Connecting leadership to patient safety
Initiative helps build accountability, trust

To build more accountability in the area of patient safety, one group has crafted a tool staff are able to carry with them throughout the day.

This tool, a patient safety expectations badge, is part of an overall contract between leadership and staff members to help build a better culture of safety in their organization.

“The first time we ever used it was with an anesthesia group in Atlanta,” says Steve Harden, chairperson and CEO of LifeWings Partners, LLC, which developed the badge and contract.

The anesthesia group was performing contracted services for the hospital and wanted to undertake a patient safety initiative of its own while the hospital worked on its own such program.

“The first thing we did was direct observations to see what they were doing and surveyed them to see what they were doing as a team, and then ran a safety climate survey,” says Harden.

What Harden’s team discovered was that this group had some of the lowest scores the team had ever seen on willingness to speak up.

“This was interesting, because the group was made up of many CRNAs, and the CRNAs were all saying that they had a great reluctance to speak up if they saw something that was amiss,” says Harden. “We began to probe that.”

One of the things Harden’s team uncovered was that there was a lack of trust between the groups and some concern about whether they’d be treated well, or whether retribution would occur, if they did speak up.
“So we sat down with the leadership group and said, ‘It’s not that they don’t know they should speak up, it’s a lack of a sense of psychological safety if they do speak up,’” says Harden. “We need to bridge that gap.”

The problem with most patient safety initiatives, Harden notes, is that you run into situations where leadership simply tells frontline staff or unit members what they need to do.

“We wanted to turn that dynamic on its ear,” says Harden. “Rather than telling your staff what they need to do, you tell them what you’re going to do as a leader that you’re willing to put in writing.”

The idea was borrowed from other industries where LifeWings has worked, such as construction. Harden’s group sat down with leadership and asked them: What are you willing to put into writing? What will you promise your staff about how you’re going to react when they speak up, and how you should be held accountable for those things?

The answers to these questions were put into writing and built into the patient safety program implementation process—and they ultimately helped improve the organization’s culture.

“We do a safety climate survey there every year to see how we’re doing, and after our first survey we saw a 300% improvement in willingness to speak up, and every year they continue to steadily improve,” says Harden.

A national problem

AHRQ does a retrospective study every year on all the hospitals that take the safety climate survey. The numbers it collects regarding willingness to speak up are not encouraging.

“If you look at the average score across the U.S. for willingness to speak up and question the decisions of those in positions of more authority, that figure hovers around 50%,” says Harden. “Basically what the survey is telling us is that all across the country, if someone perceives a problem with patient care and the person they need to say something to has more perceived authority than them, there’s only a five in 10 chance they’re going to say something. That’s not a very good score.”

And the No. 1 reason Harden and his staff have heard as to why staff won’t speak up?

“ ‘The administration won't support me,’ ” says Harden.
More frustrating still is that hospital leadership often would support that staff member if he or she came forward.

“Of course, when you tell this to administration they throw their hands up in despair,” says Harden. “The point I make with them is that you can say you will support them all you want, but what you do is talking louder than words. It’s not what you say, it’s the actions you take.”

This is why the concept of the patient safety expectations badge created by Harden’s group is so effective. The badge is essentially a contract listing what staff can expect in terms of support from their leadership, presented in a form that staff can carry with them throughout the day.

“If you’re willing to take what you say and put it in writing and then give it to your staff and say, ‘This is what you can expect from me, and if I don’t do that, I expect you to hold me accountable for it,’ it’s a huge symbolic action,” says Harden.

In the first year following implementation of the expectations badge within the anesthesiology group, surveys at the client organization showed that the group’s willingness to speak up to those in authority had increased to 70%—20% higher than the national average.

“This number would have been even better if the rest of surgical services department had participated in the program,” says Harden. Thanks to the anesthesiology’s group’s success, though, that participation may indeed happen. “As it turns out, we’re in discussions to implement the patient safety program with the rest of surgical services,” says Harden.

**Daily habits and belief systems**

Changing patient safety behavior and culture is a big picture process driven by smaller actions.

