Steven Hirsch and Associates

Accreditation News

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CMS Telemedicine Proposed Changes Delayed

The new telemedicine credentialing and privileging rule for hospitals and critical access hospitals has been delayed. Centers for Medicare and Medicaid Services (CMS) has granted an extension to The Joint Commission (TJC) on implementing the proposed rule until March 2011, to allow TJC to comment on the proposed rule by the July 26, 2010 deadline.

CMS has proposed a rule that will align the CMS telemedicine requirements with TJC "credentialing and privileging by proxy" systems. The new rule will allow hospitals to use a third party credentialing verification organization to verify the credentials of telemedicine practitioners. CMS realized that this proposed change will assist the smaller hospitals that do not have all the resources to perform the extensive credentialing and privileging process for all practitioners that the hospital may have who provide telemedicine services.

The medical staff is required to review and examine the information received from the credentialing verification organization and make its recommendations to the hospital governing body on the practitioners applying for privileges. The governing body is still ultimately responsible for all privileging decisions.

Written by Margo Smith, RHIT, CPMSM, CPHQ of Associates

Administrative Support of Infection Control

In a recent letter from the State of California, it was stated that the hospitals must give increased support to their infection control programs. What does this mean to the Hospital and to your program?

When SB1058 was first proposed, there was language that would increase the mandatory staffing to one Infection Control Practitioner (ICP) for every 100 licensed beds. This was gutted from the final legislation, but the programmatic requirements of SB1058, 158, and 739 remained. In addition, the latest iteration of the Conditions of Participation (CoP) from CMS has expanded expectations of the hospital's infection control program, including specific components for bioterrorism, surveillance, reporting, and accountability. The California Department of Public Health has also expanded the scope and magnitude of its "Patient Safety" Survey to include all of the various expectations of these laws and regulations.

The State has also changed the mandatory reporting program required by SB1058, from a simple memo to the Office to participation and reporting of infections via the National Healthcare Safety Network (NHSN). Depending on the size of the facility and the complexity of its patient mix, this process alone could occupy many hours

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Continued on the Next Page...

Continued… Administrative Support of Infection Control

each week.

Throughout the country there is a pronounced shortage of qualified, certified, Infection Prevention and Control Practitioners. Many of the tasks that are expected of the ICP can be performed by competent clinical support, and some of them by adequately trained clerical support. These tasks include data input, routine surveillance of items like hand hygiene and isolation, routine continuing education (hand hygiene, cleaning), and compliance monitoring. The certified ICP should and could devote their time to specific and targeted surveillance, data analysis, and relevant clinical interventions. The hospital must evaluate the expectations of the Infection Control Program in line with the staffing and the regulatory requirements. The ICP is the Director of one of the more essential programs in the hospital and should be considered to be a management level staff.

It is imperative that the hospital provide the ICP with unrestricted access to the Internet for CDC, NHSN, and professional society websites. They must also be a member AND participant in their professional society, either the Association for Professionals in Infection Control (APIC) and/or Society of Healthcare Epidemiology of America (SHEA). The Hospital should in addition, budget for external training such as the professional associations' annual meetings or other relevant seminars. The hospital needs to maintain a current infection control library, including relevant references and journal access.

The Infection Control Committee should be a component of the Medical Staff committee structure, with the full support of the Medical Staff Office. This committee should be able to perform peer review and/or at a minimum make recommendations for peer review. This should be a committee dedicated to the Surveillance, Prevention, and Control of Infections, and for acute care hospitals, not be nested into another committee. If the structure is such that it is part of a larger committee, there should be specific agenda headings and topics that pertain to infection prevention.

With the importance of the accuracy of infection control data with mandatory reporting, as well as pubic disclosure, hospitals should provide the ICP with optimum administrative support of the program. Hospitals must conduct an intensive review their program on a regular basis to ensure that it is meeting the organization's needs, expectations, current regulations, and goals. The administration must be involved in the process, including assuring adequate representation at Infection Control Committee meetings. There must be a critical examination of the expectations of the program given the limitations of staffing. It is not unreasonable to expect the "work to be done," but the goals must be established with the limitations of the staff in mind. To have a program that has a knee-jerk response to every newspaper article, quirk, whim, or other non-scientific finding is a waste of resources and will not produce a compliant, effective Infection Prevention and Control Program.

Written by David Woodard, M.Sc., CLS, CIC, CPHQ of Associates

Effective July 1, 2010 - Interim Staffing Effectiveness Standards

Staffing effectiveness requirements have been part of The Joint Commission (TJC) standards since 2002 when they were first introduced. In early 2009, after public comments and feedback from various healthcare facilities indicated that the standard did not significantly impact the quality and safety of patients, since few hospitals found actual correlations between clinical and human resource indicators, TJC decided to suspend standard PI.04.01.01.

Public comment and two field reviews in June and September of 2009 brought forth the revised interim Staffing Effectiveness standards, which became effective July 1, 2010, while TJC does additional research to improve the staffing effectiveness requirements. These standards apply to both Hospitals and Long Term Care Facilities.

<u>Operationalizing the Interim Standards</u>

LD.04.04.05 Element of Performance (EP) 13 an "A" category Element of Performance, with the requirement for documentation.

At least once a year, the organization must provide the Governing Body with written reports on the following:

Continued on the Next Page...

