

## Facts about The Joint Commission

**Mission:** *To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.*

**Positioning statement:** *Helping Health Care Organizations Help Patients.*

The Joint Commission evaluates and accredits more than 15,000 health care organizations and programs in the United States. An independent, not-for-profit organization, The Joint Commission is the nation's predominant standards-setting and accrediting body in health care. Since 1951, The Joint Commission has maintained state-of-the-art standards that focus on improving the quality and safety of care provided by health care organizations. The Joint Commission's comprehensive process evaluates an organization's compliance with these standards and other accreditation or certification requirements. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain The Joint Commission's Gold Seal of Approval™, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years. (Laboratories must be surveyed every two years.)

The Joint Commission is governed by a 29-member Board of Commissioners that includes physicians, administrators, nurses, employers, a labor representative, health plan leaders, quality experts, ethicists, a consumer advocate and educators. The Board of Commissioners brings to The Joint Commission diverse experience in health care, business and public policy. The Joint Commission's corporate members are the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. The Joint Commission employs approximately 1,000 people in its surveyor force, at its central office in Oakbrook Terrace, Illinois, and at a satellite office in Washington, D.C. The Washington office is The Joint Commission's primary interface with government agencies and with Congress, seeking and maintaining partnerships with the government that will improve the quality of health care for all Americans, and working with Congress on legislation involving the quality and safety of health care.

### Accreditation and certification services

The Joint Commission provides accreditation services for the following types of organizations:

- General, psychiatric, children's and rehabilitation hospitals
- Critical access hospitals
- Medical equipment services, hospice services and other home care organizations
- Nursing homes and other long term care facilities
- Behavioral health care organizations, addiction services
- Rehabilitation centers, group practices, office-based surgeries and other ambulatory care providers
- Independent or freestanding laboratories

The Joint Commission also awards Disease Specific Care Certification to health plans, disease management service companies, hospitals and other care delivery settings that provide disease management and chronic care services. The Joint Commission also has a Health Care Staffing Services Certification Program and is developing a certification program for transplant centers and health care services.

### Benefits of Joint Commission accreditation and certification

- Strengthens community confidence in the quality and safety of care, treatment and services
- Provides a competitive edge in the marketplace
- Improves risk management and risk reduction
- Provides education on good practices to improve business operations
- Provides professional advice and counsel, enhancing staff education

- Enhances staff recruitment and development
- Recognized by select insurers and other third parties
- May fulfill regulatory requirements in select states

For more information, see the fact sheets on “Benefits of Joint Commission Accreditation” and “Benefits of Joint Commission Certification.”

### **Standards and performance measurement**

Joint Commission standards address the organization’s level of performance in key functional areas, such as patient rights, patient treatment, and infection control. The standards focus not simply on an organization’s ability to provide safe, high quality care, but on its actual performance as well. Standards set forth performance expectations for activities that affect the safety and quality of patient care. If an organization does the right things and does them well, there is a strong likelihood that its patients will experience good outcomes. The Joint Commission develops its standards in consultation with health care experts, providers, measurement experts, purchasers, and consumers.

Introduced in February 1997, The Joint Commission’s ORYX initiative integrates outcomes and other performance measurement data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts. Performance measures are essential to the credibility of any modern evaluation activity for health care organizations. They supplement and help guide the standards-based survey process by providing a more targeted basis for the regular accreditation survey, for continuously monitoring actual performance, and for guiding and stimulating continuous improvement in health care organizations. Some accredited organizations are required to submit performance measurement data on a specified minimum number of measure sets or non-core measures, as appropriate, to The Joint Commission through a Joint Commission listed performance measurement system. For more information, see “Facts about ORYX.”

### **Education and information**

Joint Commission Resources is a global, knowledge-based organization that provides innovative solutions designed to help health care organizations improve patient safety and quality. An affiliate of The Joint Commission, JCR is the official publisher and educator of The Joint Commission. JCR provides expertise on the many issues organizations face in a challenging health care environment through a variety of product and services including: education programs, publications and multimedia products, its Continuous Service Readiness program, comprehensive health care consulting and custom education, and accreditation and international consulting for organizations abroad. The Joint Commission and JCR maintain strict policies that prohibit The Joint Commission from sharing any confidential information about accredited organizations with JCR. The fact that an organization has obtained services from JCR is kept completely separate from Joint Commission accreditation decisions.

Through Quality Check®, [www.qualitycheck.org](http://www.qualitycheck.org), The Joint Commission provides a comprehensive guide to the nearly 15,000 Joint Commission-accredited health care organizations and programs throughout the United States. In 2007, The Joint Commission began including organizations that are not accredited by The Joint Commission to Quality Check. Joint Commission accredited organizations are easily identified by The Joint Commission’s Gold Seal of Approval™. Quality Check includes each accredited organization’s most recent Quality Report. This report provides: detailed information about an organization’s performance and how it compares to similar organizations; the organization’s accreditation decision and the effective dates of the accreditation award; programs accredited by The Joint Commission, and programs or services accredited by other accrediting bodies; compliance with The Joint Commission’s National Patient Safety Goals; special quality awards; and, for hospitals, performance on National Quality Improvement Goals. For more information, see “Facts about Quality Check® and Quality Reports.”

### **For more information**

The Joint Commission website includes an extensive directory; just click on “Contact Us.” The general phone number is (630) 792-5000 and the Customer Service number is (630) 792-5800.

## Hospital accreditation

The Joint Commission has accredited hospitals for more than 50 years and today it accredits approximately 4,250 general, children's, long term acute, psychiatric, rehabilitation and surgical specialty hospitals, and accredits 358 critical access hospitals maintaining a unique accreditation program for these organizations. Approximately 91 percent of the nation's hospitals are currently accredited by The Joint Commission.

### Eligibility

Any health care organization may apply for Joint Commission accreditation under the Hospital Accreditation Standards if all the following requirements are met:

- The organization is in the United States or its territories or, if outside the United States, is operated by the U.S. government, under a charter of the U.S. Congress.
- The organization assesses and improves the quality of its services. This process includes a review of care by clinicians, when appropriate.
- The organization identifies the services it provides, indicating which services it provides directly, under contract, or through some other arrangement.
- The organization provides services addressed by the Joint Commission's standards.