“It’s our belief that the safety results you want in your hospital are driven by the daily habits of your staff,” says Harden. “And what people do by having a practice pattern is really driven by what they believe. What staff believe is driven by the experiences that leadership create for them.”

In other words, outcomes are really driven by the day-to-day habitual behavior of the staff. And these actions are driven by what people believe about ‘how things are done around here.’ Beliefs about ‘how things are done around here’ are driven by leadership actions.

Changing culture always begins by asking, “What results do you want?” Answer this question first. For example, are you aiming for zero sentinel events? Zero healthcare-acquired infections?

“Next, ask, ‘What actions or behaviors do you need to see from your staff to get that?’ Then, ‘What do they need to believe in order for them to act that way?’ ” says Harden. “And lastly, what can you do as a leader, what experience can you create, that’s going to change what your staff believes about how things are done around here?

“What can you do as a leader to fundamentally change your staff’s beliefs?” he continues. “This is why the expectations badge is so helpful to creating a culture of safety. A leader creates a belief-changing experience by sitting down with their staff and saying, ‘Here is what you can expect from me. And, if you don’t see that behavior from me, I want you to hold me accountable for it.’ ”

**Altering behavior**

As an outside observer working in different hospitals, Harden notes a huge misconception, particularly among healthcare leadership, that “telling is training” when it comes to safety issues.

“In other words, I tell you I’m going to support you and therefore you should believe it,” says Harden. “But telling is not training. If you’re going to train someone well enough that they’ll change the way they perform their actions or behaviors, you have to have four things.”

What are those four things?

• Explain the “why” and the “how”
• Demonstrate the physical action—what the action or behavior looks like
• Give the staff member the opportunity to practice that behavior or action under the watchful eye of an expert
• Give the staff member feedback on how well his or her practice met the desired model

“You can tell someone all you want that you want them to speak up and you’ll support them, but unless you’ve shown them what that behavior looks like, and given them an opportunity to practice it, and then given...
them feedback, you’re not really changing their behavior,” says Harden.

For example, Harden’s group was working in a hospital in Georgia where staff were struggling with speaking up. The organization had a culture of intimidation between surgeons and surgical staff.

“In the course of 16 months, eight sentinel events occurred in the OR, and in almost every one of those events it was clear there were members of the staff who had concerns about what was happening but chose not to speak up,” says Harden.

Staff were provided with all the tools and training for improved communication. Nevertheless, the organization struggled with changing the culture because hospital leadership was falling into the common trap of telling-as-training.

But then, “an incident happened that fundamentally changed the whole dynamic,” says Harden. A surgeon got extremely upset with a surgical nurse and went to the hospital CEO to complain. The surgeon told him that he had told the nurse that she would lose her job if she ever stood up to him again. “And the CEO said to the surgeon, ‘You have a mistaken idea about how we operate around here,’ ” says Harden. “ ‘We don’t treat our nurses like that here. If you want to practice medicine here, you’re going to go back, apologize to her for your behavior, and I’m going to follow up by asking her if she got that apology.’ ”

The CEO’s words created a belief-changing experience for that nurse and the rest of the OR staff, letting the nurse experience firsthand what leadership support of speaking up looked like.

“That was where the corner was turned for this organization,” says Harden. “The story of the incident spread like wildfire among the OR staff. Because of that experience, the staff began to believe they would be supported when they spoke up. Because their beliefs changed, their actions changed. Because the culture has changed, this hospital hasn’t had a patient-harming error in the OR in over five years.

“The fact that there are pockets of disruptive physicians, and that they’re tolerated by the hospital leadership, is in itself an experience that creates a belief,” he says. “Those experiences all create a belief in the nurses’ minds about how things are done. What we’re saying to leadership is that you have to change that dynamic if you want to create a sustainable culture of safety.”

**Things to do to prepare**

The expectations badge concept is important, but not sufficient on its own, says Harden.

“You’d be shocked at the number of hospitals where nowhere in the policies and procedures does it say you have a responsibility to speak up and to hold your team accountable when you perceive a problem with patient care,” he says. “We all say it is important, but very few hospitals put it in writing.”

