

2016

Joint Commission and CMS Crosswalk

Comparing Hospital Standards and CoPs



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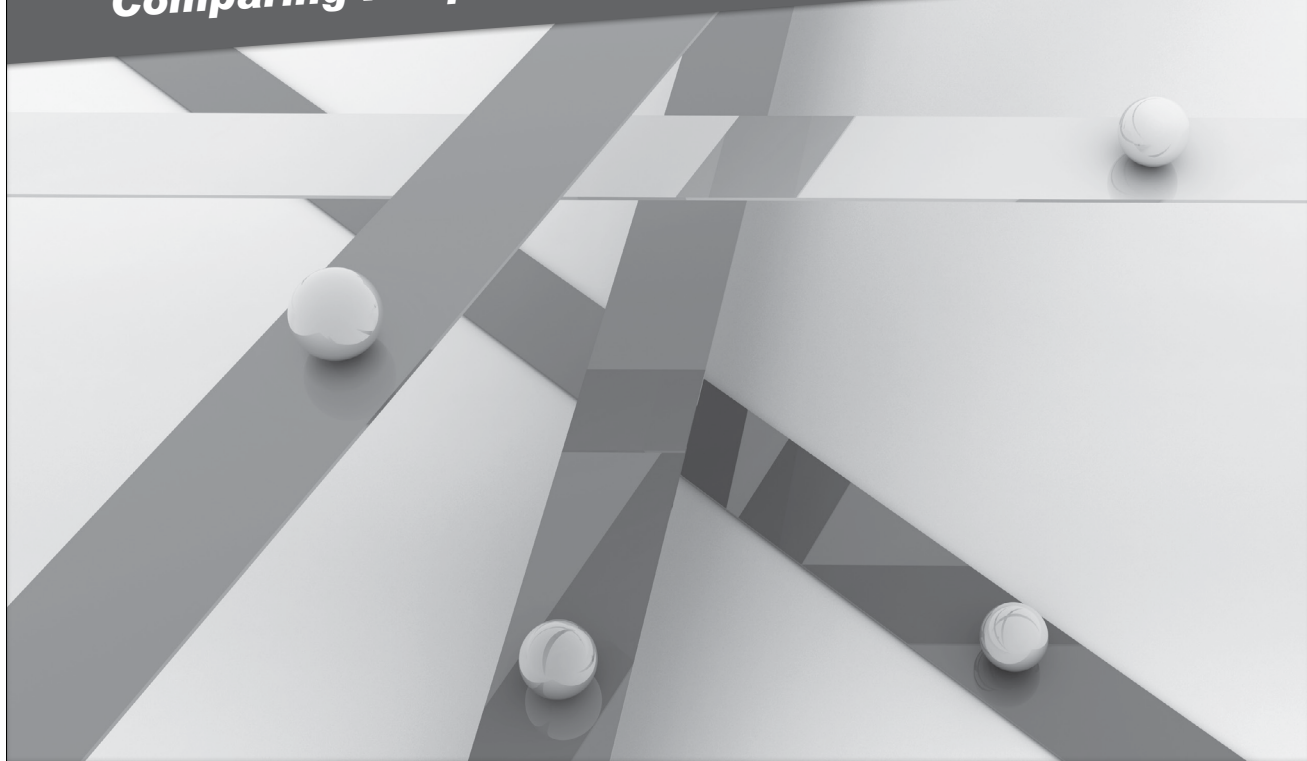
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The Joint Commission



Joint Commission
Resources



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The Joint Commission™

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Introduction

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) have a long history of working together on health care quality and safety issues. The two entities share a common goal of helping health care organizations provide high-quality, safe care, treatment, and services for all patients and their families.

In June 2014 CMS renewed The Joint Commission's deeming authority allowing it to evaluate hospitals' compliance with the requirements set forth in federal regulations. CMS also renewed deeming authority for psychiatric hospitals the following year, in February 2015. By granting deeming authority, CMS has determined that The Joint Commission's accreditation requirements meet or exceed the federal requirements for both types of organizations, called the Conditions of Participation (CoPs).

Although some believe that The Joint Commission and CMS have two vastly different sets of requirements that necessitate separate activities, processes, and approaches to support compliance, the two sets of requirements are equivalent in many ways. The Joint Commission's deeming authority means a hospital found in compliance with Joint Commission standards can be "deemed" to be in compliance with federal hospital requirements.

The *2016 Joint Commission and CMS Crosswalk: Comparing Hospital Standards and CoPs* highlights how The Joint Commission demonstrates equivalency between the Joint Commission standards and the federal CoPs. This can help your staff walk through each CoP and relate it to corresponding Joint Commission standards and elements of performance (EPs). These crosswalks can help staff identify how policies, procedures, and practices that your hospital has in place to support one or several Joint Commission standards can demonstrate compliance with equivalent CMS regulations.

Content of the Book

The *2016 Joint Commission and CMS Crosswalk: Comparing Hospital Standards and CoPs* allows your hospital easy access to the CMS requirements. Although the crosswalks found in this publication are available to accredited hospitals online in the E-dition® (accessible through the accredited organization's *Joint Commission Connect*™ extranet site), this handy reference book goes a step further. Also included are the applicable scoring information, documentation requirements, Measure of Success (MOS) requirements, and risk status (see the discussion on

"Intracycle Monitoring Process" on pages 10–15) for each Joint Commission EP. The book also provides information on how to find out more about CMS and its approach to surveying for compliance.

To foster ease of use, the book is divided into five parts:

- *Part 1: Understanding Deemed Status* takes an in-depth look at the Joint Commission accreditation process as it relates to CMS deemed status and answers some key questions your hospital may have about the process. More specifically, the chapter focuses on the eligibility requirements for using Joint Commission accreditation for deemed status, how the Joint Commission on-site accreditation survey is used to assess compliance with Joint Commission standards and the relationship with associated CoPs, and what happens when a surveyor finds an area of noncompliance.
- *Part 2: 2016 Joint Commission and CMS Hospital Crosswalk* offers a complete comparison between the 24 CoPs applicable to acute care hospitals and the equivalent Joint Commission standards and EPs.
- *Part 3: 2016 Joint Commission and CMS Psychiatric Hospital Crosswalk* compares the three special CoPs for psychiatric hospitals relating to special provisions, medical records, and staff requirements, to comparable Joint Commission standards. (Psychiatric hospitals must meet both the hospital CoPs and the special psychiatric hospital CoPs to be eligible for deemed status.)
- *Parts 4 and 5: Joint Commission Hospital Standards/EPs Equivalent to CoPs* and *Joint Commission Psychiatric Hospital Standards/EPs Equivalent to CoPs* provide reverse crosswalks listing Joint Commission standards and EPs with their comparable CoP numbers, allowing you to look up equivalencies in the opposite direction from the crosswalks provided in Parts 2 and 3. Changes to these equivalencies for hospitals over the last year are highlighted in Part 4 to allow for quick identification of updates to the crosswalk in Part 2. (There were no changes for psychiatric hospitals.) Joint Commission requirements that are not used to demonstrate equivalency with federal requirements will not appear.

More About the Crosswalks

The crosswalks in Parts 2 and 3 of this publication are the result of an iterative process between The Joint Commission and CMS during the deeming application process and are the only crosswalks reviewed and approved by both The Joint

Figure I-1. A Snapshot of the Crosswalk

CFR Number	Medicare Requirements	Joint Commission Equivalent Standards and Elements of Performance
§482.13(a)(2)		
§482.13(a)(2) continued (2) continued	[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.] The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:	EP 20 For hospitals that use Joint Commission accreditation for deemed status purposes: The process for resolving complaints includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the quality improvement organization (QIO). A
§482.13(a)(2)(i) TAG: A-0121		RI.01.01.03 The hospital respects the patient's right to receive information in a manner he or she understands.
§482.13(a)(2)(i) [At a minimum:]	(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.	EP 1 The hospital provides information in a manner tailored to the patient's age, language, and ability to understand. (See also PC.02.01.21, EP 2; PC.04.01.05, EP 8; RI.01.01.01, EPs 2 and 5) R C M 3
		RI.01.07.01 The patient and his or her family have the right to have complaints reviewed by the hospital.
		EP 1 The hospital establishes a complaint resolution process. (See also LD.04.01.07, EP 1; MS.09.01.01, EP 1) Note: The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee. A
		EP 2 The hospital informs the patient and his or her family about the complaint resolution process. (See also MS.09.01.01, EP 1) C M
§482.13(a)(2)(ii) TAG: A-0122		RI.01.07.01 The patient and his or her family have the right to have complaints reviewed by the hospital.
§482.13(a)(2)(ii) [At a minimum:]	(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.	EP 19 For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital determines time frames for complaint review and response. A
§482.13(a)(2)(iii) TAG: A-0123		RI.01.07.01 The patient and his or her family have the right to have complaints reviewed by the hospital.

In this snapshot of the crosswalk in Part 2, notice how the left column shows the Centers for Medicare & Medicaid Services (CMS) requirements and the right column shows the associated Joint Commission standards and elements of performance (EPs).

Commission and CMS. The column on the left includes the Medicare conditions and standards, including the Code of Federal Regulations (CFR) number—this is the number of the regulation published in the *Federal Register*—and the language of the condition or standard.

The column on the right shows the associated Joint Commission hospital standard(s) and EP(s) used to demonstrate equivalency. This includes the standard and EP number, language, and any icons indicating scoring category and criticality, required documentation, the need for an MOS—a numeric or quantifiable measure that illustrates whether a corrective action is effective and sustained—and the risk status of the EP. (See Figure I-1. A Snapshot of the Crosswalk, above.)

The Structure of the Standards and CoPs

To gain a full appreciation of how the two sets of requirements relate and to gain a better proficiency with the crosswalks, you must understand their differing structures. For the CMS requirements, *conditions* are the major categories, while the standards detail specific requirements under a condition. Hospitals must meet the 24 CoPs. For The Joint Commission, a *standard* makes a principle statement, and the EPs detail the specific requirements related to a standard. So, as indicated in Figure I-2. Comparing the Structure of the Requirements on page vii, the Joint Commission standards and the Medicare conditions are the “parents” that provide the overarching concepts, and Joint Commission EPs and Medicare standards are the “children” that contain the specific details required by the larger

Figure I-2. Comparing the Structure of the Requirements

Federal Requirement	Joint Commission Requirement
Condition of Participation	Standard
Standard	Element of Performance
Standard	Element of Performance

This matrix shows the association between the Joint Commission standards and elements of performance and the federal Conditions of Participation and standards.

Sidebar I-1. CMS–Related Terms and Concepts

Categorical Waiver: A *Life Safety Code*^{®*} (LSC) waiver preapproved by the Centers for Medicare & Medicaid Services (CMS) that is contingent upon specified conditions.

Central Office (CO): The headquarters of the Centers for Medicare & Medicaid Services (CMS), located in Baltimore, where all aspects of the Medicare program, Clinical Laboratory Improvement Amendments (CLIA) program, and oversight of the state Medicaid programs are coordinated.

Conditions of Participation (CoPs): A set of regulatory requirements with which a hospital must comply in order to participate in the Medicare program and to receive Medicare and Medicaid payments. Identification of noncompliance with a CoP during a survey may result in an on-site revisit survey to ensure that the facility has returned to compliance with the particular CoP.

LSC Waiver: The allowance of a condition by CMS that is not in compliance with specific LSC provisions, which if rigidly applied would result in unreasonable hardship upon a facility, but only if such condition will not adversely affect the health and safety of patients and residents.

Medicare Administrative Contractor (MAC): An organization contracted by the federal government to pay for care provided to Medicare-eligible beneficiaries by certified providers and to make Medicare Part A payments (for example, Blue Cross Blue Shield).

Immediate Jeopardy (IJ): A situation in which the provider's noncompliance with one or more CoPs has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient (as defined in 42 CFR [Code of Federal Regulations] 489.3). A hospital may be terminated from participation in the Medicare and Medicaid programs in as little as 23 days if an IJ situation is not corrected immediately.

Interpretive Guideline: The rationale and survey protocol developed by CMS for use by state survey agency surveyors and included in the State Operations Manual. Changes to the interpretive guidelines do not require public notice and comment as does regulatory approval.

Regional Office (RO): The local CMS office delegated authority by the Secretary of the Department of Health and Human Services (HHS) for ensuring that health care providers and suppliers of services meet applicable federal requirements. There are 10 Regional Offices representing the United States and US territories, such as Region 9 located in San Francisco, which provides oversight for the programs in California, Nevada, Arizona, Hawaii, and Pacific Territories.

Standard: An expectation of a CoP for which noncompliance is assessed by the degree and severity of any findings.

State Operations Manual (SOM): An online guide published by CMS to provide guidance to SAs that perform CMS surveys. This manual directs surveyors in the survey process, the regulations, and the interpretative guidelines.

State Survey Agency (SA): A state health agency or other designated agency under contract with the HHS Secretary to survey for compliance with federal health and safety requirements.

