Steven Hirsch and Associates

Accreditation News

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Important Changes to the Life Safety Survey

The Joint Commission announced in December 2010, that effective the first of this year, the Life Safety Code surveyors will be allotted additional time during hospital and critical access hospital surveys. The surveyors had identified a need for additional time to more thoroughly evaluate Life Safety Code compliance. The amount of additional time that will be provided to the Life Safety Code surveyors will depend on the size of the facility, to facilitate adequate review of Life Safety Code compliance. Additionally, Life Safety Code surveyors are likely also to conduct the bulk of the Environment of Care and Emergency Management survey activities.

For some time now, The Joint Commission has evaluated under EC.02.03.05 hospitals testing of Life Safety protection related equipment. Up until now, in accordance with NFPA 72, 1999 edition, it was expected that hospitals would test valve tamper switches and water flow devices at least every six (6) months. However, with the continuing re-alignment of Joint Commission standards with Medicare Conditions of Participation, effective July 1, 2011, hospitals will be required to test valve tamper switches and water flow devices at least quarterly, in accordance with NFPA 25, 1998 edition which is the reference utilized by the Centers for Medicare & Medicaid Services ("CMS") Life Safety Code specialists. Many organizations already are testing these devices on a quarterly basis and should assure that documentation that is presented to The Joint Commission reflects such.

In addition, documentation expectations have been intensified under a revision of EC.02.03.05 EP25, which will become effective July 1, 2011. That Element of Performance requires that "Documentation of maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems include the following:

- Name of the activity
- Date of the activity
- Required frequency of the activity
- Name and contact information, including affiliation, of the person who performed the activity
- NFPA standard(s) referenced for the activity
- Results of the activity"

Your organization should conduct a careful review of documentation of fire alarm and fire protection system testing and maintenance to assure that all required elements are reflected.

Additionally, the CMS in a letter dated December 17th clarified its interpretation of classification of various types of occupancies under the Life Safety Code. The letter attempts to provide clarification for determining appropriate occupancy classifications for off-site facilities that are non-contiguous or are separated from a hospital or critical access hospital, but are licensed as part of that organization. This recent interpretation may have a significant impact on how hospitals determine whether outpatient service locations are considered business occupancies or ambulatory healthcare occupancies.

Steven Hirsch and Associates

18837 Brookhurst Street
Suite 209
Fountain Valley, CA 92708

Toll Free: (800) 624-3750
Phone: (714) 965-2800
Fax: (714) 962-3800

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Life Safety Survey Changes Continued…

Under the revised guidelines, a facility operated as part of the hospital or critical access hospital, regardless of whether it is located in a separate building on the main hospital campus or off campus at another location, must be considered a "healthcare occupancy" under the Life Safety Code. This refers to facilities that are used for the purpose of medical care or for the treatment or care of four or more persons where such occupants are incapable of self-preservation due to their age, physical or mental disabilities, or security measures not under the occupant's control. The facilities involved are those that provide for overnight stays. The CMS interpretation further states that, in accordance with the Social Security Act, Section 1861(e), that a "hospital" is "primarily engaged in providing care to inpatients and is not based upon a minimum number of patients receiving treatment, care or services." In other words, the hospital or critical access hospital need not have four or more inpatients at all times in order to be classified as a healthcare occupancy under the revised CMS interpretation.

For those hospital services located on the main hospital campus or at a remote location, CMS does not recognize the Life Safety Code's definition of ambulatory health care occupancy as "a building or portion thereof used to provide services or treatments simultaneously for four or more patients that: (1) provides on an outpatient basis, treatment for patients that renders the patients incapable of taking action without the assistance of others; or (2) provides, on an outpatient basis, anesthesia that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others." Under the revised interpretation, if treatment or services are provided in an outpatient setting to any patients who are incapable or who are rendered incapable by that treatment or anesthesia of self-preservation, that site must be classified as an ambulatory healthcare occupancy, regardless of the number of patients treated at any given time. CMS does not consider whether or not the patient has been "rendered" incapable of taking action for self-preservation by the facility, but rather only considers whether the patient is capable or incapable of self-preservation. This revised interpretation may have significant impact on the organization as it evaluates the classification of ambulatory care service locations, under the Life Safety Code.