If a hospital does include speaking up in its policies and procedures, it should also be included in annual performance reviews. And if it’s in performance reviews, it should also be in the written job description. “In 90% of job descriptions, it’s not there,” says Harden. Logically, if it’s in the job description, it should also be in new hire and training programs. “Staff should be explicitly trained to speak up and how to stop the line. It’s a key competency,” says Harden.

Harden says he would go so far as to change the interview process to actively recruit people who can either demonstrate this behavior or can talk about times when they spoke up and held someone accountable.

“I would also have an escalation policy,” he says. “If you speak up and you don’t get a satisfactory response and you still believe it’s a problem with patient care, who do you call? And if that person doesn’t help you, who do you go to next?”

Such changes would speak volumes, he says.

“Imagine you’re a nurse and you apply for an opening, and during the interview they ask you if you’ve ever spoken up,” says Harden. “And when you get hired, leadership makes a big deal about your ability to speak up and hold people accountable. And every year, during your performance review, you get feedback on your willingness and ability to speak up. If you were that nurse, would you not believe that speaking up was something you’re expected to do? That speaking up is just the way we do things around here?”

If a hospital did all of these things, would it still have problems with getting staff to speak up? Perhaps. But it also would be taking a giant step toward drastically reducing instances of patient harm.
CMS annual report

LSC tops disparity rate numbers for last fiscal year

Continuing Education Objectives

After reading this article, you will be able to:

- Discuss how CMS surveys have changed in recent years
- Describe how CMS survey results differ from those of accrediting organizations
- Identify trends in validation surveys and disparity rates
- Describe Life Safety's influence on disparity rates in recent years

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

Every year, CMS releases an annual financial report. Within that report, the agency provides a review of Medicare’s oversight of accrediting organizations. It has become a Briefings on The Joint Commission tradition to take a look at what CMS finds, as well as how The Joint Commission and other accrediting organizations (AO) fare.

As those of us in the accreditation field know, to be eligible for CMS reimbursement, certain types of healthcare facilities (including hospitals) need to demonstrate compliance with the CMS Conditions of Participation (CoP). For the purposes of this discussion, we will focus primarily on hospital accreditation. CMS has currently approved Medicare accreditation programs for The Joint Commission, DNV Healthcare, the Center for Improvement in Healthcare Quality (CIHQ), and the Healthcare Facilities Accreditation Program (HFAP).

The number of Medicare-certified hospitals was largely unchanged between fiscal year (FY) 2008 and FY 2013. Hospital and psychiatric hospital programs are the only categories in which the majority of facilities participate in Medicare by virtue of accreditation under an approved Medicare program. On paper, the number of deemed hospitals actually decreased between those years, from 4,381 to 3,793; however, the approval of a separate Medicare psychiatric hospital accreditation program in 2011 resulted in 435 deemed psychiatric hospitals moving out of the hospital category. The proportion of Medicare-certified hospitals that were deemed has decreased from 89% to 83% during that time frame.

As we all know, AOs are responsible for surveying facilities on-site during the site visits we work so hard to prepare for. In FY 2013, according to CMS reports, AOs performed 1,770 initial surveys and 3,324 follow-up surveys. So how did this break down by individual AOs? Again, focusing on hospitals, FY 2013 saw the following:

- The Joint Commission: 3,372 deemed hospitals, 48 initial surveys, 1,165 renewal surveys
- HFAP: 168 deemed hospitals, six initial surveys, 52 renewal surveys
- DNV: 253 deemed hospitals, 41 initial surveys, 62 renewal surveys

Among those surveys, how did hospitals fare? DNV awarded full accreditation to 100% of hospitals surveyed (with two pending approval). HFAP also awarded 100% of hospitals surveyed full accreditation (though it denied one ambulatory surgical center accreditation). The Joint Commission awarded full accreditation to 98% of its hospitals, with three hospitals receiving denial of full accreditation (19 were pending approval at the time the CMS report was released).