Tag: A label used to define a regulation number. For example, instead of using a full regulatory reference, like 42 CFR 482.12(a)(2), the regulation may be referred to as A-tag 120 or A-120. Specific tags are assigned to different facility types, such as A-tags for hospitals, B-tags for acute psychiatric hospitals, and F-tags for long term care facilities.

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concepts. Additional terms and concepts related to Medicare certification are shown in Sidebar I-1. CMS–Related Terms and Concepts, page vii.

It is important to note that not every Joint Commission standard and EP map to one Medicare condition and standard. In addition, multiple Joint Commission standards and EPs can demonstrate equivalency with one Medicare condition and standard. In fact, Medicare conditions can contain several requirements in a single statement and may be associated with several Joint Commission EPs in the crosswalks. That is why using the crosswalks in Parts 4 and 5 of this publication is helpful to see the relationship between the two sets of requirements. The crosswalks are designed to highlight these relationships.

Potential Limitations with the Crosswalks

Although this publication is designed to be a comprehensive and accurate resource, it does have some potential limitations, including the following:

- The crosswalks in Parts 2 and 3 were created to demonstrate equivalency with federal requirements as part of the deeming process. Any changes made after the deeming application was approved must be evaluated by CMS to determine whether the changes continue to meet or exceed the federal requirements.
- The crosswalks represent a point in time,* and so they may not maintain 100% accuracy since Joint Commission and CMS requirements are changed and updated. Any updates to the standards and EPs are published in *The Joint Commission Perspectives*®—the official newsletter of The Joint Commission—or in updates to the *Comprehensive Accreditation Manual for Hospitals (CAMH)* and the E-dition. Further, specific

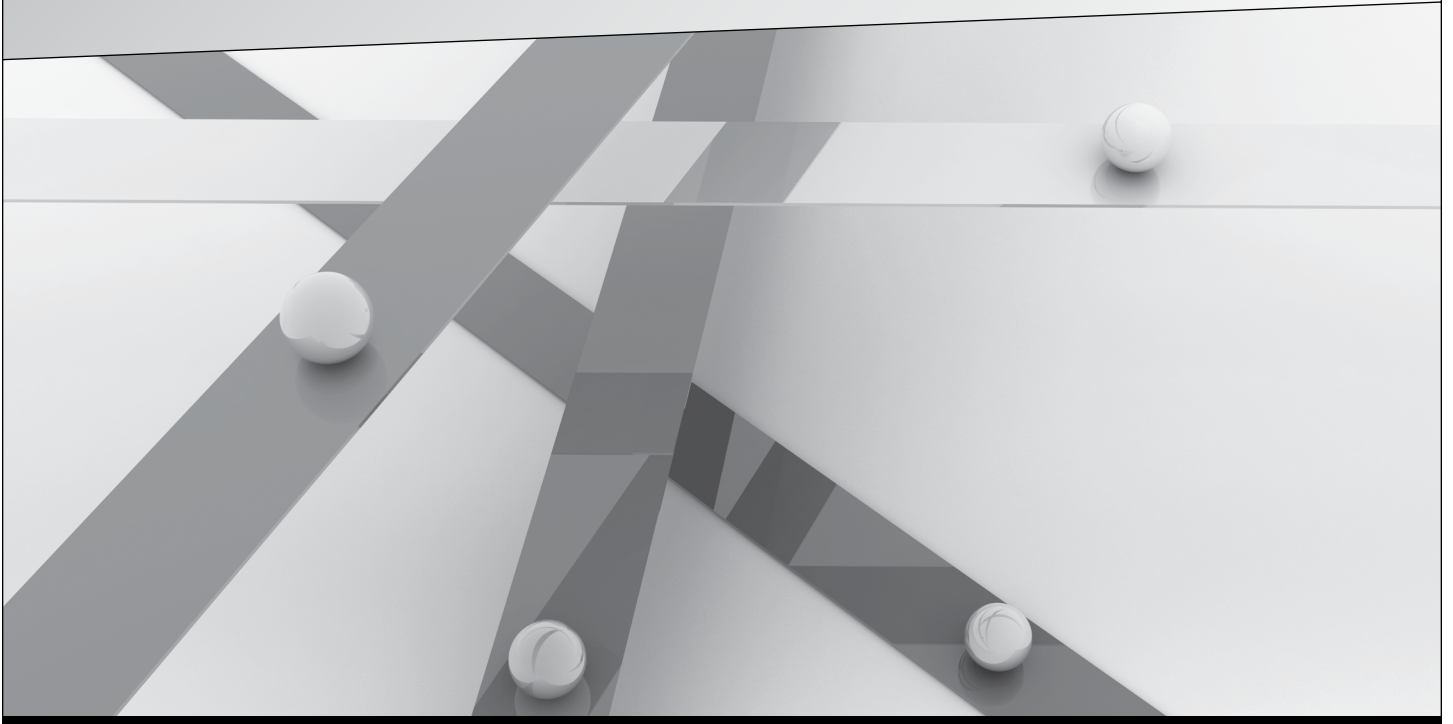
updates to a Joint Commission standard or EP may affect the equivalency with federal requirements.

- Although the crosswalks demonstrate how Joint Commission standards and EPs are equivalent to CMS requirements, they are not meant to include a comprehensive list of Joint Commission standards and EPs. The Joint Commission has additional requirements that do not appear in the crosswalk to CMS requirements, as they are not used to demonstrate equivalency and they exceed the federal requirements (for example, most National Patient Safety Goals). So hospitals seeking Joint Commission accreditation must comply with more requirements than those listed here. For a complete list of standards with which your hospital must comply, use the Standards Applicability Grid in the most recent edition of the Joint Commission's *CAMH* or your organization-specific E-dition on your *Joint Commission Connect* extranet site.
- Although it may be rare, hospitals meeting the exact crosswalk of the Joint Commission language could still, in some circumstances, find that surveyors from the state survey agency or CMS will rule them out of compliance with a Medicare condition or standard by manner or degree (*see* page 25 for more information). In addition, a surveyor may decide that a Medicare condition is out of compliance even if the supporting findings do not identify an equivalency represented in these crosswalks.

Despite the potential limitations, we hope you find value in this publication. It is designed to help your organization understand how the two sets of requirements align overall, determine how you can maintain ongoing compliance, and help ensure that you are ready for a Joint Commission, state agency, or CMS survey.

* This crosswalk was published with Joint Commission standards effective January 1, 2016.

Part 1: Understanding Deemed Status



To participate in and receive payment from the Medicare and Medicaid programs, hospitals must meet the eligibility requirements for program participation and obtain a certification of compliance with the Conditions of Participation (CoPs) set forth in federal regulations. For many hospitals, the federally sponsored Medicare and Medicaid programs provide significant revenue by reimbursing organizations for the care, treatment, and services they provide to certain elderly, low-income, and disabled patients. Certification for these programs is based on meeting several broad eligibility requirements, as outlined in the CMS-855A form (the Medicare Enrollment Application), making a civil rights attestation, and meeting the CoPs as validated by a survey that is conducted by a survey agency on behalf of the Centers for Medicare & Medicaid Services (CMS), or a CMS-approved accrediting body. CMS is the federal entity charged with administering the two programs.

What Is Deemed Status?

While undergoing a state agency survey is one option, there is another way to obtain certification. You can choose to undergo a “deemed” accreditation survey by The Joint Commission and use that accreditation for deemed status purposes. This survey would occur in lieu of a state agency survey and must meet Medicare certification requirements. In other words, participating in the Joint Commission unannounced survey process and demonstrating compliance with Joint Commission hospital standards could meet accreditation and Medicare certification requirements simultaneously, eliminating the need for separate or additional survey efforts. At the conclusion of the enrollment process, CMS determines whether to award your organization Medicare certification and a CMS Certification Number (CCN).

However, it is important to note that CMS may elect, at any time, to conduct its own additional evaluation of a hospital with deemed status through a validation survey or complaint investigation, as it would a hospital evaluated by a state agency.

CMS granted The Joint Commission deeming authority because it found that The Joint Commission has and enforces standards and a survey process that meet or exceed the Medicare CoPs. The Joint Commission is required to demonstrate that its standards and elements of performance (EPs) are equivalent to the CoPs to maintain CMS deeming authority. The crosswalk in Part 2 is the result of that demonstration. CMS renewed The Joint Commission’s hospital deeming authority effective July 15, 2014, through July 15, 2020.¹

In February 2015 CMS also granted The Joint Commission a four-year deeming authority for psychiatric hospitals for the special supplemental psychiatric CoPs. This designation is available to psychiatric hospitals that choose to be surveyed for compliance with CMS psychiatric hospital special CoPs. It does not apply to general acute care hospitals with psychiatric units. Similar to hospital compliance, the crosswalk in Part 3 demonstrates equivalency with the special supplemental psychiatric CoPs.

Joint Commission accreditation is voluntary, and seeking deemed status through Joint Commission accreditation is not a requirement of Medicare participation. Organizations seeking Medicare certification may choose to be surveyed by either an accrediting body, such as The Joint Commission, or by a state agency on behalf of CMS. However, because initial Medicare surveys may be categorized as low priority for state survey agencies due to the number of organizations in their Medicare oversight program, many hospitals pursuing initial Medicare certification choose to be surveyed by a CMS-approved accrediting body. After acceptance into the Medicare program through this route, hospitals may choose to withdraw (or drop) accreditation, and oversight of the hospital’s Medicare certification status reverts to state survey agencies.

What Are the Eligibility Requirements for Joint Commission Hospital Deemed Status?

Any hospital can seek accreditation for deemed status purposes provided it meets certain requirements:

- The hospital or health system is located in the United States or its territories. If a hospital is located outside of the United States, it must be operated by the US government, under a charter of the US Congress.
- The hospital or health system can demonstrate that it continually assesses and improves the quality of its care, treatment, and services. This process includes a review by clinicians, including those knowledgeable in the type of care, treatment, and/or services provided at the organization.
- The hospital or health system meets the CMS definition of *hospital*. (See Sidebar 1-1. Federal Definition of *Hospital*, on pages 4–5.)
- The hospital or health system identifies the services it provides, indicating which care, treatment, and/or services it provides directly, under contract, or through some other arrangement.
- The hospital or health system provides services that can be evaluated by The Joint Commission’s standards.

Sidebar 1-1. Federal Definition of *Hospital*

Hospitals seeking to obtain or maintain Medicare certification must meet all requirements for participation in the Medicare program. As such, any organization that uses its Joint Commission accreditation for deemed status purposes must meet the Centers for Medicare & Medicaid Services definition of *hospital*, as set forth in the Social Security Act, Part E, Sec. 1861 [42 U.S.C. 1395x]. That definition, provided here, can be found online at http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-e.

Hospital

(e) The term “hospital” (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

- (1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- (2) maintains clinical records on all patients;
- (3) has bylaws in effect with respect to its staff of physicians;
- (4) has a requirement that every patient with respect to whom payment may be made under this title must be under the care of a physician except that a patient receiving qualified psychologist services (as defined in subsection (ii)) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law;
- (5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times; except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6)(A) has in effect a hospital utilization review plan which meets the requirements of subsection (k) and (B) has in place a discharge planning process that meets the requirements of subsection (ee);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(continued on page 5)

Sidebar 1-1. Federal Definition of *Hospital* (continued)

For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by The Joint Commission, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available

to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients, and (iii) if the Secretary has determined that because of the facility's waiver under this subparagraph the facility should limit its scope of services in order not to adversely affect the health and safety of the facility's patients, the facility is so limiting the scope of services it provides; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary (i) may waive, for such period as he deems appropriate, specific provisions of such requirements which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

The term "hospital" does not include, unless the context otherwise requires, a critical access hospital (as defined in section 1861(mm)(1)).

2016 Joint Commission and CMS Crosswalk: Comparing Hospital Standards and CoPs

- If required by law, the hospital or health system has a facility license or registration to conduct its scope of services.
- The hospital or health system meets parameters for the minimum number of inpatients/volume of services required for organizations seeking Joint Commission accreditation for the first time; that is, 10 inpatients served, with 1 active at the time of survey.
- The tests, treatments, or interventions provided at the hospital or health system are prescribed or ordered by a licensed independent practitioner in accordance with state and federal requirements.

Psychiatric hospitals seeking accreditation for deemed status purposes must meet the above requirements for hospitals, along with several additional ones:

- The psychiatric hospital must be primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, and the services must be provided by or under the supervision of a doctor of medicine or osteopathy.
- The psychiatric hospital must meet all Medicare CoPs for hospitals.
- Compliance with the special medical record requirements (§482.61 CoP) and staff requirements (§482.62 CoP) for psychiatric hospitals must be demonstrated.

If your hospital is seeking Medicare certification *and is new to The Joint Commission*, you must also meet the following eligibility requirements at the time of your initial survey:

- One active inpatient case
- Licensure survey results
- If your average daily census (ADC) is 21 or more, or your hospital is a specialty hospital (cardiac, orthopedic, or surgical), you must be able to provide inpatient records for at least 10% of the ADC, but not less than 30 inpatient records.
- If your ADC is between 1 and 20, your hospital must be able to provide 20 inpatient records.