The Joint Commission has been asked for clarification regarding this CMS revised interpretation of occupancy classifications.

Until The Joint Commission provides clarification as to how it intends to address this revised CMS regulation, it is suggested that each accredited hospital or critical access hospital evaluate its outpatient service locations with consideration of the revised CMS Interpretive Guidelines, and consider including in the e-SOC each location which may be considered an ambulatory healthcare occupancy. For those locations which do not comply with Life Safety Code elements specific to ambulatory healthcare occupancies, "plans for improvement" will need to be developed and submitted to The Joint Commission to assure that the organization's ability to provide services Medicare and Medicaid patients under their deemed status will not be jeopardized.

Written by Steven R. Hirsch, MPA, FACHE of Steven Hirsch & Associates

Ongoing Professional Practice Evaluation for Allied Health Professional Staff

The Ongoing Professional Practice Evaluation ("OPPE") process is required by The Joint Commission on any individual who is licensed and qualified to practice a health care profession (for example, a physician, nurse, or respiratory therapist) and who is engaged in the provision of care, treatment, and services.

The OPPE is a document summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise or revoke existing clinical privilege(s) prior to or at the end of the two-year privilege renewal cycle. Privileging is the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on evaluation of the individual's credentials and performance. So, now that you know what the definitions are, how can you accomplish a valuable OPPE for your Allied Health Professional ("AHP") staff?

If your facility does not have the capability of identifying in the medical record the AHP providing patient care services you will have to request that the AHP provide you with a listing of patients that they have treated or attended to within your established timeframes. In order to assist the AHP with this task, it is recommended that they be provided a copy or listing of those clinical privileges that have been granted to them through the medical staff credentialing process.

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Ongoing Professional Practice Evaluation for Allied Health Professional Staff Continued…

What criteria should be used to evaluate the AHP staff, since there is probably no one in your facility who is tracking the AHP? Here are some of the ways you can determine how the AHP is functioning in your facility:

1. Have the unit director, physician or nurse, complete a questionnaire evaluating how the practitioner interacts with the hospital staff, the medical staff, and the patients and their families.
2. Have the supervising physician (when applicable) complete an evaluation on documentation, timeliness, interaction with hospital ancillary staff and any other established criteria.
3. Query the quality department on whether there have been any patient safety issues identified with the practitioner.
4. Request information on patient complaints or patient compliments.
5. Periodic chart review can be performed, to determine whether the practitioner is meeting documentation requirements.
6. Query the state licensing board for the current status of the AHP's license/certificate.
7. Query the Office of the Inspector General to see whether any sanctions have been filed against the practitioner.

Now that you have obtained all of this documentation, what should you do with it?

1. Develop a summary evaluation form identifying the practitioner, the supervising physician (as applicable), the unit the practitioner is assigned to, and the time frame being reviewed. Include areas where you can enter the data you have queried, e.g. date of licensure, any sanctions from OIG, receipt of any complaints or compliments, and any quality or safety issues that have been identified.
2. The six (6) general competencies defined by The Joint Commission that are being used to evaluate the Medical Staff can be adapted to the Allied Health Staff.
3. The information on the case log should be compared to the practitioner's approved clinical privileges to determine whether the practitioner is practicing within their scope and that they are performing the procedures granted.
4. All the information should be reviewed, evaluation of the allied health practitioner against the six (6) general competencies should be determined by the Director of the Department and/or the Division/Section Chief (as applicable to your facility).
5. The information resulting from the evaluation needs to be used to determine whether to continue, limit, or revoke any existing clinical privilege(s) at the time the information is analyzed, and this should be documented on the OPPE Summary Form.

Once all the information has been reviewed and the OPPE Summary Form has been completed, where do you store the information?

There needs to be a defined process on where the data will be stored. Will all the data be kept in the file or stored in a separate record? Regardless on the process, the data will need to be available as needed!