State surveys

Meanwhile, the number of state surveys continues to grow, as does the impact of those surveys. Since 2007, CMS has worked to strengthen its oversight of AOs. In FY 2013, there was a slight decrease in the number of representative sample validation surveys due to less funding available for such surveys.

In 2007, 55 hospitals and 35 nonhospitals were surveyed. This number jumped to 92 and 76, respectively, the following year. Those numbers climbed significantly each year, most significantly in 2012 with 102 hospital and 230 nonhospital surveys, although the totals were slightly lower in 2013 with 106 hospitals and 192 nonhospital surveys.

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The overall result? An increase of 231% for overall validation surveys conducted.

But what about the 60-day validation survey? This survey is meant to assess the accrediting organization’s ability to identify noncompliance with the CoPs.

CMS determines the number of validation surveys to perform on each AO based on the number of facilities that AO surveys each month, as well as factoring in the overall budgeted targets by state and facility type for validation surveys. CMS tries to create a relatively representative national sample for each program. In FY 2013, 3% of hospitals received a validation survey.

Here’s where the rubber meets the road: Following a validation survey, CMS looks at the number of condition-level deficiencies cited by the state agencies performing the survey versus those cited by the AO. CMS is looking for how accurately the AO is surveying the hospital or other program for serious deficiencies.

If the state agency cites a condition-level deficiency for which the AO has not cited a comparable deficiency, CMS

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**Total number of deemed facilities initial surveys and renewal surveys by AO accreditation program (FY 2013)**

<table>
<thead>
<tr>
<th>Program type/accreditation organization</th>
<th>Total deemed facilities</th>
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<th>Renewal surveys</th>
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<tr>
<td>AOA/HFAP</td>
<td>168</td>
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<td>52</td>
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<tr>
<td>DNV GL</td>
<td>253</td>
<td>41</td>
<td>62</td>
</tr>
<tr>
<td>TJC</td>
<td>3,372</td>
<td>48</td>
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</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>TJC</td>
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<td>21</td>
<td>153</td>
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<tr>
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<td></td>
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<tr>
<td>AOA/HFAP</td>
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<td>9</td>
</tr>
<tr>
<td>DNV-GL</td>
<td>55</td>
<td>19</td>
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<tr>
<td>TJC</td>
<td>357</td>
<td>6</td>
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<tr>
<td>TJC</td>
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<td>536</td>
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<td>ACHC</td>
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<tr>
<td>CHAP</td>
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</tr>
<tr>
<td>TJC</td>
<td>612</td>
<td>144</td>
<td>117</td>
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<tr>
<td><strong>Ambulatory surgical center</strong></td>
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<td>AAAASF</td>
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<td>AAAHC</td>
<td>846</td>
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<td>7</td>
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<tr>
<td>TJC</td>
<td>483</td>
<td>74</td>
<td>126</td>
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</table>

Source: As reported by AOs.

* The DNV-GL CAH accreditation program received initial approval in FY 2011. Therefore, no renewal surveys were due to be conducted in FY 2013.
considers that area of noncompliance “missed.” This miss factors into the AO’s “disparity rate,” which is the number of AO surveys with missed condition-level deficiency findings divided by the number of 60-day validation surveys.

How did hospital accreditors perform in FY 2013?
On the whole, according to CMS, not well—out of 96 60-day validation surveys, state agencies found 52 condition-level deficiencies, 44 of which were missed by the AO, for a disparity rate of 46%. This number has climbed over the years as validation surveys have increased: from 33% in 2008 to 36% in 2009, 38% in 2010, and 44% in both 2011 and 2012.

Let’s break down how each individual AO did. Obviously, the numbers will be somewhat skewed given the larger market share and number of surveys The Joint Commission is involved in—namely, The Joint Commission had more than seven times the number of validation surveys than either of the other organizations. That said, The Joint Commission had a disparity rate of 41% in 2013, compared to a rate of 67% for HFAP and 64% for DNV Healthcare.