If you are not sure about the appropriate sample size for your hospital, refer to your CMS-855A Medicare application to determine how your hospital was reported to Medicare and then contact your assigned Joint Commission account executive to determine the correct minimum requirements applicable to your organization. (See Sidebar 1-2. Key Steps to Beginning the Joint Commission Medicare Deemed Status Process, on pages 7–8.) You will also need to provide the following:

- Your organization's CMS Certification Number (CCN). If you do not have a CCN, you may furnish a letter from the fiscal Medicare Administrative Contractors (MACs) on CMS

letterhead indicating that the CMS 855A Medicare application was reviewed and accepted.

- A letter notifying CMS and the State Department of Health that The Joint Commission is conducting your deemed status survey

A hospital that is not seeking Medicare certification and is new to The Joint Commission must, at the time of survey, have the following:

- One active inpatient case
- Ten inpatient records

Tying Accreditation to the CCN

To comply with the requirements of its deeming authority, The Joint Commission accredits a hospital in accordance with its CCN. So, if your health system has two or more hospitals—each with a separate CCN—each hospital must be surveyed separately and receive separate accreditation decisions. Conversely, if your health system has two or more organizations that share a single CCN, they must be accredited as a single organization.

Each hospital with a separate CCN must meet all requirements as specified in the CMS definition of a hospital, shown in Sidebar 1-1, and demonstrate compliance with all applicable Joint Commission standards independent of any relationship or affiliation with any other hospital or health care organization. All programs and services reported on a hospital's CCN (or application) must meet all of the applicable hospital requirements.

A hospital system that owns several hospitals in a specified geographic area may choose to have each hospital separately enrolled in Medicare, or, if it satisfies applicable Medicare rules, it can enroll them as one multicampus hospital. In the first instance, each of the hospitals would have its own CCN, and each would be required to comply separately with the CoPs. In the second instance, the facilities would each be campuses of one hospital with one CCN, and together they would have to comply with the CoPs as one hospital. The hospital system, not CMS, makes the decision on the manner in which it enrolls the facilities, but once the hospital system has done so, it must be surveyed and accredited in the same manner. (More information about CCNs is available at http://www.jointcommission.org/faqs_ccn.)

The Joint Commission offers a concurrent survey option for health care systems with more than one accredited entity included in a single system even if the organizations maintain distinct CCNs. With this option, unannounced surveys of

Sidebar 1-2. Key Steps to Beginning the Joint Commission Medicare Deemed Status Process

Step 1: Understand the benefits of the Joint Commission deemed status process.

- The Joint Commission is approved by the Centers for Medicare & Medicaid Services (CMS) to deem hospitals in compliance with federal requirements, which is necessary for Medicare certification.
- The Joint Commission accreditation process provides accreditation and Medicare certification surveys simultaneously.
- The cost of accreditation is divided into installments paid over your three-year accreditation cycle.
- Joint Commission accreditation provides the Gold Seal of Approval®, recognizing that your organization complies with the highest national standards for safety and quality of care and is committed to continually improving patient care.

Step 2: Request deemed status information on your E-App.

- Call directly at 630-792-5817 or request an application via e-mail at qualityhospitals@jointcommission.org.
- Complete the electronic application for accreditation (E-App) online.
- Click the “yes” button for deemed status.
- Make sure to answer the specific Medicare questions.
- If you have difficulty completing the application, call your account executive directly using the number listed on your hospital’s *Joint Commission Connect*™ extranet site.
- If you are new to The Joint Commission and haven’t been assigned an account executive, send an e-mail to qualityhospitals@jointcommission.org, and someone will help you with the process.
- Provide the specific date by which your hospital will be ready to undergo an unannounced deemed status survey.
- Complete and submit the CMS-855A form—an official CMS document—to your Regional Fiscal Intermediary. It is crucial that your Fiscal Intermediary accept this form prior to scheduling a deemed status survey. To access the 855A form, go to <http://www.cms.gov/medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf>.
- When you receive notice that the Fiscal Intermediary has reviewed and accepted your request for enrollment in Medicare, send a copy of that notice to your account executive.
- Submit your deposit (e-pay or credit card payment expedites the process).

- Call 630-792-5662 if you encounter any problems submitting your deposit.
- By promptly paying your deposit, you will gain access to the E-dition®—the electronic version of your standards manual. Your application will not be processed until your deposit is received. Similarly, a deemed status survey cannot be scheduled until your deposit is received and the 855A form is accepted by your Fiscal Intermediary.

Step 3: Communicate with your account executive.

- A dedicated account executive will be assigned to your hospital when you submit an application. The name and number of this individual can be found on the home page of your *Joint Commission Connect* extranet site.
- Your account executive will review, process, and approve your E-App and contact you to verify all information.
- Your survey will be an unannounced event—survey dates will not be provided to your facility. (This is mandated by CMS.) However, your hospital will have an opportunity to identify up to 15 days in your survey eligibility range during which it may be difficult to conduct a survey.
- Inform your account executive promptly of changes to your facility construction deadlines, leadership and staff changes, and so on. Update your E-App as needed.
- Maintain regular contact with your account executive to ensure that your survey time frame is being reasonably accommodated.

Step 4: Prepare for your deemed status survey.

- Thoroughly review the standards manual to comply with both the hospital standards and the Medicare Conditions of Participation (CoPs).
- You must complete the Statement of Conditions™ (SOC)—a requirement for all surveys. This document addresses your facility’s physical plant and environment of care and is available prior to survey on your organization’s extranet site. Your surveyor(s) will need to review the completed SOC document during the survey.
- Utilize the electronic Focused Standards Assessment (FSA) tool provided on your organization’s extranet site to conduct a self-assessment of your hospital’s strengths and weaknesses.

(continued on page 8)

Sidebar 1-2. Key Steps to Beginning the Joint Commission Medicare Deemed Status Process *(continued)*

- Network—pose questions to and exchange ideas with your colleagues.
- Review the Joint Commission’s online standards FAQs—answers are provided to many standards questions your hospital may have at http://www.jointcommission.org/standards_information/jcfaq.aspx.
- If you have questions regarding your compliance with Joint Commission and deemed status requirements, contact the Joint Commission Standards Interpretation Group directly at 630-792-5900, option 3, or via the online question form at http://www.jointcommission.org/standards_information/standards_online_question_form_1.aspx.

participating organizations occur at the same time, and each participating organization must demonstrate compliance with all Joint Commission requirements independent of any other organization within the system. Each organization with a distinct CCN will receive a separate survey report and accreditation decision. The concurrent survey process works best when conducted in systems in which 12 or fewer entities wish to be surveyed at the same time.

How Does My Hospital Achieve Joint Commission Accreditation for Deemed Status Purposes?

Deciding to pursue accreditation for the purpose of deemed status does not necessitate a complete overhaul in your approach to Joint Commission accreditation. In fact, in many ways your preparation will be the same, as you will still need to undergo an unannounced on-site survey. Sidebar 1-2 on pages 8–9 outlines key steps to beginning the Joint Commission Medicare deemed status process. Although “The Accreditation Process” (ACC) chapter of the *Comprehensive Accreditation Manual for Hospitals (CAMH)* and its E-dition® provide the best source of information on the various aspects of the accreditation process, the following sections offer a brief description of the process, highlighting what is different for CMS–related surveys when there are variations.

The Unannounced Survey

The unannounced full survey is the on-site evaluation component of the accreditation process and is also used in granting deemed status. An unannounced survey can occur between 18 and 36 months after your hospital’s previous full survey. Predetermined criteria based on data across multiple quarters, as well as trends in the performance of these data, will determine the timing of your organization’s full unannounced survey.

An unannounced survey is designed to be individualized to your hospital yet consistent across organizations, supporting your hospital’s efforts to improve performance. During an unannounced survey, surveyors assess your organization’s compliance with applicable standards based on the following activities:

- Tracing the care delivered to patients, including observations of care
- Observing and interviewing staff and licensed independent practitioners
- Reviewing documents provided by your organization
- Conducting specific activities that address particular facility issues, such as the Environment of Care Session and the *Life Safety Code*®* Building Assessment

Tracer Methodology

A key element in the Joint Commission on-site survey process is individual and system-based tracers, as they help surveyors get a picture of your organization’s overall performance. This methodology represents a way to analyze your system of providing care, treatment, and services using actual patients as the framework for assessing compliance with standards and regulations. Using this methodology, surveyors follow the care experience for a number of individuals through your organization. This allows surveyors to identify performance issues within the processes of care, or in the interfaces between processes.

The tracer process is no different for hospitals seeking accreditation for deemed status purposes. However, a surveyor may need to review additional medical records during the course of a tracer conducted on a deemed status survey to meet CMS mandates for a minimum quantity of record review, as described in the next section.

During a survey, surveyors will conduct individual tracers to trace the care experiences of a patient and determine standards

* *Life Safety Code*® is a registered trademark of the National Fire Protection Association, Quincy, MA.

and CoP compliance related to the care delivered to the selected patient. Surveyors will also conduct system tracers—interactive sessions with organization staff that explore the performance of important systems and high-risk processes across your organization, including data use, infection control, and medication management. The surveyor(s) will also conduct program-specific tracers to evaluate program-specific issues and compliance with relevant standards that affect patient safety. For example, hospitals will have the patient-flow system tracer, which addresses potential treatment delays, medical errors, and unsafe practices that may occur during periods of patient congestion and if patient flow does not occur smoothly throughout an organization.

A surveyor conducting any type of tracer at a hospital might notice something involving a specific high-risk area that requires a more in-depth look. At that point, the surveyor may decide to perform a deeper and more detailed exploration of the area, process, or subject, referred to as a *focused evaluation*. During a focused evaluation, the surveyor will examine processes at a system level by asking more detailed questions or spending more time looking at the particular area.

Medical Record Review

In the course of performing individual patient tracers and systems tracers, surveyors will review patient medical records for 10% of your average daily census, or a minimum of 20 to 30 inpatient records, depending on the size and scope of services provided by your hospital. Organizations using accreditation for deemed status should be prepared to produce the appropriate number of medical records when asked.

Planning for the On-Site Visit

Although the Joint Commission survey process is designed to limit the need to ramp up performance before the on-site visit, there is a degree of planning necessary to ensure a smooth and efficient on-site survey experience. Certain documents need to be readily accessible for the surveyors to review; staff need to be prepared to participate in tracers and information sessions; and all organization staff, physicians, and leaders need to understand what The Joint Commission and CMS require and how to demonstrate hospital compliance with the standards and the CoPs. Sidebar 1-3. Survey Readiness Checklist, on page 10, offers some tips on how to prepare for the on-site survey. Sidebar 1-4. Helpful Documents to Show Compliance, pages 11–12, lists documents and policies to have handy for the surveyors to show your hospital's compliance. Advance planning

to generate data reports and locate the latest internal reports for surveyor review is recommended.

A valuable source of information when preparing for survey is the CMS State Operations Manual (SOM).[†] Published by CMS, the SOM offers guidance to state agencies that perform CMS surveys and outlines CMS policy regarding the survey procedures and Medicare certification activities. (See Appendix A in the SOM for the Hospital CoPs, and Appendix T for the Swing Bed CoP guidance.) It is basically how CMS instructs its surveyors and is a vital resource to those hospitals undergoing a state survey. Within the SOM, CMS offers interpretive guidelines that provide specific guidance on the assessment process. These guidelines are divided into three parts:

1. The survey tag number (which is included in the crosswalks in Parts 2 and 3)
2. The wording of the regulation
3. Guidance for surveyors, including additional survey procedures and probes

CMS can change its interpretive guidelines easier than its CoPs, which require public notice and comment prior to adoption. It can be helpful to review the interpretive guidelines and double-check your hospital's understanding against CMS's current interpretation of the CoPs. Be aware, however, that there may be wide variation in how the various CMS regions and state agencies use the interpretive guidelines.

Sidebar 1-5. Updates to the CMS *State Operations Manual*, pages 12–14, presents changes to the SOM during 2015.

Pursuing the Early Survey Policy Option

If your hospital is new to Joint Commission accreditation, you may not be ready for the full accreditation survey process. In such a case, you may prefer the Early Survey Policy Option. This allows your hospital to enter the accreditation process in two stages, making it possible to set up business operations on a foundation of compliance with administrative and organizational standards before you serve the first patients in compliance with quality and safety standards for delivery of care, treatment, and services.

The Early Survey Policy Option is different than a typical full survey in that it consists of two on-site visits. This type of survey is available to a hospital that is not currently accredited, except if it has been denied accreditation. To be surveyed under the

[†] To access the SOM, go to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.