### Benefits of accreditation

Hospitals seek Joint Commission accreditation because it:

- Strengthens community confidence in the quality and safety of care, treatment and services.
- Provides a competitive edge in the marketplace.
- Improves risk management and risk reduction.
- Helps organize and strengthen patient safety efforts.
- Provides education on good practices to improve business operations.
- Provides professional advice and counsel, enhancing staff education.
- Provides a customized, intensive process of review grounded in the unique mission and values of the organization.
- Enhances staff recruitment and development.
- Provides deeming authority for Medicare certification.
- Recognized by insurers and other third parties.
- May reduce liability insurance costs.
- Provides a framework for organizational structure and management.
- May fulfill regulatory requirements in select states.

### Standards

Joint Commission standards address the hospital's performance in specific areas, and specify requirements to ensure that patient care is provided in a safe manner and in a secure environment. The Joint Commission develops its standards in consultation with health care experts, providers and researchers, as well as measurement experts, purchasers and consumers. All of the standards in each performance area or chapter are rigorously reviewed and updated every three years. For 2008, the standards-based performance areas for hospitals are:

- Ethics, Rights and Responsibilities
- Provision of Care, Treatment and Services
- Medication Management
- Surveillance, Prevention, and Control of Infection
- Improving Organization Performance
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information
- Medical Staff
- Nursing

### Survey process

To earn and maintain accreditation, a hospital must undergo an on-site survey by a Joint Commission survey team. Joint Commission surveys are unannounced and occur 18 to 39 months after the previous unannounced survey. The objective of the survey is not only to evaluate the hospital, but to provide education and guidance that will help staff continue to improve the hospital's performance. The survey

process evaluates actual care processes by tracing patients through the care, treatment and services they received. It also analyzes key operational systems that directly impact the quality and safety of patient care. The survey team can include one or more health care professionals, including a physician, nurse, life safety code specialist, or hospital administrator who has senior management level experience. The Joint Commission has a cadre of more than 400 surveyors, reviewers and life safety code specialists who are trained and certified, and receive continuing education on advances in quality-related performance evaluation.

### **Performance measurement requirements**

Introduced in February 1997, The Joint Commission's ORYX initiative integrates outcomes and other performance measurement data into the accreditation process. ORYX measurement requirements are intended to support Joint Commission accredited organizations in their quality improvement efforts. In 2002, accredited hospitals began collecting data on standardized—or "core"—performance measures. In 2004, The Joint Commission and the Centers for Medicare & Medicaid Services began working together to align measures common to both organizations. These standardized common measures, called "Hospital Quality Measures," are integral to improving the quality of care provided to hospital patients and bringing value to stakeholders by focusing on the actual results of care. Measure alignment benefits hospitals by making it easier and less costly to collect and report data because the same data set can be used to satisfy both CMS and Joint Commission requirements.

### **Hospital information available to the public**

Information about the safety and quality of accredited hospitals is available to the public at Quality Check®, [www.qualitycheck.org](http://www.qualitycheck.org). This comprehensive listing includes each accredited hospital's name, address, telephone number, accreditation decision, current accreditation status and effective date, and its Quality Report. Quality Reports include detailed information about a hospital's performance and how it compares to similar hospitals.

### **Cost of accreditation**

Annual fees are based on the size and the service complexity of individual hospitals and range from \$1,780 to \$36,845. For 2008, the on-site survey fees for hospitals are: \$2,500 per surveyor for the first day and \$1,030 per surveyor for the second and subsequent days. For small hospitals (those with fewer than 26 beds and less than 50,000 visits), the 2008 annual fee is \$1,090 and the on-site survey fees are \$4,580 per survey. The on-site survey fee is paid at the beginning of the year in which the on-site survey will be conducted, along with the annual fee, and covers survey-related direct costs. Organizations have the option to receive a corporate orientation or corporate summation. These can be conducted by the entire survey team, by the team leader only, or by Central Office staff. The Joint Commission extranet includes a fee calculator to help estimate annual subscription billing costs. For more information about pricing, including a weighted volume worksheet for annual fees, contact The Joint Commission's Pricing Unit at [pricingunit@jointcommission.org](mailto:pricingunit@jointcommission.org) or (630) 792-5115.

### **For more information**

For questions about standards, contact the Standards Interpretation Group at [standards@jointcommission.org](mailto:standards@jointcommission.org) or (630) 792-5900. For questions about hospital accreditation services, call (630) 792-3007. Corporate offices for systems of accredited organizations (i.e. multi-hospital systems in all states) should call (630) 792-5778.

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## **Accreditation process overview**

The accreditation process is continuous, data-driven and focuses on operational systems critical to the safety and quality of patient care. Key components of the process are:

- **Periodic Performance Review (PPR):** A required annual review during which the health care organization evaluates its own compliance with applicable standards and develops a Plan of Action

for identified areas of non-compliance. The organization engages in conversation with The Joint Commission to obtain approval of its Plan of Action.

- **Tracer methodology:** On-site evaluation of standards compliance in relation to the care experience of patients using a “tracer” methodology. Tracer activities permit assessment of operational systems and processes in relation to the actual experiences of selected patients who are under the care of the organization. This activity actively engages all direct caregivers in the accreditation process.
- **Priority Focus Process (PFP):** An on-site survey focused on patient safety and quality of care at the specific health care organization being surveyed is directed by the PFP. The PFP uses automation to gather pre-survey data from multiple sources including The Joint Commission, the health care organization and other public sources. The PFP then applies rules to 1) identify areas of priority focus relevant standards and appropriate survey activities, and 2) guide the selection of patient tracers.
- **Unannounced survey:** Unannounced surveys were implemented to enhance the credibility of the accreditation process and to ensure that surveyors observe organization performance under normal circumstances. There are limited exceptions to unannounced surveys, including initial surveys, and accredited organizations can identify up to 10 days each year in which an unannounced survey should be avoided (i.e., black-out dates).