Physical environment versus other conditions
As has been discussed in this space previously, when looking at noncompliance it is telling to see how facilities and physical environment requirements impact totals for findings. CMS writes: Examining the specific condition-level deficiencies cited by the SAs across all 60-day validation surveys provides an indication of the types of quality problems that exist in these facility types as well as the relationship between SA and AO citations for specific conditions.

CMS uses two approaches to analyze the results: a review of types of condition-level citations and a

### 60-day validation survey results for each facility type (FYs 2008 through 2013)

<table>
<thead>
<tr>
<th></th>
<th>FY 2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tr>
<td><strong>Hospital</strong></td>
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<td></td>
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<tr>
<td>60-day validation sample</td>
<td>92</td>
<td>89</td>
<td>104</td>
<td>73</td>
<td>102</td>
<td>96</td>
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<tr>
<td>SA: Condition-level deficiencies</td>
<td>43</td>
<td>39</td>
<td>47</td>
<td>36</td>
<td>50</td>
<td>52</td>
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<tr>
<td>Missed by AO</td>
<td>30</td>
<td>32</td>
<td>40</td>
<td>32</td>
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<td>44</td>
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<tr>
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<td>36%</td>
<td>38%</td>
<td>44%</td>
<td>44%</td>
<td>46%</td>
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<td>0.06</td>
<td>0.07</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>60-day validation sample*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>SA: Condition-level deficiencies</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Missed by AO</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Disparity rate</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>75%</td>
<td>60%</td>
</tr>
<tr>
<td>Sampling fraction</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>0.05</td>
<td>0.06</td>
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<tr>
<td><strong>Critical access hospital</strong></td>
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<tr>
<td>60-day validation sample</td>
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<td>22</td>
<td>23</td>
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</tr>
<tr>
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<td>16</td>
<td>16</td>
<td>11</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Missed by AO</td>
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<td>15</td>
<td>9</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Disparity rate</td>
<td>41%</td>
<td>68%</td>
<td>65%</td>
<td>45%</td>
<td>36%</td>
<td>40%</td>
</tr>
<tr>
<td>Sampling fraction</td>
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<td>0.14</td>
<td>0.16</td>
<td>0.14</td>
<td>0.13</td>
<td>0.23</td>
</tr>
</tbody>
</table>

* Not part of the validation program as a separate program type until FY 2012. The psychiatric hospital accreditation program received initial CMS approval in FY 2011.
comparison of the number of surveys where the state agencies found physical environment condition-level deficiencies and the number of other types of deficiencies cited.

“Both approaches highlight the same conclusion,” CMS writes. “SAs identify more serious physical environment deficiencies than any other type of serious deficiency on validation surveys, and the AOs miss a significant number of these environmental deficiencies.”

This information has been consistent over the past several years of data collection. Interestingly, despite CMS finding more missed environmental deficiencies than any other type, facilities- and environmental-related citations have dominated the top 20 most-cited standards for The Joint Commission every year for the past several years as well.

According to CMS, the most missed deficiencies other than physical environment (for which CMS says AOs missed 31 out of 33 findings) were:

- Infection control, cited 15 times by state agencies and missed seven times by AOs
- Governing body, cited 12 times by state agencies and missed eight times by AOs

There were missed findings in nine other categories as well, but all were single-digit numbers in terms of both findings and missed deficiencies.

How much do aging buildings and increasing regulatory requirements play into these findings? It would be interesting in future analyses to see exactly how such factors have impeded facilities’ improvement. It would also be worthwhile to find out, should CMS release the information, which deficiencies the AOs uncovered that CMS surveyors did not as a comparison of effectiveness.

**Life Safety Code® misses**

According to the CMS report, “physical environment condition is still the single largest driver of disparity rates for hospitals” and critical access hospitals.

The disparity rate for physical environment ranges between 13 and 22 percentage points higher than the disparity rates calculated for other health and safety issues.

CMS also writes: “The majority of the physical environment disparity consists of LSC [Life Safety Code®] deficiencies.”

