KHA Presentation

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The Four Organizations Approved to Accredit Hospitals:

- TJC, (formerly JCAHO and prior JCAH -please don’t call it that).accredits 21,000 facilities. Founded 1951 by American College of Physician, American Medical Association, American Hospital Association and Canadian Medical Association.

- Healthcare Facilities Accreditation Program (HFAP), Deeming. Out of Chicago. Not for Profit. Smaller facilities
  - *(HFAP is listed on the site as the American Osteopathic Association, which was the original AO for osteopathic hospitals when Medicare was created in the 1960s. HFAP has since expanded to accredit all hospitals.)*

- DNV GL Healthcare (DNV), “The Norwegian truth” Deeming authority since 2008. Combining ISO 9001 Quality Management Program with CoPs. Accredit nearly 500 hospitals in US.

- Center for Improvement in Healthcare Quality (CIHQ). Deemed Status. Started in 1999 out of Texas.

Deemed Status

Voluntary deemed status through The Joint Commission is available for:

- Ambulatory surgical centers
- Clinical laboratories
- Critical access hospitals
- Home health agencies
- Hospice agencies
- Hospitals
- Psychiatric hospitals

Accreditation is required (and available through The Joint Commission) for:

- Advanced diagnostic imaging services
- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers
- Opioid treatment programs (deeming authority is granted through the Substance Abuse Mental Health Services Administration not CMS)

A health care organization is eligible for reimbursement for the following procedures if it is certified by The Joint Commission for:

- Ventricular assist device (VAD) destination therapy
- Lung volume reduction surgery (LVRS)

- **Validation Surveys**
- **CMS validating Accrediting Organizations with ‘deeming” authority**
- **Occur within 60 days of the Accreditation Visit**

HospitalInspections.org. "This CMS website lists all hospitals who were found to be substantially out of compliance during a State Survey Agency survey in the last six months and provides the survey report for public review."

2018, TJC updated its Accreditation Participation Requirements to specifically state that hospitals that use TJC for accreditation must notify them "immediately upon receiving notice from the Centers for Medicare & Medicaid Services (CMS) that its deemed status has been removed due to Medicare condition-level noncompliance identified during a recent CMS complaint or validation survey."

How hospitals/facilities react to and act during surveys

TJC currently has disease specific advanced certification programs for 14 clinical or procedural areas:

- Acute stroke ready hospital
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Comprehensive cardiac center
- Comprehensive stroke center
- Heart failure
- Inpatient diabetes
- Lung volume reduction surgery*
- Palliative care
- Perinatal care
- Primary stroke center
- Thrombectomy-capable stroke center
- Total hip and total knee replacement
- Ventricular assist device*
  **These are required by Centers for Medicare & Medicaid Services.*

Examples of other certification groups for specific programs in addition to TJC, such as ACE – Accreditation for Cardiovascular Excellence, or and Quality Improvement Program National Accreditation Program for Breast Center, Commission on Cancer, CARF, the Commission on Accreditation of Rehabilitation Facilities

Routine and Complaint Surveys by OSHA, ACR, CAP and others also occur routinely in facilities.

Sentinel Event Reporting

Each hospital is strongly encouraged, but not required to report to The Joint Commission any patients safety event that meets the definition of sentinel event.”

Survey Processes

- **CMS surveys consist of Observation, Record Review and Interview.**
- **TJC surveys consist of Tracers**

The **Patient Safety** and Quality Improvement Act of 2005 (PSQIA) establishes a voluntary reporting system designed to enhance the data available to assess and resolve **patient safety** and health care quality issues. PSOs are the external experts that collect and review **patient safety** information.

PSO and Sharing Info

All Quality and hospital leaders should be aware of the following:

1 - The fact is facilities are NOT required to turn over PSWP, but must otherwise demonstrate compliance with the CoPs.

2 - Facilities should be prepared to establish that they participate in a PSO and that documents requested are indeed PSWP.

When faced with a CMS surveyor demanding PSWP:

1 -Remind the surveyor that CMS does not require disclosure of PSWP. Show them the documents such as PSO membership agreement and a copy of your PSES to show that the facility is actively involved in the PSO process.

2 - Do not show the PSWP or a copy of it.

3 - Request that the surveyor contact CMS regional administrator directly.

4 - Never deny access to the surveyor. Be prepared to disclose non-privileged info to establish compliance. Consider disclosing an action plan as a result of an adverse event as long as it is not in your PSES Or has not yet been reported to your PSO or treated as deliberations or analysis.