Sidebar 1-3. Survey Readiness Checklist

Your hospital should have a game plan to follow when surveyors arrive for an on-site survey. The following are some key elements to consider when preparing that plan:

- ✓ *Greeting surveyors:* Identify the staff members usually at the main entrance of your hospital. Tell them about The Joint Commission and educate them about the unscheduled arrival of surveyors. Explain the importance of verifying any surveyor's identity by viewing his or her Joint Commission identification badge.
- ✓ *Identify leaders and staff who must be notified when surveyors arrive:* Create a list of names, phone numbers, or cell phone numbers. Also, include the individual who will be the surveyors' "contact person" during the survey. Identify alternate individuals in the event that leaders and staff are unavailable.
- ✓ *A location for surveyors:* Ask surveyors to wait in the lobby until your survey coordinator is available to accompany them to the conference room or other location identified as the surveyors' "base" for their private use throughout the survey. This location should have a desk or table, electrical outlet, phone access, and Internet access. The surveyors should be

accompanied to their workroom as soon as possible so that survey planning can begin.

- ✓ *Validation of survey:* Identify who will be responsible for the validation of the survey start and the identity of surveyors on *Joint Commission Connect*. Identify the steps to be taken for this process.
- ✓ *Program-specific document lists:* Your hospital should have necessary documents available. These documents should be given to surveyors as soon as your organization validates their identity or as soon as possible afterward.
- ✓ *Surveyor escorts:* Identify individuals who will serve as escorts for the surveyors.
- ✓ *Electronic records of care:* Identify individuals who will help the surveyors with review of electronic records of care, if used in your hospital. Surveyors may need to view some components of the records in order to facilitate tracer activity and subsequent record review.

Source: The Joint Commission. *Survey Activity Guide for Health Care Organizations*. Jul 2015. Accessed August 25, 2015. http://www.jointcommission.org/assets/1/6/Organization_SAG.pdf.

Early Survey Policy, you must declare during the application process that you wish to be surveyed under this option. The Joint Commission will then conduct two unannounced on-site surveys.

Assuming your hospital demonstrates compliance during this first survey with the subset of standards identified in the "Early Survey Policy Option" (ESP) chapter of the *CAMH* (or the "Early Survey Option 1" filter option on the E-dition), you will receive Preliminary Accreditation. Generally, this survey uses a limited set of standards and assesses only your organization's physical facilities, policies and procedures, plans, and related structural considerations. *CMS does not recognize hospitals surveyed under this policy as meeting the requirements for Medicare certification. Your organization must wait until it receives full accreditation to qualify for deemed status.*

After being preliminarily accredited, your hospital must undergo an additional unannounced survey against the full set of applicable standards within six months of the first survey.

The survey assesses your hospital's compliance with all applicable EPs, including those that tie directly to Medicare CoPs. A successful second survey and any required Evidence of Standards Compliance (ESC) will qualify for a recommendation for Medicare certification. (A hospital with a decision of Preliminary Accreditation after its first survey under this policy will have its decision changed to Unaccredited if it is not ready for its second survey at six months.)

What Is the Intracycle Monitoring Process?

To help accredited organizations with their continuous compliance efforts, The Joint Commission offers the Intracycle Monitoring (ICM) Profile, an online workspace for all Joint Commission-accredited organizations. The Focused Standards Assessment (FSA) is a major tool of the ICM Profile. The ICM Profile and FSA tool, available on the *Joint Commission Connect*[™] extranet site, identify high-risk areas and related standards for hospitals. These areas are displayed within the accreditation manual and the FSA tool with a special **R** risk

Sidebar 1-4. Helpful Documents to Show Compliance

Following is a list of some items to have available for the surveyor(s) and documents to have easily accessible should the surveyor(s) choose to review them. Your hospital should designate staff members to gather the necessary information so it is available for the surveyor(s) as soon as possible after arrival.

Note: The 12-month reference in the following items is not applicable to initial surveys.

- Optional: Your organization's expectations of both the survey team and the on-site survey experience
- Hospital license
- Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificates
- Organization chart
- Name of key contact person who can assist surveyors in planning tracer selection
- Map of the organization, if available
- List of all sites that are eligible for survey
- List of sites where deep or moderate sedation is in use
- List of departments/units/areas/programs/services within the organization, if applicable
- List of patients that includes name, location, age, diagnosis and length of stay, admit date, source of admission (ED [emergency department], direct admit, transfer)
- Lists of scheduled surgeries and special procedures (for example, cardiac catheterization, endoscopy lab, electroconvulsive therapy, cesarean sections), including location of procedure and time
- List of unapproved abbreviations
- List of all contracted services
- Agreement with outside blood supplier
- Organ Procurement Organization agreement
- Tissue and Eye Procurement Organization agreement
- Organ, tissue, and eye procurement policies
- Performance improvement data from the past 12 months
- Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
- Patient flow documentation: dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being conducted (including reasons for conducting the projects); internal throughput data collected by ED, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
- Analysis from a high-risk process
- Organ donation and procurement conversion rates (hospital)
- Environment of Care data, including the Statement of Conditions™ (SOC) from the last survey, as applicable (Typically, the SOC is available to the surveyor without any action by the organization. There is no need to provide a printed copy.)
- Environment of Care management plans and annual evaluations
- Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
- Emergency Operations Plan (EOP) and annual evaluation
- Hazard vulnerability analysis
- Emergency management drill records and after-action reports
- Written fire response plan
- Interim life safety measure policy
- Fire drill evaluations
- Infection control plan
 - Annual risk assessment and annual review of the program
 - Assessment-based, prioritized goals
- Infection control surveillance data from the past 12 months
- Medical staff bylaws and rules and regulations
- Medical record delinquency data
- Medical Executive Committee meeting minutes
- The organization's signed and dated agreement with a Quality Improvement Organization (QIO); in the absence of an agreement with a QIO, the organization's Utilization Review plan
- Governing body minutes for the last 12 months
- Autopsy policy

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Sidebar 1-4. Helpful Documents to Show Compliance *(continued)*

- Blood transfusion policy
- Complaint/grievance policy
- Restraint and seclusion policy
- Waived testing policy and quality control plan
- Available regulatory reports (Centers for Medicare & Medicaid Services [CMS], state)

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. *Surveyors may ask, on an as-needed basis, to see additional documents throughout the survey to further explore or validate observations or discussions with staff.*

Sources: The Joint Commission. Survey Activity Guide for Health Care Organizations. Jul 2015. Accessed Aug 28, 2015. http://www.jointcommission.org/assets/1/6/Organization_SAG.pdf.

Sidebar 1-5. Updates to the CMS State Operations Manual

The Centers for Medicare & Medicaid Services (CMS) uses transmittals to communicate new or revised regulations and new or revised guidelines and procedures. In 2015 CMS made revisions to the State Operations Manual (SOM) for Hospitals, Appendix A, to reflect the changes in the hospital regulations related to food and dietetic services, utilization review, nuclear medicine services, outpatient services, rehab services, respiratory services*, and radiologic services†. A summary of those changes follows.

- **On April 1, 2015**, Transmittal 137 deleted, added, and introduced revisions to the CoPs and interpretive guidelines in Appendix A of the CMS SOM for hospitals. (Note that this transmittal rescinds and replaces Transmittal 136, dated March 27, 2015.)
 - Under the CoP for Food and Dietetic Services at 42 CFR §482.28:
 - Revised the regulation and interpretive guidelines at A-0629 stipulating that menus must meet the individual patient nutritional needs in accordance with recognized dietary practices.
 - Revised the regulation and interpretive guidelines at A-0630 stipulating that all patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with state law governing dietitians and nutrition professionals.
 - Under the CoP for Utilization Review at 42 CFR §482.30:
 - Revised the interpretive guidelines at A-0652 stipulating that if the hospital does not satisfy one of

the exception criteria at §482.30(a), it must have a Utilization Review plan in effect providing for review of services to Medicare and Medicaid beneficiaries.

- Revised the interpretive guidelines at A-0653 stipulating that if a hospital has an agreement with a Quality Improvement Organization, it is not necessary for surveyors to assess the remaining Utilization Review standards.
- Clarified the definition of “professional services” in the interpretive guidelines at A-0658 to mean services provided by practitioners, including physicians and non-physician practitioners.
- Under the CoP for Nuclear Medicine Service at 42 CFR §482.53: Revised the interpretive guidelines at A-1036 to require the development of policies and procedures related to the qualifications, roles, and responsibilities of staff preparing in-house radiopharmaceuticals.
- Under the CoP for Outpatient Services at 42 CFR §482.54: Revised the regulation and interpretive guidelines at A-1080 clarifying conditions under which a physician may order outpatient services. Introduced a new regulation at A-1081 stating if the hospital provides outpatient services, they must meet the needs of patients in accordance with acceptable standards of practice.
- Under the CoP for Rehabilitation Services at 42 CFR §482.56: Clarified which practitioners can write orders for patients requiring rehabilitative services in the interpretive guidelines at A-1132.
- Under the CoP for Respiratory Services at 42 CFR §482.57: Clarified which practitioners can write orders for patients requiring respiratory care services in the interpretive guidelines at A-1163.

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Sidebar 1-5. Updates to the CMS State Operations Manual *(continued)*

- **On July 10, 2015**, Transmittal 141 deleted, added, and introduced revisions to the CoPs and interpretive guidelines in Appendix A of the CMS SOM for hospitals.
 - Under the CoP for Radiologic Services at 42 CFR §482.26:
 - Revised the interpretive guidelines at A-0528 requiring the hospital to offer diagnostic and therapeutic radiologic services via a consistent approach in its policies and procedures for safety and personnel qualifications.
 - Revised the interpretive guidelines at A-0529 requiring the hospital to maintain or make diagnostic radiological services available, according to the needs of the patients it serves.
 - Revised the interpretive guidelines at A-0535 requiring the hospital to adopt and implement radiologic services policies and procedures that provide safety for affected patients and hospital personnel consistent with accepted professional standards.
 - Revised the interpretive guidelines at A-0536 directing the development of specific policies and procedures related to radiation safety.
 - Revised the interpretive guidelines at A-0537 related to inspection and maintenance of radiology equipment.
 - Revised the interpretive guidelines at A-0538 related to radiation badges.
 - Revised the interpretive guidelines at A-0539 directing the medical staff and governing body to determine practitioners' qualifications and clinical privileges needed to order diagnostic radiologic studies or therapeutic procedures.
 - Deleted the regulations under A-0554 and A-0555 related to records of radiologic services.
 - Revised the interpretive guidelines at A-0546 requiring medical staff to establish the specific education and experience criteria necessary for radiologist privileging.
 - Revised the interpretive guidelines at A-0547 requiring the medical staff to develop policies and define the qualifications required for staff operation of radiology equipment.
 - Revised the regulation and the interpretive guidelines at A-0553 requiring the radiologist or other practitioner performing radiology services to sign reports of his or her interpretations and to maintain the records for 5 years.
 - Under the CoP for Nuclear Medicine Services at 42 CFR §482.53:
 - Developed a new interpretive guideline at A-1025 for determining the manner and degree of a deficient practice as it relates to condition-level or standard-level non-compliance. If it is a condition-level finding, it will be addressed under A-1025; if it is a standard-level finding, it will be addressed under A-1026.
 - Deleted the regulations at A-1028 and A-1029 related to the qualifications of nuclear medicine services personnel and the responsibilities of the service director and medical staff.
 - Deleted the regulations at A-1045 related to equipment requirements in nuclear medicine services facilities.
 - Deleted the regulations at A-1052 and A-1053 related to the maintenance of nuclear medicine reports and authorization of diagnostic procedures interpretation.
 - Revised the interpretive guidelines at A-1055 permitting the hospital governing body to authorize practitioners with no clinical privileges to order nuclear medicine procedures and outpatient studies, as permitted under state law.
 - Revised the interpretive guidelines at A-1027 related to the scope of diagnostic studies and/or therapeutic procedures in the hospital. Where these services are provided and the appropriately trained staff and equipment needed must be specified in writing.
 - Revised the interpretive guidelines at A-1035 related to the establishment and implementation of policies and procedures for the use of radioactive materials in hospitals.
 - Revised the interpretive guidelines at A-1038 related to laboratory tests performed in connection with nuclear medicine services. These tests must comply with the hospital CoP of laboratory services.
 - Revised the regulation and interpretive guidelines at A-1044 requiring that equipment and supplies must be appropriate for the types of nuclear medicine services offered. They must be maintained for safe and efficient performance, be in safe operating condition, and be inspected, tested, and calibrated at least annually by qualified personnel.
 - Revised the interpretive guidelines at A-1051 requiring the retention of nuclear medicine records and the

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Sidebar 1-5. Updates to the CMS State Operations Manual (continued)

- signature/date of the test's interpretation.
- Revised the interpretive guidelines at A-1054 related to the tracking of radiopharmaceuticals throughout the hospital.
 - Revised the interpretive guidelines at A-1055 permitting the hospital governing body to authorize practitioners with no clinical privileges to order nuclear medicine procedures and outpatient studies, as permitted under state law.

* Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; Conditions of participation for hospitals. Fed Regist. 2014 May 12;79(91):27154–27155. Accessed Oct 22, 2015. <http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/FR-2014-05-12.pdf>.