CMS engineers have generated a report that identifies the top LSC deficiencies cited by state agencies for FY 2013, which are consistent with the previous two years as well. The report is intended, CMS notes, to provide AOs with “an understanding of the emphasis of CMS LSC surveys, which should allow the AOs to ensure their programs are focusing on the same LSC provisions. Should AOs choose to focus on the top LSC deficiencies cited by the SAs, we would expect this would result in a reduced LSC disparity.”

CMS reports that AOs have particular difficulty identifying deficiencies related to the LSC 2000 edition requirements CMS has adopted. This might catch followers of the progress of the 2012 LSC by surprise—CMS notes that it has issued a number of categorical waivers to the LSC 2000 edition that aligns its requirements more closely with the LSC 2012 edition, but AOs are required to use standards that are “consistent with Medicare standards, and may not unilaterally impose a

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**Number and type of condition-level deficiencies cited by SAs/missed by hospital AOs (FY 2013)**

<table>
<thead>
<tr>
<th>Medicare CoPs</th>
<th>Cited by state agency</th>
<th>Missed by accrediting organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size: 96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governing body</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Patient rights</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>QAPI</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Medical staff</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Nursing services</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Medical record services</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Pharmaceutical services</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Food &amp; dietetic services</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Physical environment</td>
<td>33</td>
<td>31</td>
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<tr>
<td>Infection control</td>
<td>15</td>
<td>7</td>
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<tr>
<td>Surgical services</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>2</td>
<td>1</td>
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</table>
different LSC edition than CMS has adopted.”

The CMS report states that the agency does not believe a difference in LSC editions accounts for the extent and persistence of AOs’ problems with LSC deficiencies.

**CMS improvements**

CMS has also made several moves to improve its oversight and collaboration with accrediting organizations. Let’s review some of the most significant updates:

- **Communication.** CMS meets periodically with national AOs to foster communication between the AOs and CMS. These meetings also serve as a forum to discuss operational and program-specific issues, to “better assure ongoing deemed facility compliance with Medicare conditions,” and to provide information and education to those organizations.

- **Consultation.** CMS is also working to increase opportunities for AOs and other stakeholders to provide input into the development of “sub-regulatory guidance concerning Medicare standards and survey processes.”

- **AO education.** CMS also works to provide formal written and oral feedback to AOs as part of both the deeming process and the data review process. In addition, CMS invites AOs to send representatives to state agency surveyor training courses.

- **ASSURE upgrade.** In the previous fiscal year, CMS upgraded the desktop version of its ASSURE database with a Web-based application.

### Survey results

**60-day validation survey results for facility types with LSC requirements (FY 2013)**

<table>
<thead>
<tr>
<th>Validation survey analysis</th>
<th>Hospital All other CoPs</th>
<th>Hospital PE</th>
<th>Psych hospital All other CoPs</th>
<th>Psych hospital PE</th>
<th>CAH All other CoPs</th>
<th>CAH PE</th>
<th>ASC All other CoPs</th>
<th>ASC PE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA: Condition-level deficiencies</td>
<td>39</td>
<td>33</td>
<td>7</td>
<td>4</td>
<td>7</td>
<td>14</td>
<td>26</td>
<td>14</td>
</tr>
<tr>
<td>Missed by AO</td>
<td>18</td>
<td>31</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>11</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Disparity rate</td>
<td>19%</td>
<td>32%</td>
<td>30%</td>
<td>20%</td>
<td>9%</td>
<td>31%</td>
<td>23%</td>
<td>23%</td>
</tr>
</tbody>
</table>
CMS issues guidelines update
Hospitals see numerous changes

Continuing Education Objectives
After reading this article, you will be able to:
• Describe changes to CMS requirements for food and dietetic services
• Discuss changes to CMS outpatient services regulations
• Discuss how recent changes have made ambulatory surgical center requirements different from hospital-specific requirements

CMS issued a recent memo with updates to the Interpretive Guidelines impacting hospitals across several areas. The memo updated portions of existing guidelines. In addition, the guidelines addressed areas in the requirements for ambulatory surgical centers, rural health clinics, and federally qualified health centers.