Continued… Effective July 1, 2010 - Interim Staffing Effectiveness Standards

- All system or process failures
- The number and type of sentinel events
- Whether the patient/resident and their families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences
- And for Hospitals that use the Joint Commission accreditation for deemed status purposes only: The determined number of distinct improvement projects to be conducted annually
- All results of the analysis related to the adequacy of staffing (see also PI.02.01.01 EP4) which states *"The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations"*

Rather than bogging the Governing Body down with a list of errors that occurred during the entire year as a result of system or process failures, the organization might consider generating these reports on a quarterly basis instead. All sentinel events should be reported to the Governing Body as soon as possible after they have occurred and are analyzed. Actions that are implemented as a result of any root cause, other in-depth analysis or FMEA needs to be reported to the Governing Body as they are implemented, with a report that identifies the results of the actions taken.

PI.02.01.01 EP12 also an "A" category Element of Performance and a direct impact standard.

When the hospital identifies undesirable patterns, trends or variations in its performance it includes the adequacy of staffing, including nursing staffing, in its analysis of possible causes. This means that it would include the number, skill mix, competency of all staff, as well as include any processes related to work flow issues, competency assessment, credentialing, supervision of staff, training and education in its analysis. Hospitals might find it useful to use as part of their analysis, the staffing effectiveness indicators which include the National Quality Forum Nursing Sensitive Measures, as follows *(note: These can be found in the SEI chapter of the CAMH manual)*:

1. Patient/family complaints/satisfaction (Clinical/Service)
2. Adverse drug events (Clinical/Service)
3. Injuries to patients (Clinical/Service)
4. Skin breakdown (Clinical/Service)
5. Pneumonia (Clinical/Service)
6. Postoperative infections (Clinical/Service)
7. Urinary tract infections (Clinical/Service)
8. Upper gastrointestinal bleeding (Clinical/Service)
9. Shock/cardiac arrest (Clinical/Service)
10. Length of stay (Clinical/Service)
11. Death among surgical inpatients with treatable serious complications (failure to rescue) (Clinical/Service) (National Quality Forum Measure)
12. Pressure ulcer prevalence (Clinical/Service) (National Quality Forum Measure)
13. Falls prevalence (Clinical/Service) (National Quality Forum Measure)
14. Falls with injury (Clinical/Service) (National Quality Forum Measure)
15. Restraint prevalence (vest and limb only) (Clinical/Service) (National Quality Forum Measure)
16. Urinary catheter-associated urinary tract infection for intensive care unit patients (Clinical/Service) (National Quality Forum Measure)
17. Central line catheter-associated blood stream infection rate for intensive care unit and high-risk nursery patients (Clinical/Service) (National Quality Forum Measure)
18. Ventilator-associated pneumonia for intensive care unit and high-risk nursery patients (Clinical/Service) (National Quality Forum Measure)
19. Smoking cessation counseling for acute myocardial infarction (Clinical/Service) (National Quality Forum Measure)
20. Smoking cessation counseling for heart failure (Clinical/Service) (National Quality Forum Measure)
21. Smoking cessation counseling for pneumonia (Clinical/Service) (National Quality Forum Measure)
22. Overtime (Human Resource)

Continued on the Next Page...

Continued… Effective July 1, 2010 - Interim Staffing Effectiveness Standards

23. Staff vacancy rate (Human Resource)
24. Staff satisfaction (Human Resource)
25. Staff turnover rate (Human Resource)
26. Understaffing as compared to organization's staffing plan (Human Resource)
27. Staff injuries on the job (Human Resource)
28. On-call or per diem use (Human Resource)
29. Sick time (Human Resource)
30. Agency staff use (Human Resource)
31. Skill mix (registered nurse, licensed vocational nurse/licensed practical nurse, unlicensed assistive personnel, and contract) (Human Resource) (National Quality Forum Measure)
32. Nursing care hours per patient day (registered nurse, licensed practical nurse, and unlicensed assistive personnel) (Human Resource) (National Quality Forum Measure)
33. Practice Environment Scale-Nursing Work Index (PES-NWI) composite and five subscales (Human Resource) (National Quality Forum Measure)
34. Voluntary turnover (Human Resource) (National Quality Forum Measure)

PI.02.01.01 EP13, an "A" category Element of Performance and a direct impact standard

When adequacy of staffing is identified to be a contributing factor post analysis, the organization needs to inform Leadership responsible for the Patient Safety Program of the results of the analysis and any actions that were taken to address the identified issue(s).

PI.02.01.01 EP14 also an "A" category Element of Performance and a direct impact standard

At least once a year or on a more frequent basis, such as quarterly, the Leaders responsible for the organization's Patient Safety Program review the written report of the results of the analysis related to the adequacy of staffing and any actions taken to resolve identified issues. There is a documentation requirement for this EP, so the written report, as well as meeting minutes, will satisfy the documentation requirement. It is also helpful to include the fact that these reports are part of an annual requirement in an existing document, such as a policy of Performance Improvement Plan, that describes or lists all of the annual reporting requirements to the Governing Body.

Take Note:

The Joint Commission placed three of the EP's related to staffing effectiveness as direct impact standards which it believes, if the organization is not in compliance, poses an immediate risk to patient safety.

Written by Linda Lawrence, RN, BSN, MBA of Associates

About Steven Hirsch & Associates

As recognized experts on Joint Commission, HFAP, and DNV accreditation, licensure preparedness and facility management issues, Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987.

Beyond accreditation and licensure survey preparedness, our healthcare consulting team can provide assistance in a number of areas including Medicare certification, performance improvement, nursing management, infection prevention and control, Life Safety Code compliance, clinical lab management and compliance with HIPAA.

For more information on how Steven Hirsch & Associates can assist you with accreditation and licensure preparedness, Medicare certification and other management challenges, please contact us at (800) 624-3750 or go to our web site at www.shassociates.com.