† Centers for Medicare & Medicaid Services. Accessed Oct 22, 2015. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141SOMA.pdf>.

Source: Centers for Medicare & Medicaid Services. Accessed Aug 28, 2015. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2015-Transmittals.html>

icon. There were several changes to which EPs are marked with the **R** icon effective January 1, 2016.

The Joint Commission encourages organizations to participate in the ICM process by using the ICM Profile and having an annual “TouchPoint Conference Call” with the Joint Commission Standards Interpretation Group to review performance.

The FSA tool enables organizations to conduct their own self-assessment of standards compliance throughout the triennial accreditation cycle. Organizations that submit a full FSA have the option to focus their self-assessment on a minimum subset of risk-related standards, which encompasses about 28% of total applicable standards, depending on services provided and deemed status. Options 1, 2, and 3 continue to be available. (These options are available in lieu of the full FSA and allow an organization to either attest that it has self-assessed its compliance or to request a special on-site ICM survey with or without documented findings.)

The ICM process (and FSA) is not different for hospitals seeking accreditation for deemed status purposes. As with any hospital seeking accreditation, your hospital will be required to submit an FSA approximately 12 and 24 months after the organization's triennial survey. FSA submission will not be required at the 36th month of the accreditation cycle.

Seeking an Extension Survey

The Joint Commission conducts an extension survey to verify that the accreditation decision previously awarded to your hospital is still appropriate under changed conditions. The Joint Commission will conduct an extension survey at your hospital, or at a site that is owned and operated by your hospital, if your

current accreditation is not due to expire for at least nine months and when at least one of the following conditions is met:

- Your hospital has changed ownership and has a significant number of changes in its management and clinical staff or operating policies and procedures.
- Your hospital is offering at least half of its services at a new location or in a significantly altered physical plant.
- Your hospital has expanded its capacity to provide services by 50% or more, as measured by patient volume, pieces of equipment, or other relevant measures.
- Your hospital is providing a more intensive level of service.

If your hospital uses Joint Commission accreditation for deemed status purposes, The Joint Commission will conduct an extension survey within six months of your organization acquiring a new service, program, or site to allow you to include a new service or site into your existing standard of performance. The results of this extension survey will immediately affect the accreditation status of a hospital using accreditation for deemed status purposes. (Results for hospitals that do not use accreditation for deemed status will be kept separate for 12 months.)

When Your Hospital Ceases Services

If your hospital is closed or does not resume services within six months (for example, following a disaster), or if it decides to cease operations, The Joint Commission will discontinue its accreditation. When a hospital ceases to provide patient care services, it is required to notify The Joint Commission. If your hospital resumes services, it must reapply to become accredited.

In the case of resuming services more than six months after a disaster, the accreditation process will involve at least two unannounced surveys. The first survey will be conducted at your hospital's request and will assess your ability to provide

safe patient care. Your hospital may qualify for an accreditation award as a result of this survey. However, at this point you will not be recognized by CMS as meeting the requirements for Medicare certification. The second survey will be conducted approximately four months later to assess sustained compliance with Joint Commission requirements. The results of this second survey will drive whether your hospital will be eligible for accreditation and ultimately Medicare certification.

How Do We Know What Requirements to Meet?

During the on-site survey, surveyors will be verifying that your hospital complies with all applicable Joint Commission standards and EPs. These may be required only for Joint Commission accreditation or for both accreditation and Medicare deemed status. Those additional standards that are required only for hospitals using Joint Commission accreditation for deemed status begin with the phrase, “For hospitals that use Joint Commission accreditation for deemed status purposes” or “For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes.”

Your organization-specific E-dition will automatically display only those standards that apply to your organization. To identify which standards in the print manual apply to your hospital, you can use the “Standards Applicability Grid” (SAG) chapter found in the *CAMH*. This grid lists all the standards in the manual, both accreditation-only standards and those required only for hospitals pursuing CMS certification. The grid identifies standards and EPs applicable to the following services: acute, long term acute care, psychiatric, surgical specialty, and swing beds.

As mentioned in the Introduction, there is an unnecessary concern among some individuals that hospitals must comply with two separate sets of requirements to achieve accreditation for deemed status purposes. If your hospital complies with Joint Commission standards, then it is “deemed” to be in compliance or to exceed compliance with the CoPs. However, complying with the CoPs does not guarantee compliance with all applicable Joint Commission standards because there are additional Joint Commission standards that do not directly link to the CoPs and are not used to demonstrate equivalency to the CMS requirements.

Ensuring Equivalency Between Requirements

As part of The Joint Commission’s ongoing process to

maintain deeming authority and ensure equivalency between Joint Commission standards and Medicare CoPs, The Joint Commission reviews and updates its requirements as needed.

CMS makes changes to the CoP requirements by deleting, revising, and adding regulations and interpretive guidelines. During the renewal process for deeming authority, The Joint Commission realigns its standards for hospitals that use Joint Commission accreditation for deemed status purposes with CMS requirements and revisions to how CMS interprets certain requirements. Table 1-1. Recent Standards Changes for Deemed Status Hospitals, on pages 16–20 lists recent changes for these requirements and their effective dates.

CMS has granted a series of categorical waivers for requirements in the 2000 edition of the *Life Safety Code*. Additional waivers have been granted each year since then. Overall, the waivers are designed to protect the physical environment while preserving hospital resources and maintaining life safety. They can have an immediate beneficial effect on patient care and safety. Sidebar 1-6. CMS *Life Safety Code* Categorical Waivers, pages 21–23, summarizes these waivers. The sidebar also includes information on two memorandums released by CMS during 2015 that affect earlier categorical waivers[‡].

Categorical waivers are not mandatory. An organization must decide whether to invoke the categorical waivers or not. Because of this, The Joint Commission will not be adjusting the standards and EPs related to these topics. Before electing to use a waiver, an organization should fully educate itself on the waiver’s requirements and make sure that the waiver’s approach aligns with its operations. An organization must fully satisfy all the requirements for each specific waiver found in the *Life Safety Code* or the mandatory reference specified in the waiver.

The Joint Commission will continue examining its standards to maintain alignment with CMS each year.

What Happens If a Joint Commission Surveyor Identifies Noncompliance?

As mentioned previously, surveyors will use the on-site survey process to assess compliance with Joint Commission standards. At the conclusion of the on-site survey, surveyors will meet to discuss notes, observations, interviews, and so forth. At this meeting, the surveyors will share their findings, evaluate the

(Text continues on page 24.)

[‡] <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-27.pdf>; <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-32.pdf>

Table 1-1. Recent Standards Changes for Deemed Status Hospitals

Standard Number	Revised Language	Effective Date
LD.04.03.01, EP 1	<p>The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.</p> <p>Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: <i>If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program.</i></p>	February 1, 2015
LD.04.03.01, EP 14	<p>For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: <i>The psychiatric hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.</i></p> <p>Note: <i>The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.</i></p>	February 1, 2015
LS.01.01.01, EP 2	<p>The hospital maintains a current electronic Statement of Conditions (SOC).</p> <p>Note 1: <i>The SOC is available to each hospital through The Joint Commission Connect™ extranet site.</i></p> <p>Note 2: <i>For the process on how a hospital may submit a request for an equivalency to The Joint Commission for review, please go to http://www.jointcommission.org/assets/1/6/Equivalency-Request-Information.pdf.</i></p>	February 1, 2015
PC.01.02.13, EP 2	<p>Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:</p> <ul style="list-style-type: none"> • Current mental, emotional, and behavioral functioning • Maladaptive or other behaviors that create a risk to the patient or others • Mental status examination • For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Reason for admission as stated by the patient and/or others significantly involved in the patient’s care • For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Onset of the patient’s illness and circumstances leading to admission • For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Inventory of the patient’s strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan (See also PC.01.03.01, EP 1) 	February 1, 2015
PC.01.02.13, EP 5	<p>Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:</p> <ul style="list-style-type: none"> • The patient’s family circumstances, including the composition of the family group • The community resources currently used by the patient • The need for the family members’ participation in the patient’s care • For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: <i>A social history and reports of interviews with patients, family members, and others</i> 	February 1, 2015

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Table 1-1. Recent Standards Changes for Deemed Status Hospitals (continued)

Standard Number	Revised Language	Effective Date
PC.01.02.13, EP 6	<p>Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:</p> <ul style="list-style-type: none"> • A psychiatric evaluation • Psychological assessments, including intellectual, projective, neuropsychological, and personality testing • For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4) 	February 1, 2015
PC.01.03.01, New EP 6	<p>For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The written plan of care includes the following:</p> <ul style="list-style-type: none"> • A substantiated diagnosis (The substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines. The substantiated diagnosis may be the same as the initial diagnosis or it may differ, based on new information and assessment.) • Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out • Documentation that demonstrates all active therapeutic efforts are included 	February 1, 2015
PC.04.01.03, EP 3	<p>The patient, the patient's family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer.</p> <p>Note 1: <i>The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).</i></p> <p>Note 2: <i>For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital.</i></p> <p>Note 3: <i>For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move in writing. The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly.</i></p>	July 1, 2015

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Table 1-1. Recent Standards Changes for Deemed Status Hospitals *(continued)*

Standard Number	Revised Language	Effective Date
RC.02.01.01, EP 10	<p>For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Progress notes are recorded by the following individuals involved in the active treatment of the patient:</p> <ul style="list-style-type: none"> • The doctor of medicine or osteopathy responsible for the care of the inpatient • A nurse • A social worker • Others involved in active treatment modalities <p>The above individuals record progress notes at least weekly for the first two months of a patient’s stay and at least monthly thereafter. The progress notes include recommendations for revisions in the plan of care as indicated, as well as a precise assessment of the patient’s progress in accordance with the original or revised plan of care.</p>	February 1, 2015
RC.02.01.01, EP 2	<p>The medical record contains the following clinical information:</p> <ul style="list-style-type: none"> • The reason(s) for admission for care, treatment, and services • The patient’s initial diagnosis, diagnostic impression(s), or condition(s) • Any findings of assessments and reassessments (<i>See also</i> PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8) • Any allergies to food • Any allergies to medications • Any conclusions or impressions drawn from the patient’s medical history and physical examination • Any diagnoses or conditions established during the patient’s course of care, treatment, and services (including complications and hospital-acquired infections). <p>For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.</p> <ul style="list-style-type: none"> • Any consultation reports • Any observations relevant to care, treatment, and services • The patient’s response to care, treatment, and services • Any emergency care, treatment, and services provided to the patient before his or her arrival • Any progress notes • All orders • Any medications ordered or prescribed • Any medications administered, including the strength, dose, and route • Any access site for medication, administration devices used, and rate of administration • Any adverse drug reactions • Treatment goals, plan of care, and revisions to the plan of care (<i>See also</i> PC.01.03.01, EPs 1 and 23) • Results of diagnostic and therapeutic tests and procedures • Any medications dispensed or prescribed on discharge • Discharge diagnosis • Discharge plan and discharge planning evaluation (<i>See also</i> PC.01.02.03, EPs 6–8) 	February 1, 2015

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Table 1-1. Recent Standards Changes for Deemed Status Hospitals (continued)

Standard Number	Revised Language	Effective Date
RC.02.04.01, EP 3	<p>In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:</p> <ul style="list-style-type: none"> • The reason for hospitalization • The procedures performed • The care, treatment, and services provided • The patient's condition and disposition at discharge • Information provided to the patient and family • Provisions for follow-up care <p>Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.</p> <p>Note 2: When a patient is transferred to a different level of care within the hospital and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.</p> <p>Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.</p>	February 1, 2015
MS.01.01.01, EP 13	<p>The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff.</p> <p>Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.</p>	July 1, 2015
RI.01.01.01, EP 7	<p>The hospital respects the patient's right to privacy. (See also IM.02.01.01, EPs 1–5)</p> <p>Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, please refer to Standard IM.02.01.01.</p> <p>Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident's right to privacy includes privacy and confidentiality of his or her personal records and written communications, including the right to send and receive mail promptly.</p>	July 1, 2015
RI.01.06.03, EP 1	<p>The hospital determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services.</p> <p>Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion.</p>	July 1, 2015

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Table 1-1. Recent Standards Changes for Deemed Status Hospitals *(continued)*

Standard Number	Revised Language	Effective Date
RI.01.06.03, EP 3	The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. (See also PC.01.02.09, EPs 6 and 7) Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: <i>Alleged violations of mistreatment, neglect, or abuse and misappropriation of resident property are reported immediately to the administrator of the hospital.</i>	July 1, 2015
RI.01.06.03, New EP 4	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	July 1, 2015
RI.01.06.03, New EP 5	For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or his or her designated representative within five working days of the incident.	July 1, 2015
PC.02.01.03, EP 1	<p>For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.*</p> <p>Note: <i>Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:</i></p> <ul style="list-style-type: none"> • Responsible for the care of the patient • Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements • Acting within his or her scope of practice under state law • Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services <hr/> <p>* For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).</p>	January 1, 2016

evidence, and make decisions regarding compliance with both Joint Commission standards and CoP requirements. Surveyors will look for compliance trends that might point to potential system-level issues in the organization. Although the results of this assessment will vary depending on the hospital and its circumstances, The Joint Commission developed the accreditation process to be organization-specific, to be consistent, and to support the hospital’s efforts to improve safety and quality.