Food and dietetic services
Requirements for food and dietetic services were revised to permit a qualified dietitian or nutrition professional to order diets if authorized by the medical staff and in accordance with state law governing dietitians and nutrition professionals. This includes diet ordering, which is no longer restricted to physicians and nonphysician practitioners such as nurse practitioners (NP) or physician assistants (PA).

“This was pretty interesting,” says Sue Dill Calloway, RN, Esq., AD, BA, BSN, MSN, JD, CPHRM, CCMSCP, president of Patient Safety and Healthcare Consulting and Education in Dublin, Ohio. “Who knows more about dietetics than dietitians?”

These changes include therapeutic diet and supplemental feeding orders and allow nonphysicians with the proper training and expertise to order diets for patients. Organizations, however, must remain consistent with their own state laws, Dill Calloway notes.

Nuclear medicine services
These regulations were revised to remove the requirement for “direct” supervision of in-house preparation of radiopharmaceuticals, to be provided by an appropriately trained registered pharmacist or MD/DO. This means a supervising physician or pharmacist need not always be present when radiopharmaceuticals are being prepared.

The final rule itself addresses this, stating that CMS expects most hospitals will follow the guidelines of the Society of Nuclear Medicine and Molecular Imaging with respect to the use of nuclear medicine technologists.

“The nuclear medicine part of the memo is pretty straightforward. No surprises there,” says Dill Calloway.

Outpatient services
A new standard was added to the hospital outpatient services Conditions of Participation (CoP) reflecting current Interpretive Guidelines on the ordering of outpatient services. These services, CMS notes, may be ordered by any practitioner:
• Responsible for the care of the patient
• Who is licensed and acting within his or her scope of practice in the state where he or she provides care to the patient
• Who has been authorized in accordance with state law and by the medical staff and approved by the governing body to order specific outpatient services

This new standard applies to members of the medical staff who have been granted privileges to order outpatient services; it also applies to practitioners not on the medical staff but who meet the criteria for authorization to order outpatient services.

“They’re really adamant about orders,” says Dill Calloway. “The whole idea was where they got this wrong previously.”

CMS has handled this section incorrectly and has made several attempts to make it right.

“The CoPs [previously] said that only a physician, an MD or DO, can order rehab or respiratory therapy,” says Dill Calloway. “But PAs, NPs, they would order respiratory therapy treatments or oxygen. They have those roles.”

CMS tried to change this in the regulations. “They
said if you are credentialed and privileged you can” order those services, says Dill Calloway.

However, this also impacted outpatient orders. “There was a big issue because you had to have a physician order, so if you have open heart surgery in the next county and they send you back to your own county to have cardiac rehab, [the ordering physician] isn’t credentialed and privileged there,” says Dill Calloway. “That started this whole issue on who can order outpatient tests.” The more mobile people became, the more problematic this requirement grew.

**Swing-bed services**

Although not the most headline-catching change in the memo, this update is of specific interest to accrediting organizations.

According to the CMS memo, this regulation was moved from Subpart E, concerning specialty hospitals, to Subpart D, concerning optional hospital services. This means that CMS-approved Medicare hospital accreditation programs are required to develop and implement standards for swing-bed services, and that separate state surveys of swing-bed services will not be required in deemed status hospitals once CMS has approved the revised accreditation organization standards.

**Utilization review**

Rather than outright changing this regulation, CMS “took this opportunity to correct our guidance to reflect statutory changes to section 1865 of the Social Security Act, enacting part of the Medicare Improvements for Patients and Providers Act,” the memo states.

Based on these changes, any accrediting organization seeking CMS approval of its hospital accreditation program must demonstrate that it has standards for utilization review and that its standards meet or exceed Medicare standards.

“Thus,” CMS writes, “we are removing language in our guidance indicating that utilization review CoP compliance must always be assessed by State Survey Agencies (SA), since this is no longer the case for deemed status hospitals.”

“There were no regulatory changes, but they took this opportunity to reflect changes for accrediting organizations seeking CMS deemed status,” says Dill Calloway.

“Those organizations have to demonstrate that their utilization review standards have met or exceeded existing standards.”

