate that the purchase of physician offices by healthcare organizations is on the rise—could this be the reason behind these increased figures? Future surveys may give a clearer picture of these intriguing changes in survey coordinator roles and responsibilities.

Speaking of multiple hats, the survey also looked into whether accreditation specialists coordinated other areas or functions in their organization. Proving the old saying to be true once again, 69% of respondents said they do oversee other hospital functions. That other role included quality improvement almost half the time (49%), with safety management making up almost a third (31%) of responses. Here’s the full breakdown compared to 2012:

- Quality improvement: 49%, up from 48%
- Safety management: 31%, up from 28%
- Medical staff: 18%, down from 21%
- Risk management: 26%, up from 19%
- Nursing: 6%, down from 8%

A whopping 41% specified other roles not on the list above. The most common write-in roles were emergency management, infection control or some variation of it, regulatory compliance, and patient safety. Others included:

- Stroke centers, case management
- Continuing medical education
- Social work
- Interpreter services
- Clinical informatics, emergency department
- EMTALA

Because of the changing face of accreditation and the various options available to hospitals for accrediting bodies, survey takers were asked which accrediting body they use. The vast majority (95%) are accredited through The Joint Commission, while 25% use direct CMS/state survey accreditation. Smaller percentages use DNV Healthcare (6%) or the Healthcare Facilities Accreditation Program (1%).

**Training and education**

Training and education is a huge part of being a successful accreditation professional. On the whole, accreditation specialists are well educated—among this year’s respondents, the largest number (37%) stated they held a master’s degree, and another 3% hold a doctorate. Another 10% have pursued some amount of graduate-level work but do not yet have their degree. The percentages between categories vary a bit from 2012, but both this year and last, roughly half of all respondents have pursued some sort of postgraduate education.

Nearly a third of those remaining (31%) possess a bachelor’s degree, and 11% have an associate’s degree. Rounding out the respondents, another 9% hold some amount of college credits.

Certifications are also a key part of survey coordinator studies. Almost half of respondents are RNs (47%) and another 29% are BSNs, a slight downshift from last year’s 86% of RN or BSN respondents, but still a massive percentage. Interestingly, 5% of respondents this year identified as MDs.
Finally, respondents were asked in which part of the country they worked. Though there were smaller showings from the mid-Atlantic states than other regions this year, overall, the responses were well-distributed across the country:

- Southeast (AL, FL, GA, KY, MS, NC, SC, TN, VA, WV): 20%
- North Central (IA, IL, IN, MI, MN, ND, NE, OH, SD, WI): 20%
- Pacific (AK, CA, HI, OR, WA): 17%
- Northeast (CT, MA, ME, NH, NY, RI, VT): 18%
- Mid-Atlantic (DC, DE, MD, NJ, PA) 6%
- West (AZ, CO, ID, MT, NM, NV, UT, WY): 9%

What do you think of this year’s results? Take the conversation to the listserv by emailing ahap_talk@hcpro.com. We are also accepting suggestions for our next AHAP benchmarking survey, and would love to hear any feedback or suggestions. Please contact AHAP Director Matt Phillion at mphillion@hcpro.com.

Common professional certifications include Certified Professional in Healthcare Quality (CPHQ, 23%), always the most frequently noted professional certification, followed by Certified Specialist in Healthcare Accreditation (CSHA, 17%). There was also a jump from 4% to 7% among respondents holding the Certified Professional in Medical Staff Services (CPMSM) credential, proving that there is still a clear connection between medical staff and accreditation professionals.

Geography and hospital type
Lastly, to help paint a picture of our respondents, we asked a few basic questions about hospital and location. Every year the AHAP salary survey sees a bit of fluctuation between rural, urban, and suburban hospital responses, and this year the survey attracted more urban hospital responses (49%) than suburban (29%) or rural (25%).

This year also saw a slant toward larger hospitals (over 300 beds) among respondents, at 49%. Mid-sized hospitals (150 to 300 beds) and smaller hospitals (under 150 beds) were roughly on par at 27% and 25%, respectively.