For any issues of noncompliance, the survey team will reach a consensus. Only current noncompliance as of the date of the

survey will be cited on the survey report. The team will document its decisions, the substance of the evidence, and the scope of the issue to identify the extent of facility noncompliance. The surveyors will then identify in the report the Joint Commission standards and Medicare CoPs with which the hospital is noncompliant. Every Joint Commission standard scored as not compliant at the time of survey will generate a Requirement for Improvement (RFI). Surveyors will determine which RFIs constitute noncompliance with CMS at the standard level and/or the condition level.

Sidebar 1-6. CMS Life Safety Code Categorical Waivers

Categorical waivers differ from *Life Safety Code*^{®*} (LSC) waivers in that initiating a categorical waiver is not related to a survey event but may be elected at any time.[†] To satisfy the Centers for Medicare & Medicaid Services' (CMS's) conditions related to categorical waivers, organizations are required to do the following:

1. Ensure that current conditions comply with the requirements of the categorical waivers. For example, all conditions must be met to allow "openings in an exit enclosure" as per NFPA 101-2012, 7.1.3.2 and 7.1.3.2(9)(c).
2. Document the decision to use a categorical waiver. If a waiver involves a specific requirement in the Joint Commission's "Life Safety" (LS) chapter, an organization must annotate the "Additional Comments" field of the basic building information (BBI) in the Statement of Conditions (SOC). However, if the requirements involve the "Environment of Care" (EC) chapter, an organization must document the decision in its EC committee minutes or an equivalent place, such as a management plan.
3. Notify Joint Commission and CMS surveyors at the beginning of a survey that they have chosen to declare a categorical waiver. This is critical. It is not acceptable for an organization to wait until after it receives an LSC citation to notify the surveyor that it wishes to declare a categorical waiver. If an organization neglects to document the waiver decision or forgets to tell the surveyor at the beginning of survey, the surveyor will assess compliance with the applicable requirements found in the 2000 edition of the *Life Safety Code*. Any areas of noncompliance as a result of not documenting the decision to apply the categorical waiver, or failing to declare that decision at the beginning of survey, will result in a finding.

Recent CMS Memorandums

During 2015 CMS issued two Survey & Certification Group memorandums that *do not waive any requirements*. Both are detailed here, followed by summaries of existing waivers.

S&C 15-27: Relative humidity in ORs. The potential adverse impact of lower relative humidity (RH) in operating rooms (ORs) may affect the performance of some sterile supplies and electro-medical equipment. In its February 2015 memorandum, CMS alerted hospitals that before electing or continuing to use categorical waiver 13-25, which allows acceptable RH levels in operating rooms down to 20%, the organization is expected

to ensure that the humidity levels in their ORs are compatible with the manufacturers' instructions for use for the supplies and equipment used in that setting. This alert places additional analysis requirements before invoking 13-25. (See Standard EC.02.06.01, EP 13.)

S&C 15-32: Reprocessing of Endoscopes. Outbreaks of Carbapenem-Resistant *Enterobacteriaceae* (CRE) during gastrointestinal endoscopy (particularly Endoscopic Retrograde Cholangiopancreatography or ERCP) prompted the CMS memorandum listing expectations for hospitals to reprocess duodenoscopes. The April 2015 S&C letter stated that hospitals are expected to meticulously follow the manufacturer's instructions for reprocessing these instruments, as well as adhering to nationally recognized Multisociety Guideline on Reprocessing Flexible Gastrointestinal Endoscopes[‡], developed by multiple expert organizations and issued in 2011.

The memo directs surveyors to ask during the entrance conference whether duodenoscopes are used. If the answer is yes, then surveyors must request a copy of the manufacturer's instructions for use of the device, as well as any automated endoscope reprocessors the facility uses. Surveyors must observe endoscopes being reprocessed and ask responsible staff to demonstrate and explain how they are adhering to both the instructions and the Multisociety Guidance recommendations. (See Standard EC.02.04.03, EP 2.)

Existing Categorical Waivers

Categorical waivers relate to distinct topic areas, with specific waivers targeted to various requirements in each area. These topics are as follows:

- **Power strips.** Organizations often need more power outlets to meet patient care needs. However, installation of additional sources often means expensive and disruptive upgrades to the electrical system. Traditionally, fire and patient safety regulations prohibited hospitals from using power strips (also known as "relocatable power taps," or RPTs), as did the 2000 edition of the *Life Safety Code*. In its September 2014 memorandum, CMS determined that the 2012 NFPA 99 provisions regarding RPTs provided an adequate alternative level of protection. In other words, CMS now allows the use of RPTs, provided that certain conditions are met. The list of conditions includes

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Sidebar 1-6. CMS *Life Safety Code* Categorical Waivers (continued)

permanent attachment to equipment assemblies, limits on the total amperage of appliances relying on the RPT, ongoing maintenance, and other conditions. (See Standard EC.02.06.01, EP 1.)

- **Openings in exit enclosures.** Many existing buildings have mechanical rooms or spaces (such as penthouses) that only open directly into an exit enclosure, such as an exit stair. To bring these spaces into compliance with the 2000 edition of the *Life Safety Code*, an organization would need to construct a new exit enclosure that provides exiting from the unoccupied spaces. Building a compliant exit enclosure would typically be cost prohibitive and, in many cases, not even possible. The CMS waiver tied to this topic permits organizations to keep existing openings in exit enclosures for mechanical equipment spaces, if those spaces are protected by fire-rated door assemblies. Note that organizations can only use the mechanical spaces cited by the waiver for non-fuel-fire mechanical equipment, and the spaces must not house any combustibles. In addition, the spaces must be located in a fully sprinklered building. (See Standard LS.02.01.20, EP 32.)
- **Emergency generators and standby power systems.** Another CMS categorical waiver reduces the time an organization must annually test any diesel-powered emergency generator that does not meet monthly load level requirements. The NFPA 110 Technical Committee has determined that a 1.5-hour test (as opposed to the 2-hour test required by NFPA 110-1998 as cited in the 2000 edition of the *Life Safety Code*) is sufficient to detect problems with a generator and adequately test its reliability. By reducing the test time, it is estimated that an organization reduces emissions by at least 25%—thus helping to preserve the environment. The total cost of the load bank test may also be reduced by approximately 25%, based on fuel savings and duration of the exercise. (See Standard EC.02.05.07, EP 5.)
- **Doors.** Two CMS categorical waivers address the topic of doors. One allows for door locking arrangements in areas where patients meet at least one of the following criteria:
 - Have specific clinical needs (such as on a psychiatric or Alzheimer’s unit)
 - Pose a security risk (such as a potentially violent patient in the emergency department)

- Require certain protective measures to ensure their safety (such as patients in a neonatal unit)

Specifically acknowledging patient safety as associated with allowed locking arrangements is a change from the 2000 edition of the *Life Safety Code*. The second waiver permits more than one delayed egress lock to be installed in the path of egress. This is significant because an organization can now lock more than one exit access door along the egress path, allowing, for example, more than one unit to be secured. (See Standard LS.02.01.20, EP 1.)

- **Suites.** Suites are room and space groupings that function more efficiently than individual rooms off a corridor. To facilitate the use of suites, later editions of the *Life Safety Code* allow larger sleeping suites, up from 5,000 square feet in the 2000 edition to 7,500 square feet (and in certain conditions to 10,000 square feet). Suites are required to have one exit into an egress corridor in the 2000 *Life Safety Code*, but in later editions one exit may be to an exit stair, and the second required exit may be into a second compliant suite. From a patient care perspective, allowing the suite-to-suite configuration provides the patient with consistent care, as patient care equipment would be available in the second suite (rather than having to relocate the patient into the egress corridor to access equipment, for instance). The categorical waiver provides clarifying language specific to allowing the suite-to-suite separation, which is equivalent to a corridor separation. (See Standard LS.02.01.20, EP 18.)
- **Extinguishing requirements.** Another CMS categorical waiver reduces the required testing frequency for sprinkler system alarm devices and electric motor-driven fire pump assemblies. The 2000 *Life Safety Code* requires organizations to inspect, test, and maintain all automatic sprinkler and standpipe systems in accordance with the 1998 edition of NFPA 25, *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems*. This document requires quarterly testing of vane-type and pressure switch water flow alarm devices and weekly testing of electric motor-driven pump assemblies. The waiver allows organizations to return testing frequency to the previous Joint Commission requirement of semiannual or vane-type and pressure switch-type water flow alarm devices for an

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Sidebar 1-6. CMS Life Safety Code Categorical Waivers (continued)

estimated savings of 50% (reduction from four tests per year to two). Electric motor–driven pump assemblies may now be tested monthly rather than weekly for an estimated 77% reduction of testing costs and time. This will reduce both the labor and testing cost burden without negatively impacting the equipment’s reliability. (See Standard EC.02.03.05, EPs 2 and 6.)

- **Clean waste and patient record recycling containers.** Another CMS categorical waiver permits organizations to use 96-gallon containers for recycling clean waste—for example, paper and cans—and patient records awaiting destruction. The goal of this waiver is to reduce the number of trash containers an organization must use, thus reducing the cost burden. (See Standard LS.02.01.70, EP 2.)
- **Medical gas alarms.** An additional CMS categorical waiver permits organizations to substitute a centralized computer system for one of the medical gas master alarms required by the 1999 edition of NFPA 99-1999, *Standard for Health Care Facilities*, which is referenced in the 2000 edition of the *Life Safety Code*. The provision requires that the computer system meet the requirements outlined in section 5.1.9.4 of the 2012 edition of NFPA 99. Using a centralized computer system may result in a one-time savings, and in most cases will be a more efficient means to monitor the status of piped medical gas systems. (See Standard EC.02.05.09, EP 1.)
- **Wheeled equipment.** With certain provisions and restrictions (see NFPA 101-2012, 18/19.2.3.4(6)) equipment such as lifts are allowed in the egress corridor provided that at least 5 feet clearance remains and the fire plan includes management of the device in a fire condition. Other wheeled equipment would include crash carts, transport carts (including wheelchairs), and isolation carts. Fixed seating

with at least 6 feet clearance and other restrictions (see NFPA 101-2012, 18/19.2.3.4(5)) is also allowed. (See Standard LS.02.01.20, EPs 12 and 13.)

- **Alternative kitchen cooking arrangement.** Per NFPA 101-2012, 18/19.3.2.5, one alternative arrangement that is open to the egress corridor is allowed per smoke compartment. It must follow the requirements at 18/19.3.2.5.2. (See Standard LS.02.01.30, EP 25.)
- **Direct vent gas fireplaces.** Use of these in smoke compartments containing patient sleeping rooms and the installation of solid fuel–burning fireplaces in areas other than patient sleeping areas is allowed, with certain restrictions as defined in *Life Safety Code* section 18/19.5.2, Heating, Ventilating, and Air Conditioning. (See Standard LS.02.01.50, EP 1.)
- **Combustible decorations.** Installation is allowed on walls, doors, and ceilings, with very specific restrictions as required in the 2012 *Life Safety Code*, 18/19.7.5.6. (See Standard LS.02.01.70, EP 1.)

Note that organizations must fully satisfy all the requirements for each specific waiver found in the 2012 *Life Safety Code*.

* *Life Safety Code*[®] is a registered trademark of the National Fire Protection Association, Quincy, MA.

† In an LSC waiver, if CMS identifies a noncompliant life safety condition during a survey and writes a citation, the organization is then required to implement corrective action. At that point, if an organization feels it will have a difficult time implementing corrective action (or for other reasons), it may request a LMS waiver. However, in a categorical waiver, permission is received outside of any survey activity.

‡ The complete guideline can be found at http://www.asge.org/uploadedFiles/Publications_and_Products/Practice_Guidelines/Multisociety%20guideline%20on%20reprocessing%20flexible%20gastrointestinal.pdf.

Source: Adapted from The Joint Commission. Clarifications & expectations: What the CMS *Life Safety Code* waivers mean for you: Getting your questions answered. *Environment of Care News*. 2013;16(11):1, 3–5.

Last year, The Joint Commission revised its Accreditation Survey Findings Report to add two new sections. The Open Plans for Improvement (PFIs) section will list open PFIs from a hospital’s Statement of Conditions™ (SOC), while the Opportunities for Improvement (OFI) section will list single observations of noncompliance with Category C EPs. Because the latter will still not require ESC follow-up, the organization will not be able to use the clarification process in an effort to remove them from the report.

Although The Joint Commission and CMS may have slightly different approaches to identifying noncompliance, they are similar in that they both focus on the degree of severity or criticality associated with noncompliance. The following two sections discuss the differences in citing noncompliance and how your organization may need to respond to any findings made by the survey team.