The information for each OPPE review should be factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Written by Margo Smith, RHIT, CPMSM, CPHQ of Steven Hirsch & Associates

Handling Media Inquiries in an Age of Outcomes Security

There is a well-known truism that states: you know it will be a bad day when a reporter from "60 Minutes" is sitting in your outer office. With the increasing focus on outcomes and the requirements for public disclosure of health information, the reality is that reporters are now frequently demanding explanations from hospital administrators on any statistics that seem out of the norm. In this increasingly inquisitive environment, Public Information Officers as well as key players such as the CEO and Chief Nursing Officer need to have a strategy in place to handle such inquiries ***before*** the call or visit ever comes. Here are some guidelines to put into place to help you respond to the media.

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Handling Media Inquiries in an Age of Outcomes Security Continued…

1. Know what data are being reported and into which databases. All hospitals are reporting some data to numerous regulatory and accrediting agencies via Core Measures, mandatory infection control data, outcomes and more. Hospital executives need to see these data when they are submitted, or at least an executive summary of the data so they understand the mechanisms of collection, potential errors, and possible land-mines.
2. In cases where the hospital shows data out of the acceptable range, prepare a response that includes what is known about the process or data. Use your experts to help you, and if reasonable and possible have them with you at the press conference, if it comes to that.
3. When dealing with reporters, speak in plain English, not "statistic-speak." No good can come from trying to explain how a 2SD change in data with a sample size of less than the recommended number to a journalist who has a deadline.
4. If possible have the actual data with you. If you plan to refute the data, have a clear rationale and an explanation. If you are going to quote some other source, make sure your subject matter experts have vetted the source and the relationship.
5. If a vulnerability clearly exists, acknowledge the fact and lay out the actions you are going to take to rectify the situation reflected in the data. Explain what you will be doing, again in plain English. Do not make "off the cuff" remarks--they will become headlines. And remember, nothing is ever off the record with a reporter.

Written by Becky Barney-Villano of BBV Marketing & Communications

Reporting Central Line-Associated Bloodstream Infections ("CLABSI")

Beginning January 1, 2011, the Centers for Disease Control and Prevention's ("CDC")'s National Healthcare Safety Network ("NHSN") is the data source to be used by healthcare facilities who participate in the Centers for Medicare & Medicaid Services ("CMS") healthcare-associated infections ("HAI") Inpatient Prospective Payment System ("IPPS"). As part of that program, central line-associated bloodstream infections ("CLABSI") data from each facility's adult and pediatric intensive care units as well as the neonatal intensive care units shall be reported to NHSN. The CMS will "pull" their information from this database. California hospitals are currently required to be reporting all CLABSI hospital wide through NHSN system and should already be in compliance with this requirement. Each facility's data will be included in the CMS "Hospital Compare" tool, which is used to publicly report hospital performance.

Data collection began on January 1, 2011, for the first reporting quarter (January 1 through March 31, 2011). All data should be entered as soon as it is available, do not attempt to do a batch system if at all possible. If your hospital is new to the NHSN, you should become enrolled as soon as possible in order to be placed on the CDC/CMS list of participants. Your hospital's Infection Preventionist must utilize the NHSN program to report these infections. Training is available through the NHSN at *www.cdc.gov/nhsn/training.html*

It is important to note that the data entry system, and the data demands of the NHSN system are generally more comprehensive than the "usual" hospital infection control report. Because of this your ICP must review the data requirements and ensure that the required elements are available at the time of initial submission. One of the most common "missing" elements is the antimicrobial susceptibility profile of the organism. As the data entry process is time consuming, and each case must be completed at the time of submission, it is imperative that the ICP have uninterrupted time to complete the process.

CMS does not plan to include CLABSI data validation in the initial year of reporting to the quality reporting program. Your hospital may elect to perform a validation of the data submitted to the program if your rates exceed the published NHSN guidelines. These base line rates are found in the American Journal of Infection Control ("AJIC") annual report available at *www.cdc.gov/nhsn/PDFs/dataStat/2009NH*.

Written by Susan Viker, RN, CIC of Steven Hirsch & 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.

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.