Joint Commission announces clinical alarms NPSG
The Joint Commission announced in June a new National Patient Safety Goal (NPSG) aimed at improving the safety of clinical alarm systems. The goal is currently planned for implementation on January 1, 2014, and has been designated as NPSG.06.01.01.

According to The Joint Commission’s website (www.jointcommission.org), the purpose of the NPSG is to address improper management of alarms. Although alarms are necessary and serve an important role in the healthcare setting, mismanagement of those alarms can reduce or eliminate the benefits they provide.

The Joint Commission has identified a series of issues, distinct but interconnected, that contribute to the overall problem with clinical alarms:

- Unreliable detection: Some clinical alarms are difficult to detect in the healthcare setting amidst other noises and distractions.
- Staff desensitization: Faced with a barrage of alarms from various sources, staff become immune to the noises of alarms, presenting a danger when an alarm that requires immediate response falls on desensitized ears.
- Improper disabling of alarms: Closely tied to the previous example, staff find workarounds to remove what they consider “unnecessary” alarms. But in the process, staff may disable alarms that need to remain active.
- Alarm overload: In an environment rich with alarms of all kinds, identifying and prioritizing alarms becomes nearly impossible.
- Inability to personalize alarm settings: Some of the above challenges could be circumvented if organizations had the ability to change the tones and volumes of various alarms to ensure each signal remains distinct.

The Joint Commission has recommended two additional resources for alarm safety in preparation for the January 2014 implementation date for NPSG.06.01.01:
Hospitals and critical access hospitals have until January 1, 2016, to put into place policies and procedures for managing alarms. What does The Joint Commission mean by “managing alarms”? Specifically, the policies and procedures should address concerns such as conditions in which alarms can be disabled or altered, how and by whom parameters for alarms are established or altered, and ongoing alarm monitoring and maintenance.

By the beginning of 2016, hospitals and critical access hospitals will also need to create an educational component to their alarm management to ensure proper distribution of responsibilities and alarm use.

“The field has known that this has been a priority,” says Jodi Eisenberg, MHA, CPMSM, CPHQ, CSHA, manager of clinical compliance and policy management at Northwestern Memorial Hospital and AHAP chair. This is a topic to stay on top of, says Eisenberg. It has been a known concern in the field prior to the NPSG announcement.

“All organizations should be working through the recommendations that were communicated in Sentinel Event Alert 50,” she says. “Similar to recent NPSG releases, these have an extended timeline for implementation. The expectations seem to be in line with what hospitals should be doing to ensure patient safety.”

Stages of implementation
While NPSG.06.01.01 becomes effective January 1, 2014, the overall implementation of requirements will be staggered as follows:

Hospital leaders have until July 1, 2014, to make alarm system safety “a priority,” according to The Joint Commission.

Throughout 2014, hospitals should begin prioritizing alarms, garnering feedback from staff, care providers, units and clinical departments, and other sources. They should begin to address the results of a missed or ignored alarm and whether the alarm is in fact critical—is it necessary, or does it just add to the overall level of sound pollution and prevent staff from hearing truly important alarms?

Hospitals and critical access hospitals should look for best practices to prevent risks caused by alarm overuse and overexposure.

Alarm fatigue: The Joint Commission’s stance on prevention

Editor’s note: The following report was authored by AHAP advisor Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, a healthcare consultant in Trabuco Canyon, Calif., and former Joint Commission surveyor.

Spend a few moments in any hospital and it is likely you’ll encounter them—the endless beeps, sirens, alarms, and call tones that staff face every shift. We as a healthcare community have come to recognize that alarm fatigue is a real danger—everyone knows a story, either in passing or from firsthand experience, of the wrong alarm being silenced or simply missed among the many alerts assaulting our ears.

In April, The Joint Commission stepped up its focus on alarm fatigue by issuing Sentinel Event Alert #50, which specifically addresses medical device alarm safety in hospitals.

(The Sentinel Event Alert can be found on The Joint Commission’s website by visiting the following link: www.jointcommission.org/assets/1/18/SEA_50_alarms_4_5_13_FINAL1.PDF.)