The Joint Commission's Levels of Criticality

Joint Commission accreditation decisions are driven by a “criticality” model. This model is based on the premise that the immediacy of risk to quality of care and patient safety—based on noncompliance with Joint Commission standards and EPs—is variable, with certain situations constituting more immediate risks than others. Thus, the more immediate the risk is to quality of care and patient safety, the shorter the period of time your hospital will have to address any relevant standards with which it is found to be noncompliant.

The Joint Commission has defined the following four levels of criticality:

- 1. Immediate Threat to Health or Safety.** These most critical findings warrant prompt response. In the event of an Immediate Threat to Health or Safety finding (which will be scored at Accreditation Participation Requirement APR.09.04.01, EP 1), an expedited decision of Preliminary Denial of Accreditation will be issued by the president of The Joint Commission, or his or her designee if the president is not available. Because Preliminary Denial of Accreditation is an official accreditation decision category, the decision will be posted the following day on Quality Check®—The Joint Commission’s website for posting descriptive and performance information about accredited organizations available to the public. An organization notified of a Preliminary Denial of Accreditation decision due to an Immediate Threat to Health or Safety situation does not have a right to “clarify” the survey findings relative to the situation.
- 2. Situational Decision Rules.** These specific problematic situations are present at the time of survey and warrant a Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey decision. (See Sidebar 1-7. Accreditation Decision Categories, page 25, for a brief summary of the accreditation decision categories.) For example, a situational decision rule finding may be made if a surveyor identifies evidence of an unlicensed facility, an unlicensed individual who requires a license, or failure to implement corrective action in response to identified *Life Safety Code* deficiencies. In follow-up to such a decision, your hospital must demonstrate resolution of identified issues through ESC submission. (See Sidebar 1-8. Evidence of Standards Compliance Process, page 25, for information on the ESC process.) The Joint Commission will conduct an on-site survey to validate ongoing implementation of a corrective action made to resolve a situational decision rule.
- 3. Direct Impact Requirements.** These are based on implementation of care processes. An organization’s failure to resolve these compliance issues has a direct impact if noncompliance is likely to create an immediate risk to patient safety or quality of care. The difference between direct impact requirements and other criticality levels is that the direct risk usually results because there are no or few processes (or no or few protective defenses) intervening between the noncompliance and the impact on the safety or quality of patient care. For example, a direct impact requirement would be the need to conduct a time-out before surgery or the need to assess, reassess, and respond to a patient’s pain. If an organization is found to be partially or insufficiently compliant with one or more direct impact requirement EPs under a standard, all EPs under that standard with which the organization has been found to be partially or insufficiently compliant must be addressed in an ESC within 45 days. The organization’s accreditation decision will be held in abeyance, pending demonstration of ESC within the established time frame. Failure to resolve the instances of partial compliance or insufficient compliance with the associated EPs will lead to progressively more adverse accreditation decisions (Accreditation with Follow-up Survey, Contingent Accreditation, or Preliminary Denial of Accreditation).
- 4. Indirect Impact Requirements.** These requirements pose less immediate risk to patient care and safety than direct impact requirements, but noncompliance with them increases risk to patient safety and quality of care over time. This risk may ultimately even exceed in scope or severity that of a direct impact requirement. Examples of an indirect impact requirement would be the need to have a designated qualified individual perform the duties of the chief executive when the chief executive is absent from a hospital, or the need to designate a qualified individual to oversee the infection control and prevention program.

If there are no direct impact requirement EPs out of compliance, any remaining indirect impact requirement EPs under a standard must be addressed in an ESC submission within 60 days. Again, the hospital’s accreditation decision will be held in abeyance pending submission of ESC within the established time frames. As with the direct impact requirement, failure to resolve instances of partial compliance or insufficient compliance with indirect impact requirements will lead to progressively more adverse accreditation decisions.

Under this criticality model, the immediacy of risk to the patient and your hospital’s accreditation status increases as you

Sidebar 1-7. Accreditation Decision Categories

The Joint Commission's six accreditation decision categories are as follows:

1. *Preliminary Accreditation.* The organization demonstrates compliance with selected standards in the surveys conducted under the Early Survey Policy. (**Note:** *This decision cannot be used for Medicare certification.*)
2. *Accredited.* The organization is in compliance with all applicable requirements at the time of the on-site survey or has successfully addressed all Requirements for Improvement (RFIs) in an Evidence of Standards Compliance (ESC) within 45 or 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.
3. *Accreditation with Follow-up Survey.* The organization is not in compliance with specific standards that require a follow-up survey within 30 days to 6 months. The health care organization also must successfully address the identified problem area(s) in an ESC submission. All open, accepted Plans for Improvement items in the Statement of Conditions™ must be completed within six months of their projected completion date, or the organization may receive a decision of Accreditation with Follow-up Survey.
4. *Contingent Accreditation.* The organization has successfully abated an Immediate Threat to Life situation through direct

observation or other method, fails to successfully address all requirements of the Accreditation with Follow-up Survey decision, and/or shows some evidence of engaging in possible fraud or abuse.

5. *Preliminary Denial of Accreditation.* There is justification to deny accreditation to the organization as evidenced by
 - An Immediate Threat to Health or Safety to patients or the public, and/or
 - Submission of falsified documents or misrepresented information, and/or
 - Lack of a required license or similar issue at the time of survey, and/or
 - Failure to resolve the requirements of Contingent Accreditation, and/or
 - Significant noncompliance with Joint Commission standards.

The decision is subject to review and appeal by the organization prior to the determination to deny accreditation.

6. *Denial of Accreditation.* The organization has been denied accreditation. All review and appeal opportunities have been exhausted. For an organization undergoing an initial survey, the organization has failed to demonstrate compliance with all applicable Joint Commission standards.

Sidebar 1-8. Evidence of Standards Compliance Process

For every Requirement for Improvement (RFI) your organization receives, you must submit an Evidence of Standards Compliance (ESC) report, which either (1) details the action(s) that you took to bring your hospital into compliance with a standard or (2) clarifies why your hospital believes that it was in compliance with the standard at the time of survey.*

The ESC report is available for completion on your hospital's secure *Joint Commission Connect*™ site at the same time that your hospital's Accreditation Survey Findings Report is posted. The time line for submitting a corrective ESC (45 or 60 calendar

days) is dependent on the criticality of the survey findings. A corrective ESC must address compliance at the element of performance (EP) level and include a Measure of Success (MOS) for all applicable corrections.

An MOS is a numeric or quantifiable measure, usually related to an audit, which determines whether an action is effective and sustained. It is due four months after notification of an acceptable ESC. The MOS report should demonstrate whether each MOS identified in the hospital's ESC report was reached.

* The hospital must submit a clarification within 10 calendar days following the posting of the hospital's report on its *Joint Commission Connect* site. The submission of a clarification does not negate the requirement to submit a corrective ESC within the original 45- or 60-day time frame if the RFI continues.

Sidebar 1-9. Example of a Condition-Level Finding

During tracer activity in the operating room, a surveyor noted the substerile room serving the operating room contained a flash sterilizer. This was one of two flash sterilizers contained in the operating room suite. The second flash sterilizer was not operable at the time of the tracer. The surveyor reviewed the logbook for the functioning flash sterilizer during the tracer. Although staff had used this unit to flash sterilize instruments needed urgently for active cases occurring in the operating room, the chemical indicator strips that were used to monitor the performance of the sterilizer had expired for use.

The surveyor spoke with staff who indicated that the biological monitoring that was required for the flash sterilizer was performed and documented by the central sterile processing department. However, when the surveyor interviewed staff members from the central sterile processing department, they could not provide any documentation that the biological monitoring had been performed in the past 18 days.

Further investigation confirmed that, due to an apparent communication issue between the operating room and central sterile processing staff, there had been no biological monitoring of the flash sterilizer for more than two weeks. During that time, instruments were processed in the flash sterilizer at least three times. Hospital policy requirements dictated that the biological indicator should be run more frequently. The organization was found to be noncompliant with both Joint Commission Infection Prevention and Control (IC) Standard IC.02.02.01, EP 2; Environment of Care (EC) Standard EC.02.04.03, EP 4; and CoP §482.42: Infection Control (A-0747). Prior to the end of the survey, the hospital requalified the sterilizer by running three consecutive biological indicators and making changes to ensure that the required biological monitoring would occur consistently in the future. Despite the hospital's action of putting a plan in place to adequately address the issue going forward, the non-compliance was still cited as a Medicare condition-level finding, and IC.02.02.01, EP 2, was still noted as a finding on the report.

move from noncompliance with standards that have an indirect impact on patient care toward Immediate Threat to Health or Safety situations. At the same time, the time frame in which your hospital is required to demonstrate resolution of instances of noncompliance decreases as you increase criticality.

Every Joint Commission standard scored as an RFI at the time of survey will necessitate a response from your hospital in the form of an ESC report. Ultimately, accreditation decisions will consider the criticality of findings, any previously scored RFIs your hospital received that have not been resolved, other risk factors identified, and the submission of acceptable ESC within established time frames.

CMS Focuses on Manner and Degree

Noncompliance is cited at a condition level or at a standard level, depending on the manner and degree of noncompliance. (Joint Commission surveyors also use manner and degree when determining if a finding related to a CoP is a standard or condition level deficiency.) The manner of noncompliance would be its prevalence—how widespread and pervasive the noncompliance is. This may be shown by the number or frequency of non-compliant occurrences. The degree would be the magnitude and severity of the noncompliance. For example, if there is a single requirement out of compliance that is of such magnitude to

result in noncompliance with the entire condition, the surveyor may cite the entire condition as being noncompliant. Even a seemingly small breach in critical actions or at critical times can severely injure or kill a patient and represents a significant health or safety threat.

Consider this example: §482.23 CoP: Nursing Services requires hospitals to have an organized nursing service that provides 24-hour nursing care. According to the CoP, the nursing services must be provided or supervised by a registered nurse (RN). If the hospital is found to be noncompliant with any part of this condition—for example, there is no 24-hour nursing service, or an RN is not the one in charge of supervising or furnishing care—then the surveyor will cite noncompliance at the condition level. (See Sidebar 1-9. Example of a Condition-Level Finding, above, for another example of a condition-level deficiency.)

A patient does not have to be harmed or an adverse event does not have to occur before the surveyor will cite noncompliance at the condition level. Noncompliance with any detail of a CMS root condition statement can constitute condition-level noncompliance. Common issues that could contribute to a condition-level deficiency include the following:

- Endoscope processing and other sterilization, high-level disinfection, and storage issues

- Generator testing issues
- Clinical alarm issues
- Infection control issues
- Medication management issues—for example, unsafe administration, ordering issues
- Restraint and seclusion issues
- A performance improvement plan that is not integrated hospitalwide

For Medicare-certification purposes, a standard-level deficiency represents noncompliance with any single requirement or several requirements within a particular branch standard that is not of such character as to substantially limit your facility's capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of patients if the deficient practice recurred.

Again, the survey team determines the level of noncompliance based on the evidence gathered during the survey. The impact of noncompliance is based on team judgment as applied to the unique circumstance of each situation and the assessment of the manner and degree of noncompliance. If additional information is needed to determine the level of compliance, then the surveyors may ask your hospital to supply further information.

Given the nature of the Joint Commission accreditation process, surveyors will likely provide education to help your hospital address noncompliance issues. However, the noncompliance will still be cited in your accreditation report even when you correct the issues while the surveyors are still on site. Corrective actions do not change the level of the citation.

Should surveyors determine noncompliance occurred *prior* to the first day of survey, and your hospital states you have corrected the problem, the surveyors will examine whether the corrective action is adequate, systemic, currently in place, and being monitored to realize sustainability. If the deficient practice is corrected prior to the survey, surveyors will not cite the noncompliance as a finding in their report. However, if they note any continued noncompliance during the course of the survey because the hospital failed to implement planned improvements, even if the hospital corrects the noncompliance during the survey, they will cite noncompliance.

When surveyors identify any condition-level deficiencies during survey, they are required by CMS to include a condition-level deficiency in the Leadership (LD) standards. So, if your hospital

receives a condition-level deficiency, you should expect to see an RFI and condition-level deficiency cited at LD.01.03.01, EP 2.

On-Site Follow-up Survey for a Condition-Level Deficiency

The Joint Commission will conduct an on-site, unannounced follow-up survey whenever your hospital is found to be noncompliant with Medicare CoPs at the time of a Joint Commission survey. If a condition-level deficiency is found in a "new" hospital or a hospital that is seeking a new CCN, then The Joint Commission will not make a recommendation to CMS that the hospital be Medicare certified. The hospital will be required to undergo an additional full Joint Commission survey to determine compliance with Medicare requirements. For all other hospitals, when a condition-level deficiency is found, The Joint Commission will conduct a follow-up survey within 45 calendar days to evaluate the hospital's implementation of corrective action to demonstrate compliance with the CoPs in question.