5 - Should there appear to be no other way to demonstrate compliance with the CoPs without disclosure of PSWP, if you have not already reported or treated as deliberations or analysis this participate PSWP in the PSES, you could show them which then means that information/document can not then be sent to the PSO.

6 - There is a written authorization disclosure exception whereby the facility can authorize the disclosure of its PSWP and not that of any individual or not so authorized, while still preserving the privilege protections under the Patient Safety Act.

TJC SAFER MATRIX

Immediate Threat to Life (a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served)

Likelihood to Harm a Patient/Staff/Visitor

	LIMITED	PATTERN	WIDESPREAD
HIGH			
MODERATE			
LOW			

Patient Safety Improvement. Public Law 109–41 109th Congress. July 29, 2005.

N. Galvani (email communication, March 11, 2019).

https://www.jointcommission.org/

CMS Plan of Correction

- RESPONSIBLE PARTY
- ACTION(S)
- EDUCATION
- MONITORING
- DATES OF COMPLETION
- SIGNED BY PRESIDENT OR CEO

TJC Evidence of Standards Compliance

<u>I. Assignment of Responsibility</u> the one person most responsible.

If the finding carries a moderate to high risk for patient harm additional leadership content is required:

A. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more) they provide you a list of titles

B. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future.

For all findings:

II. Correcting the Non-Compliance: elements required include: Concisely describe the actions completed to correct each finding. This should include policies/procedures developed, revised, and approved. All corrective actions should also include staff training, communications, and/or spreading awareness. This description must illustrate the finding was fully corrected.

A. Preventive Analysis:
What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying
reasons for the failure were addressed as well?

B. All corrective actions identified below must be completed prior to submission.

C. Date all corrective actions were completed.

III. Ensuring Sustained Compliance

A. <u>What procedures or activities have been identified to monitor your compliance with this element of performance?</u>

B. <u>What is the frequency of the monitoring activities?</u>

C. <u>What data will be collected from these activities?</u>

D. <u>To whom, and how often, will this data be reported?</u>

Appendix Q

Completing IJ Template – Noncompliance: Answer **Yes** or **No** to whether the entity has failed to meet one or more federal health, safety, and/or quality regulations. If Yes, in the blank space for Noncompliance, identify the survey data tag and briefly summarize the issues that led to the determination that the entity is in noncompliance with that requirement. This includes the action(s), error(s), or lack of action, and the extent of the noncompliance (for example, number of cases). Use one IJ template for each tag being considered at the IJ level.

Completing IJ Template – Serious injury, serious harm, serious impairment or death: Answer Yes or No whether there is evidence that a serious adverse outcome occurred, or a serious adverse outcome is likely as a result of the identified noncompliance. If Yes, in the blank space for Serious Injury, Serious Harm, Serious Impairment, Death, briefly **summarize** the serious adverse outcome, or likely serious adverse outcome to the recipient. Surveyors must not restate all the findings that will be included in the CMS-2567 form.

Completing IJ Template – Need for Immediate Action: Does the entity need to take immediate action to correct noncompliance that has caused or is likely to cause serious injury, serious harm, serious impairment or death?

If yes, in the blank space for **Need to Immediate Action**, briefly explain why.

So how do you keep up?

Read official CMS and TJC (or your other accrediting organization's) publications, some are free and some cost a little extra. There are other publications out there that provide ideas and tips on accrediting processes, but those can be or can not be accurate.

Read the S&C memos that come our periodically, not all will be pertinent to your organization but many will.

Belong to local and state Quality groups. Information share among members is invaluable.

If you are part of a system be sure that all facilities share information.

If you are new, there is no better way to get to know what you need to know than to read the standards and regulations. But time it will take time to get to know them all.

Don't be afraid to look it up or ask someone.

When surveyors are on sight, learn as much as you can from them about what they are looking for and the techniques they use.

Attend local and national TJC (or your accrediting organization's) seminars. Remember, not all are created equally, but you can always learn something. Just don't take everything non-Accrediting Organization's speakers (including me) say as 100% accurate, we all have our bias.

References

- Patient Safety Improvement. Public Law 109–41 109th Congress. July 29, 2005.
- N. Galvani *(email communication, March 11, 2019)*.
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- https://aasm.org/palmetto-gba-now-requiring-sleep-specific-accreditation-jurisdictions-j-m/ *(March 23, 2018)*
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf *(March 3, 2019)*

Questions ?