### **Standards**

In October 2006, The Joint Commission launched a Standards Improvement Initiative as part of its continuous effort to improve the standards. The goal of this initiative is to:

- Clarify standards language
- Ensure that standards are program-specific
- Delete redundant or non-essential standards
- Consolidate similar standards

As additional benefits to users, the manuals will be reorganized and the scoring and decision process will be refined. Improvements—both format and language edits—are targeted to go into effect January 2009 for the ambulatory, critical access hospital, home care, hospital, and office-based surgery programs. The 2009 accreditation manuals for these programs will include the improvements from the SII. These 2009 manuals will become available in the fall of 2008. Beginning in 2008, feedback will be sought on standards for the behavioral health care, laboratory and long term care accreditation programs. For more information about SII, visit <http://www.jointcommission.org/Standards/SII/>.

SII builds on Shared Visions-New Pathways, which involved the substantial consolidation of the standards to reduce the paperwork and documentation burden of the accreditation process and increase its focus on patient safety and health care quality. Joint Commission standards are the basis of an objective evaluation process for health care organizations that can help measure, assess and improve organization performance. The standards focus on important patient, client or resident care and organization functions that are essential to providing quality care in a safe environment. The Joint Commission’s state-of-the-art standards set expectations for organization performance that are reasonable, achievable and surveyable. Joint Commission standards are developed with input from health care professionals, providers, measurement experts, consumers and employers. New standards are added only when they will have a direct impact on the quality of care.

### **Survey process**

In 2004, the survey process was substantially modified to be more data-driven and patient-centered thus enhancing its value, relevance and credibility. The survey process focuses on evaluating actual care processes as patients are traced through the care, treatment and services they receive. This “tracer methodology” is guided by the Priority Focus Process and involves visits to care and service areas. In addition, surveyors conduct “systems tracers” to analyze key operational systems that directly impact the quality and safety of patient care. System tracers involve discussion and education about the use of data in performance improvement (as in core measure performance and the analysis of staffing), medication management, infection control, and other current topics of interest to the organization. During the survey, surveyors validate the organization’s implementation and monitoring of the Plan of Action emanating from the PPR and review the environment of care, human resources and credentials.

## **Accreditation decisions**

The accreditation decision process focuses on ongoing standards compliance and is based primarily on the number of standards that are scored not compliant. Compliance with the standards is scored by determining compliance with Elements of Performance, which are specific performance expectations that must be in place for an organization to provide safe, high quality care, treatment and services. After the on-site survey, organizations do not receive an overall score or grid element score, and no scores are shared with the health care organization. The final accreditation decision will be made after The Joint Commission receives and approves an organization's Evidence of Standards Compliance submission. As of January 1, 2008, the accreditation decision categories are accreditation, provisional accreditation, conditional accreditation, preliminary denial of accreditation, denial of accreditation, and preliminary accreditation. For more information about accreditation decisions, see "Facts about accreditation decisions."

For more information, visit The Joint Commission website, [www.jointcommission.org](http://www.jointcommission.org). Accredited organizations may also visit their secure site on The Joint Commission Connect extranet, or contact their account representative.

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## **Joint Commission accreditation standards**

Joint Commission standards are the basis of an objective evaluation process for health care organizations that can help measure, assess and improve organization performance. The standards focus on important patient, client or resident care and organization functions that are essential to providing quality care in a safe environment. The Joint Commission's state-of-the-art standards set expectations for organization performance that are reasonable, achievable and surveyable.

### **Standards development process**

Joint Commission standards are developed with input from health care professionals, providers, measurement experts, consumers, government agencies and employers. New standards are added only when they will have a direct effect on the quality or safety of care. The standards development process includes the following steps:

1. The need for new standards is identified by accredited organizations, professional associations, consumer groups and others.
2. The Joint Commission prepares draft standards using input from external task forces, focus groups and experts.
3. The draft standards are reviewed by field-specific Professional and Technical Advisory Committee(s) and a committee of the Board of Commissioners.
4. The draft standards are sent to the field and other stakeholders for review.
5. The draft standards are revised and reviewed by the appropriate PTAC(s) and the Board.
6. The approved standards are published for use by the field.

### **Standards manuals**

Each accredited organization receives one free copy of the applicable comprehensive standards manual. The manuals are divided into two sections. Section 1 covers patient, client or resident-focused functions that relate directly to the provision of care, treatment and services:

- Ethics, rights and responsibilities
- Provision of care, treatment and services
- Medication management
- Surveillance, prevention and control of infection

Section 2 contains organization functions that are vital to the organization's ability to provide high-quality care, treatment and services:

- Improving organization performance
- Leadership
- Management of the environment of care
- Management of human resources
- Management of information
- In addition, the hospital manual contains two extra chapters with standards specific to the medical staff and nursing services.

### **Standards Improvement Initiative**

In August 2006, The Joint Commission launched a Standards Improvement Initiative as part of its continuous effort to improve the standards. The goal of this initiative is to make the standards more clear, objective, and program-specific, and to refine scoring of the standards. The manuals will also be reorganized. Improvements — both structural and language changes — are targeted to go into effect January 2009 for the ambulatory, critical access hospital, home care, hospital, and office-based surgery programs. Beginning in 2008, feedback will be sought on standards for the behavioral health care, laboratory and long term care accreditation programs.

### **WikiHealthCare™ and standards development**

Beginning in mid-2007, any health care professional can collaborate to develop standards and quality improvement solutions through The Joint Commission's WikiHealthCare™ application. This Internet-based forum can be accessed through a link on The Joint Commission's home page, or directly at [wikihealthcare.jointcommission.org](http://wikihealthcare.jointcommission.org). Those who are registered on the site can discuss content, edit existing content, and create new content which is then available to the entire community.

### **For more information**

To see the latest initiatives, improvements and FAQs about Joint Commission standards, go to [www.jointcommission.org/Standards](http://www.jointcommission.org/Standards).

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## **2008 National Patient Safety Goals**

On June 1, 2007, The Joint Commission's Board of Commissioners approved the 2008 National Patient Safety Goals. The Goals and related requirements are below. New Goals and requirements are indicated in **bold** and accreditation program applicability is indicated in brackets. Gaps in the numbering indicate a Goal has been "retired," usually because the requirements were integrated into the standards. Program-specific language changes are omitted from this version.