When condition-level deficiencies remain after a follow-up survey, another survey will take place within 30 calendar days of the first follow-up survey. If the hospital fails to clear a condition-level deficiency after the second survey, The Joint Commission will notify CMS that the organization is no longer recommended for continued Medicare certification. During follow-up surveys, The Joint Commission will focus on those RFIs that were determined to be condition-level deficiencies. However, surveyors can score other issues that are identified during the on-site visit.

How Will We Learn About Our Joint Commission Survey Findings?

After your triennial on-site accreditation survey is over, surveyors communicate their findings related to the Joint Commission standards and Medicare CoPs at the closing conference. This includes describing the regulatory requirements that your hospital does not meet and the findings that substantiate these deficiencies.

After the survey, the surveyor(s) will transmit the survey findings to The Joint Commission's Central Office. Central Office staff will review and/or verify any unique issue, such as a possible Medicare condition-level deficiency, possible noncompliance with an Accreditation Participation Requirement, or an unusual question or circumstance that could not be resolved during the survey. Based on the review, there may be differences in your

Figure 1-1. Sample Survey Report

CoP: §482.13 Tag: A-0115 Deficiency: Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights
A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(4)(ii)	A-0167	HAP- PC.03.05.03/EP1	Standard
§482.13(e)(8)(iii)	A-0173	HAP- PC.03.05.05/EP6	Standard
§482.13(e)(16)(v)	A-0188	HAP- PC.03.05.15/EP1	Standard

Source: The Joint Commission, Oakbrook Terrace, IL.

This survey report shows the Condition of Participation (CoP) compliance deficiencies (shown in the first and second columns) and the linked Joint Commission hospital accreditation program (HAP) standards to which they correspond. Note in the "Deficiency" column in the table that each of these findings was at the standard level, which affected the overall deficiency level of the condition (located in the first line) to be rated at the standard level as well.

organization's final report from the Summary of Survey Findings Report shared at your closing conference.

Your organization's official Accreditation Survey Findings Report will be posted on your *Joint Commission Connect* extranet site within 10 business days of completing a survey. This survey report will show all the RFIs your organization received as well as any noncompliance at the Medicare condition and standard level. The report will also display the relationship of RFIs to federal requirements to further highlight the issues. (See Figure 1-1. Sample Survey Report, above.) Although the focus of the survey findings report is your hospital's compliance with Joint Commission standards, the CoP summary section of the report indicates the level of citation.

How Will CMS Be Notified of Our Joint Commission Survey Results?

After your hospital is accredited, you will receive an official accreditation award letter from The Joint Commission. For hospitals that use Joint Commission accreditation for deemed status purposes, The Joint Commission will also issue a Medicare recommendation letter to inform CMS that a new or existing

Medicare provider has participated in a deemed status survey and that The Joint Commission is making a recommendation for Medicare certification as a result. The letter includes information on the dates of the survey, the outcome of the survey, the effective date of accreditation, and the locations included in the scope of the accreditation survey.

The Joint Commission provides a copy of the letter to the CMS central office and appropriate Regional Office. The Regional Office then makes the final determination regarding the Medicare participation and the effective date of participation, in accordance with the regulations at 42 CFR §489.13. (See Figure 1-2. Sample Notification Letter, page 29, for a sample of the Medicare recommendation letter.)

Should your hospital fail to achieve accreditation, or fail to resolve condition-level deficiencies, The Joint Commission will let CMS know of this situation as well. The Joint Commission is obliged to provide CMS with a listing of, and related documentation for, deemed organizations receiving decisions of Accreditation with Follow-up Survey, Contingent Accreditation, Preliminary Denial of Accreditation, and Denial of Accreditation.

Figure 1-2. Sample Notification Letter



December 2, 2015

Re: # 5678
CCN: #14XXXX
Program: Hospital
Accreditation Expiration Date: August 30, 2018

Jane Doe
Chief Executive Officer
ABC Medical Center
123 Main Street
Anytown, IL 6789

Dear Ms. Doe:

This letter confirms that your August 26, 2015 - August 29, 2015 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals, as well as the special Conditions for psychiatric hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on October 22, 2015 and December 02, 2015, The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of August 30, 2015.

The Joint Commission is also recommending your organization for continued Medicare certification effective August 30, 2015. Please note that the Centers for Medicare & Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

ABC Medical Center
123 Main Street, Anytown, IL 6789

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

A handwritten signature in cursive script that reads 'Mark Pelletier'.

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care
Services CMS/Regional Office 5/Survey and Certification Staff

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

Source: The Joint Commission, Oakbrook Terrace, IL.

This figure shows a sample Medicare notification letter.

If, as a result of survey, The Joint Commission identifies a serious situation in your organization that may jeopardize the health or safety of patients or the public, it will immediately take action to deny accreditation. After informing the hospital's CEO of the designation of an Immediate Threat to Health or Safety, The Joint Commission will notify CMS of this occurrence.[§]

The Joint Commission will also report to CMS or the Office of the Inspector General, as appropriate, any credible evidence of potential fraud or criminal or civil law violation. The Joint Commission will notify the hospital of this report as well.

The Joint Commission will share with CMS, in accordance with deemed status or other recognition requirements, any complaint information requested. Such information may include the following:

- The nature of the complaint
- Action taken on the complaint
- The standards area(s) in which an RFI(s) was issued as a result of the complaint evaluation
- The status of the case
- Specific information when an organization is assigned an Accreditation with Follow-up Survey, Contingent Accreditation, Preliminary Denial of Accreditation, or Denial of Accreditation decision. This includes all final RFIs and a statement, if any, from the organization regarding its views on the validity of Joint Commission survey findings.

The Joint Commission also provides CMS with Accreditation Survey Findings Reports for deemed organizations involved in CMS validation surveys and any other deemed status survey report upon request by CMS.

What Is a CMS Validation Survey?

All accrediting bodies in all CMS certification programs that grant deeming authority are subject to validation surveys. Even if your hospital chooses to be accredited by The Joint Commission for deemed status purposes, you may still receive a visit from CMS to verify your compliance. CMS conducts random, unannounced validation surveys of Joint Commission-accredited and deemed organizations as a means of validating The Joint Commission's survey and accreditation process. These surveys are conducted by a state agency on behalf of CMS.

Should your hospital be chosen for a random validation survey, representatives from the state agency would come on site within 60 days of your triennial survey to verify compliance with Medicare CoPs applicable to your hospital. The number of surveyors that arrive at your facility may be greater than that of a typical Joint Commission survey, and the time they are on site will most likely be longer. The survey will be much more inspection-focused, rather than education-focused, and thus will require more surveyors, time, and document review.

Random CMS validation surveys may be comprehensive, but state surveyors can also focus on a particular condition or set of conditions. When conducting the validation survey, the survey team will request medical records to review, inspect the various aspects of the facility, engage in staff and patient interviews, and observe patient services or procedures to assist them in determining compliance. During this process, surveyors may ask to see relevant portions of personnel files, credentials files, maintenance records, staffing documents, policies, procedures, and contracts.^{2,3} The specifics of a particular validation survey will vary by state, and the degree to which the state surveyors will assess your hospital may depend on the state's approach to these types of surveys.

Complaint Investigations

In addition to random validation surveys, CMS conducts allegation or complaint investigations when it receives a credible allegation of condition-level noncompliance. These complaints can come from a variety of sources, including, but not limited to, patients, employees, members of the public and the media. Like random validation surveys, CMS complaint investigations are unannounced, but they initially focus on those conditions that CMS determines are related to the allegations. During the survey, if the state survey agency substantiates a condition-level deficiency or identifies additional problems, the state agency may conduct a full survey of all the CoPs.

In addition to conducting its own complaint survey, CMS may forward any complaints to The Joint Commission to address in the accreditation process. CMS has a specific process for evaluating and acting on complaints. For further information about this process, see the CMS State Operations Manual, Chapter 5—Complaint Procedures.^{||}

[§] See "The Accreditation Process" (ACC) chapter in the E-dition or the *Comprehensive Accreditation Manual for Hospitals* for more details on Immediate Threat to Health or Safety situations, or see Appendix Q—Guidelines for Determining Immediate Jeopardy of the State Operations Manual (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf).

^{||} To access this chapter of the SOM, go to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c05.pdf>.

Figure 1-3. Medicare Statement of Deficiencies and Plan of Correction

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: _____	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED _____
NAME OF FACILITY _____		STREET ADDRESS, CITY, STATE, ZIP CODE _____		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
<small>Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.</small>				
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete			If continuation sheet Page ____ of ____	

This figure shows Medicare form CMS-2567. If a state survey agency finds a violation during a CMS validation or complaint survey, the state will have 10 business days to provide the hospital with a complete statement of deficiencies. The hospital then has 10 calendar days to submit the associated plan of correction.

If a random survey or complaint survey yields a finding of noncompliance with one or more conditions, the state agency will report the noncompliance and any recommendations to the CMS Regional Office, which will ultimately determine the nature and seriousness of the violations and the next steps for your hospital. The Regional Office will send you a Statement of Deficiencies (Medicare form CMS-2567), which will do the following³:

- Detail specific factual findings
- List the alleged CoP violation(s)
- State whether “Immediate Jeopardy” has been found (the nature of the noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient)
- Describe the time frames for hospital response

If the state agency finds only standard-level deficiencies, then your hospital should be able to continue to participate in Medicare if you submit an acceptable plan of correction that brings you into compliance within a reasonable time frame.

This plan of correction should detail what your hospital will do to come into compliance, who will be responsible for the work, and what the target completion dates of the activity are. (See Figure 1-3. Medicare Statement of Deficiencies and Plan of Correction, above.)

If the state agency finds a condition-level violation, then you may no longer be deemed to meet Medicare conditions, and survey jurisdiction will shift from The Joint Commission back

to the state agency. If you do not correct the noncompliance within 90 days, then your Medicare certification may be terminated. In addition, a copy of the validation survey findings will be subject to public disclosure after your facility has been given an opportunity to review the findings, present comments to CMS, and submit a plan of correction for any deficiencies cited.

Should the surveyor discover an Immediate Jeopardy situation, your hospital may be terminated from Medicare in as little as 23 days if you cannot fix the situation immediately. After your organization has submitted a plan of correction, the state agency will conduct a resurvey.

Should your hospital refuse to cooperate with a validation survey—either a random or complaint-related survey—you will no longer be deemed to meet the Medicare conditions but will be subject to full review by the state survey agency and may be subject to termination of your provider agreement as well as and termination from the Medicare program.

Disparity in Survey Findings

Hospitals may also be concerned about issues found during a state validation survey that are not found by Joint Commission surveyors. The most common disparity for all accrediting organizations occurs with the Physical Environment CoPs, more specifically with the *Life Safety Code* requirements. Less frequently cited disparities occur in Governing Body, Patient Rights, Quality Assurance, and Infection Controls CoPs, among others.⁴

There are a few possible reasons for this disparity. Fundamentally, The Joint Commission and CMS approach surveys differently: While The Joint Commission offers an education-focused, collaborative process through evaluation of compliance with its standards, CMS is inspection oriented and will expand its sample when an issue is found to seek additional findings.

In addition, Joint Commission on-site surveys—as well as state surveys—also represent a snapshot in time. Issues that were not present during your Joint Commission survey may be present at the time of the validation survey. For example, an exit sign lightbulb might be out the day state surveyors show up, but that lightbulb may have been fine during the Joint Commission survey. However, CMS will cite the darkened lightbulb as a *Life Safety Code* deficiency.

The Joint Commission identified the need to increase the field's awareness and understanding of the *Life Safety Code*, and to this end publishes a monthly column, "Clarifications and Expectations," authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission, in *Joint Commission Perspectives*[®]. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care.

In another effort to address environmental challenges in the field, The Joint Commission partnered with the American Society for Healthcare Engineering to unveil an online portal during 2015. The purpose of the portal is to provide guidance and education to reduce instances of noncompliance with the top eight Environment of Care/Life Safety standards—requirements frequently cited during survey activity over the past few years. The Physical Environment Portal is publicly available at http://www.jointcommission.org/topics/the_physical_environment.aspx and offers resources and tools for facilities managers as well as hospital leaders.

Finally, the very nature of the tracer process results in variations in surveys. Because state surveyors are reviewing documentation associated with different patients at different points in time, they could pull a record that Joint Commission surveyors did not review and find an issue (for example, an unsigned informed consent form). This could lead them down a different path than that of the tracer process in the Joint Commission survey.

When it comes to getting ready for a Joint Commission accreditation survey for deemed status purposes, knowledge is power. The more your organization understands the relationship between Joint Commission standards and the Medicare CoPs the better. Leveraging resources such as this publication, the CMS State Operations Manual, your Joint Commission account executive, and the online resource CMSAccess[™]# can help you prepare for the process and support a successful outcome.

This online portal to the latest information about Medicare certification, requirements, and survey methodology for hospitals is available for purchase from Joint Commission Resources at <http://www.jcrinc.com/cmsaccess-sup-/sup->.

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