This rectifies a few issues, she says. “I don’t think there’s ever been a deficiency in utilization review. It hasn’t been updated in many years. People update their utilization review plan based on medical necessity and different tools they’re using, but what CMS told me is they come in and ask, ‘Do you have a contract or are you participating in a [quality improvement] program with the state?’ ”

**Ambulatory surgical center changes**

Some of the changes issued for ambulatory surgical centers (ASC) in the CMS memo may be of interest across the board. Specifically, CMS has revised a technical error for surgical services at ASCs. The regulations now correctly cross-reference the right tag numbers when referencing the regulation permitting ASCs in certain states to be exempt from the requirement for physician supervision of nonphysician practitioners who administer anesthesia.

“We are also introducing a standard-level tag for the regulatory language found in the condition stem statement related to a requirement to perform surgery in a safe manner, to allow citation at either the standard or condition level, as appropriate,” according to CMS.

The memo also updates several components of ASC laboratory and radiological services. CMS revised the requirements to explicitly state that radiological services may only be provided at ASCs when it is integral to surgical procedures offered at the center.

“Rewriting this section was important,” says Dill Calloway. “They had just adopted the hospital radiology standards, and that hadn’t made any sense. They never should have done that, and so this fixes the issue.”

CMS now requires ASCs providing radiological services to comply with only certain provisions of the hospital CoPs for radiological services.

Lastly, CMS has revised the ASC requirements to require the ASC’s governing body to appoint an individual qualified in accordance with state law and the ASC’s policies who will be responsible for ensuring that all radiologic services are provided in accordance with the cross-referenced hospital requirements.
Two cultures, one location

Editor’s note: Patrick Pianezza, MHA, currently works for VEP Healthcare as the manager of patient experience, overseeing patient experience and special projects across VEP’s vast networks of emergency departments. He has worked with the Studer Group and Johns Hopkins in the past, and can be reached at ppianezza@gmail.com.

Hospitals are unique places. They take patients facing medical crises and provide them with clinical excellence, diagnostics, nourishment, environmental services, and business systems that correlate all those services into a bill. On the flip side, there is the individual patient, brought into the steel belly of the healthcare system for any number of reasons. That person is also unique, and oftentimes that uniqueness is overlooked.

That conundrum is what individualized patient care plans, or IPCs, set out to address. An IPC recognizes that patients are not just numbers in a study or occupants in a bed for census purposes—they are individuals who enjoy different hobbies and have their own sets of cultural norms and values. More effort from hospitals is required in order to provide not only clinical excellence but true holistic care that takes the entirety of a patient into consideration.

Hospitals can enhance IPCs through different methodologies, the simplest being a whiteboard in the room. Whiteboards are not new, technologically savvy, or bleeding-edge innovation. They do, however, offer an excellent and low-cost way to connect with patients meaningfully and individualistically. A typical whiteboard contains patient information like the assigned nurse and physician, the date, and perhaps a pain scale or identification of a fall risk. What if hospitals used these boards to connect to patients by writing down something personal about them? Jotting down the patient’s preferred name, for example, or the fact that he is a Chicago Bears fan gives hospital staff a point of interaction. Any clinician, housekeeper, or leader who comes into that patient’s room can start a meaningful conversation based on a shared interest rather than a stark “Mr. Smith.” The patient, in turn, is likely to feel more integrated into the hospital culture and has a way to connect with the people providing his care.

IPCs also increase employee engagement by keeping clinicians tied to the work they want to do. With increased pressures of computerized charting and order entry, taking the time to get to know their patients allows clinicians to reconnect with why they got into healthcare—to take care of people, not computers.

Often patients are expected to conform to hospital norms. Specific rounding times, meal times, and efficiencies are created for what’s in the hospital’s best interest. However, while the stresses and cultures of a hospital are very familiar to the organization and its employees, they’re unfamiliar to patients, who (hopefully) don’t have to visit the hospital very often. Creating meaningful IPCs and understanding that the patient is not the exception to the hospital culture, but the center of it, transforms an organization from good to great.

IPCs

Source: Patrick Pianezza