**This year's new requirements (3E and 16A) have a one-year phase-in period that includes defined expectations for planning, development and testing ("milestones") at 3, 6 and 9 months in 2008, with the expectation of full implementation by January 2009. See the Implementation Expectations for milestones.**

- |        |   |
|--------|---|
| Goal 1 | Improve the accuracy of patient identification.   |
| 1A     | Use at least two patient identifiers when providing care, treatment or services. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]   |
| 1B     | Prior to the start of any invasive procedure, conduct a final verification process, (such as a "time out,") to confirm the correct patient, procedure and site, using active—not passive—communication techniques. [Assisted Living, Home Care, Lab, Long Term Care]  |
| Goal 2 | Improve the effectiveness of communication among caregivers.  |
| 2A     | For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, |

- Office-Based Surgery]
- 2B Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- 2C Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values. [Ambulatory, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, **Long Term Care**, Office-Based Surgery]
- 2E Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- Goal 3 Improve the safety of using medications.
- 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs. [Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Long Term Care, Office-Based Surgery]
- 3D Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field. [Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery]
- 3E Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. [Ambulatory, Critical Access Hospital, Home Care, Hospital, Long Term Care, Office-Based Surgery]**
- Goal 7 Reduce the risk of health care-associated infections.
- 7A Comply with current **World Health Organization (WHO) Hand Hygiene Guidelines** or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- 7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- Goal 8 Accurately and completely reconcile medications across the continuum of care.
- 8A There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery]
- 8B A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery]
- Goal 9 Reduce the risk of patient harm resulting from falls.
- 9B Implement a fall reduction program including an evaluation of the effectiveness of the program. [Assisted Living, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Long Term Care]
- Goal 10 Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- 10A Develop and implement a protocol for administration and documentation of the flu vaccine. [Assisted Living, Disease-Specific Care, Long Term Care]

- 10B Develop and implement a protocol for administration and documentation of the pneumococcus vaccine. [Assisted Living, Disease-Specific Care, Long Term Care]
- 10C Develop and implement a protocol to identify new cases of influenza and to manage an outbreak. [Assisted Living, Disease-Specific Care, Long Term Care]
- Goal 11 Reduce the risk of surgical fires.
- 11A Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels with enough time for patient preparation, and establish guidelines to minimize oxygen concentration under drapes. [Ambulatory, Office-Based Surgery]
- Goal 12 Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.
- 12A Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements. [Networks]
- Goal 13 Encourage patients' active involvement in their own care as a patient safety strategy.
- 13A Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- Goal 14 Prevent health care-associated pressure ulcers (decubitus ulcers).
- 14A Assess and periodically reassess each resident's risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks. [Long Term Care]
- Goal 15 The organization identifies safety risks inherent in its patient population.
- 15A The organization identifies patients at risk for suicide. [Behavioral Health Care, Hospital (applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals)]
- 15B The organization identifies risks associated with long-term oxygen therapy such as home fires. [Home Care]
- Goal 16 Improve recognition and response to changes in a patient's condition**
- 16A The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening. [Critical Access Hospital, Hospital]**

The goals and requirements for each accreditation program are also available on The Joint Commission website at <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>. As of January 1, 2008, all Joint Commission accredited health care organizations and the Disease-Specific Care certified programs will be surveyed for implementation of applicable 2008 goals and requirements—or acceptable alternatives (see below)—as appropriate to the services the organization or program provides. Compliance with applicable requirements or acceptable alternatives will be scored at the associated implementation expectation(s) for that requirement in the NPSGs chapter of each standards manual.

### **Derivation of the goals**

The development and annual updating of the NPSGs and requirements is overseen by an expert panel of widely recognized patient safety experts, as well as nurses, physicians, pharmacists, risk managers, and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. Each year, the Sentinel Event Advisory Group works with Joint Commission staff to undertake a systematic review of the literature and available databases to identify potential new goals and requirements. Following a solicitation of input from practitioners, provider organizations, purchasers, consumer groups, and other parties of interest, the advisory group determines the highest priority goals and requirements and makes its recommendations to The Joint Commission. In order to maintain the

focus of accredited organizations on the most critical patient safety issues, the Sentinel Event Advisory Group may, as part of its annual review, recommend the retirement of selected requirements from the NPSGs. In such cases, they will usually continue as accreditation requirements under the relevant standards.

The Sentinel Event Advisory Group was formed in February 2002 and the Board of Commissioners approved the first NPSGs in July 2002; they became effective in January 2003. Program-specific goals were developed for all accreditation programs in 2004 for implementation in 2005. The Joint Commission established the NPSGs to help accredited organizations address specific areas of concern in regards to patient safety. The Sentinel Event Advisory Group is charged with conducting a thorough review of all *Sentinel Event Alert* (The Joint Commission's widely read patient safety advisory) recommendations and other sources of patient safety recommendations, and identifying those that are candidates for the annual NPSGs. The Group also advises The Joint Commission as to the evidence for and face validity of these recommendations, as well as their practicality and cost of implementation. The Advisory Group's recommendations for annual NPSGs and associated requirements are forwarded to The Joint Commission's Board of Commissioners for approval prior to the year in which they are to be implemented.

### **Submitting alternative approaches**

An alternative approach to a NPSG requirement must be accepted by The Joint Commission based on the Sentinel Event Advisory Group's review and recommendation that it is at least as effective as the published requirement in achieving the goal. Organizations that wish to submit alternative approaches to the requirements associated with the NPSGs can do so by filling out a "Request for Review of an Alternative Approach to a NPSG Requirement" form. The form and instructions for submitting it are available at <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>. Members of the Sentinel Event Advisory Group will review each form and advise The Joint Commission on the acceptability of the alternative. If not accepted, the organization will be provided with the rationale and will need either to revise the alternative until it is approved, or to implement the requirement as issued by The Joint Commission. Surveyors will accept organizations' use of approved alternatives and will evaluate the implementation of those alternatives and other relevant requirements associated with the NPSGs.