Think about the average number of alerts and alarms a healthcare provider might encounter in the course of a day. They come from sources such as the following:

- Electrocardiogram machines
- Pulse oximetry devices

The Association for Advancement of Medical Instrumentation has provided additional information on alarms at www.aami.org/htsi/alarms.

ECRI (formerly the Emergency Care Research Institute) lists its top hazards, including alarms, at www.ecri.org/forms/pages/alarm_safety_resource.aspx.
• Blood pressure monitors
• Bedside telemetry
• Central station monitors
• Infusion pumps and ventilators

These systems are all pivotal for patient care, but they each have the tendency to drown the others out, either through similar sounds or simply just the buildup of noise.

According to The Joint Commission's alert, depending on the unit, a healthcare provider can hear hundreds of alarms daily. This translates into thousands of alarms in each unit, and an exponentially larger number across the entire hospital.

Studies show that anywhere between 85% and 99% of these alarms do not require critical attention. The Association for the Advancement of Medical Instrumentation (AAMI)’s report on alarms notes that many of these sounds have to do with machine maintenance—dried out electrodes or misplaced sensors, for example—as opposed to patient health. Is it any wonder that, when so few of the alarms indicate an immediate threat to health and safety, staff begin to tune them out?

And yet, it is because of that fatigue that real danger emerges.

Alarm-related events
The Joint Commission’s Sentinel Event database includes 98 alarm-related events from the start of 2009 through June 2012—80 fatal and 13 with permanent injuries.

Perhaps the best way to look at this issue, though, is not with numbers but with specific examples. There is an extensive write-up in the March 2012 issue of FIRST Do No Harm, a newsletter from the Quality and Patient Safety Division of the Massachusetts Board of Registration in Medicine, in which leadership from Massachusetts General Hospital (MGH) frankly and openly discuss a case where alarm fatigue directly led to a sentinel event.

The incident, which garnered significant press coverage, involved an 89-year-old cardiac patient who died after being found without a pulse in his hospital room. It was discovered during the organization’s own investigation that the lethal arrhythmia alarm setting (a default setting) had been turned off at the central station, and that the bedside monitor audible volume alarm had also been turned off.

The details of the incident are well documented in the press, but for our purposes we’ll concentrate on the follow-up actions. MGH found that its monitoring system was incredibly complex, with two different central monitoring systems, seven unique monitor models, and various software versions. It also found that there was a lack of consistency in monitoring practice across the continuum of care.

The MGH incident also brought to light the impact of alarm desensitization on staff, particularly the study “Monitor Alarm Fatigue: Standardizing Use of Physiological Monitors and Decreasing Nuisance Alarms” published in the American Journal of Critical Care.

“When alarm frequency is high, nurses are at risk for becoming desensitized to the alarms that are intended to protect their patients. Cardiac monitor algorithms are intentionally set for high sensitivity at the expense of specificity,” according to the study.

MGH then created a multidisciplinary team to develop clinical decision-making tools for monitoring patients as well as key education and communication components for the use of these tools.

It also oversaw the development of practice standards for transporting monitored patients from a patient care unit to a testing site, and lastly worked to build and support a culture of alarm awareness and responsiveness. MGH called this campaign “Every Alarm Warrants Action.”

Who should be involved?
Consider involving all of the following disciplines or related areas when examining alarm fatigue in your organization:

• Medicine
• Emergency department
• Intensive care
• Medical staff
• Nursing
• Biomedical engineering
• Quality personnel
• Clinical engineers
Constant alarms can be a deterrent for recovering patients who are trying to sleep. In fact, studies have shown that electronic sounds designed to alert are among the most powerful disrupters of sleep (though this seems like something you wouldn't need a study to prove!), and can cause issues even when set at the quietest levels.