For more information, visit <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>, contact the Standards Interpretation Group at (630) 792-5900, or complete the Standards Online Question Submission Form at <http://www.jointcommission.org/Standards/OnlineQuestionForm/>.

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## **Unannounced survey process**

The Joint Commission conducts unannounced surveys:

- To help health care organizations focus on providing safe, high quality care at all times, and not just when preparing for survey.
- To affirm the expectation of continuous standards compliance both by The Joint Commission of its accredited organizations and by these organizations of themselves.
- To enhance the credibility of the accreditation process by ensuring that surveyors observe organization performance under normal circumstances.
- To reduce the unnecessary costs that health care organizations incur to prepare for survey.
- To address public concerns that The Joint Commission receive an accurate reflection of the quality and safety of care.

Organizations due for survey between 2006 and 2008 will have their unannounced survey in the year that the organization is due for survey. Beginning with the cohort of organizations due for survey in 2009, organizations will have their unannounced survey between 18-39 months after the organization's first unannounced survey. The time of this latter survey and all succeeding unannounced surveys will be based on pre-established criteria generated from Priority Focus Process data, as well as other factors.

On the morning of an organization's survey, the biographies and pictures of the surveyors assigned to

conduct the survey will be posted to the organization's secure site on the Joint Commission's extranet, Joint Commission Connect. In addition, the organization's Priority Focus Process summary report and the survey agenda will also be posted there.

### **Exceptions to unannounced surveys**

The following surveys are not conducted unannounced:

- Initial surveys (organizations undergoing their first Joint Commission survey)\*
- First surveys for organizations that choose the Early Survey Policy option
- Periodic Performance Review Option 2 and Option 3 surveys

\*All hospital and Centers for Medicare & Medicaid deeming or recognition surveys are unannounced.

A five-day notice is given for the following surveys:

- Department of Defense facilities
- Bureau of Prison facilities
- "Small" laboratories
- Foster Care Programs
- Health care staffing organizations with two or fewer full-time employees
- Immigrant facilities
- Ambulatory health care organizations that provide specified diagnostic and therapeutic services and have fewer than 3,000 annual visits or four or fewer licensed independent practitioners
- Ambulatory health care organizations that provide mobile diagnostic services
- "Small" home care organizations that provide only one service
- Disease-Specific Care reviews (excludes organ transplant, Ventricular Assist Device and Lung Volume Reduction Surgery reviews)

Accredited organizations can identify up to 10 days in which an unannounced survey should be avoided (i.e., black-out dates). These 10 days shouldn't include federal holidays, but may include regional events in which it may be difficult to conduct a survey during a given period. The Joint Commission will make every effort to accommodate the organization's request, but reserves the right to conduct a survey during an "avoid period" if the reason given to avoid a survey is such that a survey can be reasonably accomplished.

For more information, visit The Joint Commission website at [www.jointcommission.org](http://www.jointcommission.org). Accredited organizations may visit the Joint Commission extranet, Joint Commission Connect, or contact their account representative for additional information.

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## **Priority Focus Process**

The Priority Focus Process is a data-driven tool that helps focus survey activity on issues most relevant to patient safety and quality of care at the specific health care organization being surveyed. The PFP uses automation to gather pre-survey data from multiple sources including The Joint Commission, the health care organization and other public sources. The PFP then applies rules to 1) identify areas of priority focus relevant standards and appropriate survey activities, and 2) guide the selection of patient tracers.

The PFP does not imply that priority areas are out of compliance or deficient in any way, rather, it lends consistency to the surveyor's on-site sampling process. By providing surveyors with pre-survey information that has been developed using a standardized methodology, the PFP helps surveyors evaluate health care organizations' performance more consistently. The PFP also helps to focus the surveyors' assessment on quality and safety issues specific to an individual health care organization.

The output of the PFP process includes:

- The top four-to-five **priority focus areas**—the processes, systems or structures within a health care organization known to significantly impact the safety and quality of care specific to the health care organization being surveyed. The priority focus areas include, for example, communication, equipment use, infection control, organizational structure, patient safety and staffing.
- The **clinical/service groups**—groups of patients, residents or clients in distinct clinical populations for which data are collected. For example, in a hospital setting, clinical/service groups might include cardiology, general surgery or orthopaedic and rehabilitation. In an ambulatory setting, an example of clinical/service groups might be gastroenterology, obstetrics and pediatrics.

Information from the priority focus areas and clinical/service groups is then used to help guide the focus of the on-site survey activities.

The PFP reports will be posted to The Joint Commission Connect extranet site quarterly and as changes warrant. For more information about the PFP or the accreditation process, visit The Joint Commission website at [www.jointcommission.org](http://www.jointcommission.org), or see your program manual.

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## Tracer methodology

The Joint Commission's on-site survey process includes tracer methodology. Tracer methodology is an evaluation method in which surveyors select a patient, resident or client and use that individual's record as a roadmap to move through an organization to assess and evaluate the organization's compliance with selected standards and the organization's systems of providing care and services. Surveyors retrace the specific care processes that an individual experienced by observing and talking to staff in areas that the individual received care. As surveyors follow the course of a patient's, resident's or client's treatment, they assess the health care organization's compliance with Joint Commission standards. They conduct this compliance assessment as they review the organization's systems for delivering safe, quality health care.

While conducting tracer activities, the surveyor may identify compliance issues in one or more elements of performance. Surveyors will look for compliance trends that might point to potential system level issues in the organization. The tracer activity also provides several opportunities for surveyors to provide education to organization staff and leaders, as well as to share best practices from other similar health care organizations.

The number of tracers completed depends on the length of the survey, however, the average three-day hospital survey with a team of three surveyors typically allows for completion of approximately 11 tracers. Tracer patients, residents or clients are primarily selected from an active patient list. Typically, individuals selected for the tracer activity are those who have received multiple or complex services. The surveyor may speak to the patient, resident or client during the tracer activity, if it is appropriate. As always, the surveyor asks for patient permission before speaking to him or her.

If problem trends are identified, surveyors will issue the organization a Requirement for Improvement. The organization has 45 days from the end of the survey to submit Evidence of Standards Compliance and identify Measures of Success that it will use to assess sustained compliance over time. Four months after approval of the Evidence of Standards Compliance, the organization will submit data on its Measure of Success to demonstrate a track record. Any exchange of information between the health care organization and The Joint Commission will meet HIPAA requirements.

For more information about the tracer methodology, or other key components of the accreditation process, visit The Joint Commission website at [www.jointcommission.org](http://www.jointcommission.org).

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## Scoring and accreditation decisions

The accreditation decision process focuses on ongoing standards compliance and is based primarily on the number of standards that are scored not compliant.

- Compliance with the standards is scored by determining compliance with Elements of Performance, which are specific performance expectations that must be in place for an organization to provide safe, high quality care, treatment and services.
- After the on-site survey, organizations do not receive an overall score or grid element score, and no scores are shared with the health care organization.
- The final accreditation decision is made after The Joint Commission receives and approves an organization's Evidence of Standards Compliance submission.

**Elements of Performance**

EPs are scored on a three-point scale: 0 = insufficient compliance, 1 = partial compliance, 2 = satisfactory compliance. Each standard has one or more EP. Each EP is labeled in the accreditation manuals and EPs all have the same weight. EPs are divided into three scoring categories:

- **“A”** EPs usually relate to structural requirements (for example, policies or plans) that either exist or do not exist. They may also address an issue that must be fully compliant even though it focuses on performance or outcome (e.g., National Patient Safety Goals). “A” EPs may also be related to a Condition of Participation that must always be fully compliant.
- **“B”** EPs relate to the presence or absence of requirements and are usually answered yes or no. If the organization meets the requirements, but there is concern about the quality or comprehensiveness of the effort, the surveyor will review the applicable principles of good process design with the organization.
- **“C”** EPs are frequency-based EPs and are scored based on the number of times an organization does not meet a particular EP.

After an organization's compliance with an EP is scored, its track record is evaluated as noted below. The track record illustrates the amount of time that an organization has been compliant with an EP. This can affect the EP score.

Score	Full Survey
2	12 months or more
1	6 to 11 months
0	Fewer than 6 months

EPs are then aggregated to determine standards compliance. Standards are scored either compliant or not compliant.

**Evidence of Standards Compliance**

If standards are scored not compliant at the time of the on-site survey, an organization must demonstrate that it has corrected systems and processes to be in compliance with those standards by submitting Evidence of Standards Compliance. Organizations have 45 days to submit an ESC to The Joint Commission. Also, if required by the EP, the organization will also submit an indicator, or Measure of Success, that it will use to assess sustained compliance over time. Four months after approval of the ESC, the organization will submit data on its Measure of Success to demonstrate sustained compliance over time.

**Accreditation decision categories**

The final accreditation decision will be made after The Joint Commission receives and approves an organization's ESC submission and Measures of Success (when required). The categories are:

- **Accreditation** — The organization demonstrates compliance with all of the standards at the time of the on-site survey, or it resolves Requirements for Improvement via an acceptable ESC submission.
- **Provisional Accreditation** — Results when a health care organization fails to do one or more of the following: 1) Successfully address all requirements for improvement in an ESC within 45 days following the survey. 2) Achieve an appropriate level of sustained compliance as determined by a Measure of Success result. 3) Meet all requirements for the timely submission of data and information to The Joint Commission within 31 days of the due date(s).\*

- **Conditional Accreditation** — Results when a health care organization fails to be in substantial compliance with the standards or fails to meet all requirements for the timely submission of data and information to The Joint Commission.
- **Preliminary Denial of Accreditation** — Results when the number of not compliant standards exceeds established thresholds at the time of survey. The decision is subject to appeal prior to the determination to deny accreditation; the appeal process may also result in a decision other than Denial of Accreditation.
- **Denial of Accreditation** — An organization is denied accreditation because it did not permit a survey, or failed to meet requirements for timely data submission, resolve a Conditional Accreditation status, or submit required fees.
- **Preliminary Accreditation** — The organization demonstrates compliance with selected standards in the first of two surveys conducted under the Early Survey Policy Option 1. This decision remains in effect until one of the other official accreditation decision categories is assigned, based on a complete survey against all applicable standards approximately six months later.

For more information about scoring or accreditation decision categories, visit The Joint Commission website, [www.jointcommission.org](http://www.jointcommission.org). Accredited organizations may also visit their secure site on The Joint Commission Connect extranet, or contact their account representative.

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## Review hearing and appeal processes

The Accreditation Committee of The Joint Commission's Board of Commissioners oversees the accreditation decision process to ensure its accuracy and validity. The Committee also establishes and monitors the application of all policies and procedures regarding the accreditation and certification decision process. The Committee is composed of 11 board members and has nine scheduled meetings.

Between 5,300 and 6,000 accreditation decisions are rendered annually, and approximately 4 percent are referred to the Accreditation Committee for direct review and determination. Decisions are referred to the committee under various circumstances that include, but are not limited to, the following:

- If, after survey, the organization is found to meet the decision rules for Preliminary Denial of Accreditation or Conditional Accreditation.
- If The Joint Commission president determines to preliminarily deny accreditation based on identification of a condition that poses a serious threat to patient care or safety.

When the Accreditation Committee determines that an organization may be denied accreditation, the organization is placed on Preliminary Denial of Accreditation—a decision that is subject to public release. The health care organization has the right to request a review of the decision before a decision to deny accreditation is rendered. The organization has five business days to request a review.

During these five days and throughout the review process, the organization retains the Preliminary Denial of Accreditation status. A decision to deny accreditation is rendered if the organization allows five days to elapse without submitting a request for review, or if the organization abandons its request for review at *any* point in the process.

### Review Hearing Panel

If an organization decides to request a review of the Preliminary Denial of Accreditation decision, a hearing is scheduled before a Review Hearing Panel. The panel is composed of a member of the Accreditation Committee and two individuals who have knowledge about or experience with the type of services involved in the Preliminary Denial of Accreditation decision. The surveyor(s) who conducted the survey will be present at the hearing, if available.