That lack of sleep has ripple effects on a person's health. Specifically, it can contribute to:

- Obesity
- Hypertension
- Diabetes
- Increased mortality
- Increased morbidity
- Impaired glucose tolerance
- Increased inflammatory markers
- Lower antibody blood levels after immunization

All of these conditions can lessen the patient's ability to heal and recover, requiring longer stays and even creating the potential for readmission for future health issues. Lack of sleep can also lead to impaired performance, such as:

- Slower, less accurate mental states
- Unpredictable emotions
- Feelings of pessimism
- Unreliable memory
- Higher likelihood of risky behavior
- Stress
- Exhaustion
- Weak executive decision-making
- Poorer insights and fewer creative solutions

Perhaps most disturbing: According to the World Health Organization, background noise is doubling every 10 years, and thus, auditory system alarms must grow increasingly louder.

FMEAs
As we look for sources of advice for prevention, it is worth examining a report that, although issued back in 2008, has advice that's still applicable today.

The Pennsylvania Patient Safety Authority (PPSA)

- Administrators
- Ancillary staff

AAMI coverage
As we're compiling best practices and stories for avoiding alarm fatigue, we would be remiss if we didn't mention the AAMI's 2011 report on clinical alarms (available at www.aami.org/htsi/alarms/pdfs/2011_Alarms_Summit_publication.pdf). This excellent resource calls itself a “call to arms” and focuses on seven “clarion themes” that can help in the fight against alarm fatigue:

- Deepen all stakeholders’ understanding of use environments
- Improve alarm system management
- Innovate to improve alarm system integration
- Reconcile challenges and differences in use environments
- Strengthen medical electrical equipment standards and contracting language to promote success in all intended use environments
- Clarify regulatory requirements
- Share illuminating practices and lessons learned with all stakeholders

The AAMI report supplies some alarming statistics: It states that over a four-year period, the FDA received more than 500 reports of patient deaths that were related to alarm systems on monitoring devices.

In 2010 alone, some 2,500 adverse events were reported related to ventilator use, and roughly a third of the ventilator events indicated an alarm system–related problem. In fact, the participants of a recent AAMI summit believed these figures were low and that cases were underreported.

The ECRI Institute listed alarm system–related hazards as No. 1 on its top 10 health technology hazards for the year (alarm system–related hazards were listed as No. 2 in both 2010 and 2011).

The physical impact of alarms
Although we focus most often on the effect alarms have on staff’s ability to address patient emergencies, it is worth noting that alarms also have a direct impact on human health—both the well-being of staff and of patients.
addressed prevention in a patient safety advisory supplement entitled “Alarm Interventions During Medical Telemetry Monitoring: A Failure Mode and Effects Analysis.”

The PPSA took and deciphered data on alarm-related incidents from the Pennsylvania Patient Safety Reporting System, then narrowed its focus to responses to telemetry-related alarm interventions so that it could reasonably perform a failure mode and effects analysis (FMEA).

A fringe benefit of this analysis is that it fell into the FMEA format recommended by The Joint Commission. The initial report can be found here: www.patientsafetysolutions.com/docs/April_1_2008_Pennsylvania_PSAs_FMEA_on_Telemetry_Alarm_Interventions.htm.

The organization also provided an FMEA document, which can be viewed at the following link: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2008/mar5(suppl_rev)/Documents/mar5(supprev).pdf.

Tips for improving alarm recognition
The following tips were suggested by Julian Goldman, director of the CIMIT/MGH (Center for Integration of Medicine & Innovative Technology/Massachusetts General Hospital) Program on Medical Device Interoperability for the AAMI:

- Implement more individually customizable, “smarter” alarm settings at the point of care.
- Install a device/network data log to obtain a complete data set to optimize systems and alarm systems.
- Ensure that the healthcare community is actively participating in the process, whether through a clinician or engineer developing change, or end users evaluating and testing the systems. It’s not just up to the manufacturers to improve alarm settings.
- Use an open “app platform” to enable the efficient development of clinical decision support and alarm system apps.
- Adopt interactive alarms in patient rooms that vary their pitch and speed based on criticality. You can see an example of such an alarm at the following link: www.boston.com/lifestyle/health/specials/alarmsgraphic.