An organization must submit materials to be considered by a Review Hearing Panel, including any materials specifically requested by The Joint Commission, at least 10 days before the scheduled hearing date. At least 30 calendar days before the scheduled hearing date, The Joint Commission will send the organization written notice of the time and place of the hearing and any additional materials related to the Preliminary Denial of Accreditation decision.

At the hearing before the Review Hearing Panel, the organization may be accompanied by legal counsel. The organization may make oral and written presentations. Only information about the organization's activities and performance *at the time of* the organization's survey is considered relevant to the deliberations by the Review Hearing Panel. Thus, the panel will not ordinarily consider information presented at the hearing concerning actions taken subsequent to the survey upon which the Preliminary Denial of Accreditation decision was based. The Accreditation Committee member who served on the panel presents the panel's report to the Accreditation Committee. The organization will be furnished a copy of the panel's report and may submit comments on it.

After consideration of the panel's report, and any comments from the organization, the Accreditation Committee may decide to award Accreditation, Provisional Accreditation or Conditional Accreditation, or deny accreditation to the organization.

If the Accreditation Committee decides to deny accreditation, the organization may appeal to the Board Appeal Review Committee and may submit its arguments—whether procedural or substantive—in writing to the Committee.

### **Board Appeal Review Committee**

The Board Appeal Review Committee is composed of five members of the Board of Commissioners who were not involved in the original accreditation decision. The Accreditation Committee member who served on the Review Hearing Panel attends the Board Appeal Review Committee meeting to present and respond to questions about the Review Hearing Panel report. The Accreditation Committee member does not participate in the deliberations of the Board Appeal Review Committee or vote. Representatives of the organization do not attend the meeting.

After review of the decision of the Accreditation Committee that considered the Review Hearing panel's report and the organization's written submission to the Committee, the Board Appeal Review Committee issues The Joint Commission's final accreditation decision.

*For more information, call The Joint Commission, (630) 792-5800, or visit The Joint Commission website, [www.jointcommission.org](http://www.jointcommission.org).*

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## **Periodic Performance Review**

The Periodic Performance Review is a compliance assessment tool designed to help organizations with their continuous monitoring of performance and performance improvement activities. The PPR provides the framework for continuous standards compliance and focuses on the critical systems and processes that affect patient care and safety. There are four ways that an organization can complete the PPR process: the full PPR or Options 1, 2 or 3. The options were created in response to concerns about legal disclosure of PPR information shared with The Joint Commission.

### **Benefits of the PPR and options**

Both the full PPR and the options facilitate a continuous accreditation process by incorporating an additional form of evaluation. The full PPR and the Option 2 survey have the additional benefit of helping to ensure consistency in the accreditation process, since approved Plans of Action cannot be challenged during the survey, and the scoring methodology for the PPR is the same as that used by surveyors during the on-site survey.

### **Full PPR**

- Each year, the organization uses the automated PPR tool to assess and score compliance with the Elements of Performance for each applicable standard.
- The organization creates a Plan of Action addressing each EP scored as partial or insufficient compliance within any standards found not compliant.
- The organization identifies Measures of Success (as indicated) for each EP scored as partial or insufficient compliance within any standards scored as not compliant.
- The organization submits its PPR to The Joint Commission annually.
- Joint Commission staff reviews all PPR submissions. Approval of Plans of Action can only occur during a conference call with the Standards Interpretation Group.

### **Option 1**

- The organization uses the PPR tool to annually affirm that legal counsel advises the organization not to participate in the full PPR. Instead, the organization completes a PPR and Plan of Action and identifies appropriate MOS (as indicated).
- The organization may use the PPR tool to score compliance, and can print and view standards and EPs to conduct its assessment on paper.
- The organization affirms that it has completed an assessment of its compliance with applicable EPs and developed Plans of Action and MOS, if needed, but does not submit these data to The Joint Commission when the affirmation is submitted.
- The organization can submit standards-related issues in the PPR tool for telephone discussion with Joint Commission staff. No approvals are given for Option 1 PPRs.

### **Option 2**

- The organization uses the PPR tool to annually attest that, after careful consideration with legal counsel, it has decided not to participate in the full PPR and instead will undergo a limited PPR survey. The organization can choose a full PPR survey without legal consideration. (Fees will be charged.)
- The organization submits the PPR tool again within 30 days of the survey. This submission addresses not compliant standards, choice of a conference call, and topics for discussion with Joint Commission staff.
- The organization creates a Plan of Action and any required MOS for each standard scored not compliant and submits data to The Joint Commission via the PPR tool within 30 days of survey.
- Joint Commission staff reviews the submitted plans and MOS. Approval can only be given during a conference call with the Standards Interpretation Group.

### **Option 3**

- The organization uses the PPR tool to annually attest that after careful consideration with legal counsel, it has decided not to participate in the full PPR and instead will undergo either a limited survey or a full-length PPR survey. (Fees will be charged.)
- Unlike Option 2, Option 3 stipulates that no written report of findings will be left at the organization. The surveyor delivers an oral report of findings at the closing conference of the on-site survey. No findings are transmitted to The Joint Commission.
- The organization submits the PPR tool again within 30 days of the survey. This submission addresses the choice of a conference call and any topics for discussion with Joint Commission staff.

If an organization selects the full PPR, Option 1 or Option 2, surveyors will ask to see MOS data at the time of the full survey. It's important to note that an organization's accreditation decision is not affected by the results of its PPR.

For more information about the PPR, visit The Joint Commission website at [www.jointcommission.org](http://www.jointcommission.org). Accredited organizations may also visit their secure site on The Joint Commission Connect extranet, review their accreditation manual, or contact their account representative.

## Quality Check® and Quality Reports

The Joint Commission has had a longstanding commitment to providing meaningful information about the comparative performance of accredited organizations to the public. In 1994, The Joint Commission first published organization-specific Performance Reports. In 1996, Quality Check®, a directory of Joint Commission accredited organizations and performance reports, became available on the website. In 2004, Quality Reports replaced Performance Reports, although historical Performance Reports are still available.

Improvements continued in 2006 and 2007 with a redesign of Quality Check. The process included extensive testing, field surveys and input from consumer focus groups and stakeholders, including four advisory groups and state hospital associations. The feedback was used to refine and clarify Quality Reports for both health care professionals and the public.

### Quality Check

Quality Check — [www.qualitycheck.org](http://www.qualitycheck.org) — is a comprehensive guide to health care organizations in the United States. Visitors can search by city and state, or by name and zip code (up to 250 miles).

### New in 2007

As of October 1, The Joint Commission's Quality Check website includes organizations that are not accredited by The Joint Commission as well as Joint Commission accredited organizations. Joint Commission accredited organizations are easily identified by The Joint Commission's Gold Seal of Approval™.

Organizations not accredited by The Joint Commission can request to be added to Quality Check by accessing [www.qualitycheck.org/qcdirectory](http://www.qualitycheck.org/qcdirectory).

The search function has been expanded so that users can find organizations by type of service provided within a geographic area. Once a service and area have been selected, the health care organizations displayed can be filtered by type of provider, setting of care or patient population. Some of the pre-defined services that can be selected for search are cardiac care, developmental disabilities, dialysis, home medical equipment, neurology, occupational health and optometry.

The search results page now includes a cleaner display for readability, a special quality awards display, a link to view all services provided at the health care organization's sites, and links to directions and websites for the health care organization, when available.

### Quality data downloads

The Joint Commission provides hospital performance measure results to any external third party for free via Quality Check. By clicking on the **Quality Data Download** tab, an individual can download any of the performance measure results available for hospitals on Quality Check. The information can then be saved electronically or printed out. The availability of this data supports the Joint Commission's commitment to transparency in calculating performance measures. Providing performance measure results at no fee to third parties allows for flexibility in customizing performance measure results for use in performance improvement initiatives and quality of care-related reporting.

### Quality Reports

Quality Reports feature a user-friendly format with checks, pluses and minuses to help the general public compare health care organization performance in a number of key areas. While Quality Check displays demographic and service information for organizations not accredited by The Joint Commission on the Quality Check Search Results page, Quality Reports are only available for organizations that are accredited by The Joint Commission. Quality Reports provide information about a health care organization's:

Joint Commission accreditation decision and the effective dates of the accreditation award. For Provisional, Conditional, and Preliminary Denial of Accreditation decisions, the reports will list the standards cited for Requirements for Improvement.

Programs accredited by the Joint Commission, and programs or services accredited by other accrediting bodies.

Compliance with the Joint Commission's National Patient Safety Goals, as applicable to the organization.

Performance on National Quality Improvement Goals (hospitals only). These goals allow hospitals to report on key quality of care indicators in up to five treatment areas: heart attack, heart failure, community acquired pneumonia, pregnancy and related conditions, and surgical care improvement project for infection prevention. This performance data is updated quarterly. As more measures are approved and endorsed by the National Quality Forum, the Joint Commission will explore ways to incorporate that data in Quality Reports.

Special quality awards, including recognition such as Disease-Specific Care Certification, Ernest A. Codman Award, Eisenberg Patient Safety Award, Franklin Award, and Magnet status (awarded by the American Nurses Credentialing Center), Medal of Honor for Organ Donation and others approved by the Joint Commission Board of Commissioners.

### **New in 2008**

Quality Reports for organizations that have pursued disease-specific care certification. The initial reports will include listings of certifications by site and performance against the National Patient Safety Goals.

### **For more information**

For information about Quality Check send an e-mail to [qualitycheck@jointcommission.org](mailto:qualitycheck@jointcommission.org). For information about Quality Reports send an e-mail to [qualityreport@jointcommission.org](mailto:qualityreport@jointcommission.org).

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## **Federal deemed status and state recognition**

### **What is federal deemed status?**

In order for a health care organization to participate in and receive payment from the Medicare or Medicaid programs, it must meet the eligibility requirements for program participation, including a certification of compliance with the Conditions of Participation, or standards, set forth in federal regulations. This certification is based on a survey conducted by a state agency on behalf of the Centers for Medicare & Medicaid Services. However, if a national accrediting organization, such as The Joint Commission, has and enforces standards that meet or exceed the federal Conditions of Participation, CMS may grant the accrediting organization "deeming" authority and deem each accredited health care organization as meeting Medicare and Medicaid certification requirements. The health care organization would have deemed status and would not be subject to Medicare's survey and certification process.

Accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement. Organizations seeking Medicare approval may choose to be surveyed either by an accrediting body, such as The Joint Commission, or by state surveyors on behalf of CMS. All deemed status surveys are unannounced. Deemed status options are available for:

**Ambulatory Surgical Centers.** Effective December 1996, Joint Commission accredited centers are deemed to meet the Medicare Conditions for Coverage for Ambulatory Surgical Services. The deemed status survey is unannounced.

**Clinical Laboratories.** Laboratories that receive accreditation through a biennial survey are deemed to meet the requirements of the federal Clinical Laboratory Improvement Amendments (CLIA) of 1988. The Joint Commission began conducting surveys for CLIA certification in January 1995.

**Critical Access Hospitals.** Effective November 2002, Critical Access Hospitals accredited by The Joint Commission are deemed to meet Medicare certification requirements. The deemed status survey is unannounced.

**Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).** Effective November 2006, The Joint Commission is deemed to accredit suppliers of DMEPOS as meeting new quality standards under Medicare Part B. In 2007, bidding will occur in 10 selected metropolitan areas for the equipment that is most frequently billed to Medicare. A supplier must have at least applied for accreditation to submit a bid, and must achieve full accreditation prior to being awarded a competitively bid contract.

**Home Health.** Effective June 1993, surveys to be used for deemed status must be unannounced. Survey intervals, which may be one, two or three years, will be determined using CMS criteria. More frequent surveys may be necessary for an accredited home health agency that, for example, has had a change of ownership.

**Hospices.** Effective June 1999, hospice deemed status surveys must be unannounced. This deemed status option is open to organizations seeking Medicare funding for hospice services as well as those already Medicare certified. Organizations choosing this option will be evaluated against both Joint Commission standards and Hospice Medicare Conditions of Participation. Accreditation remains voluntary and seeking deemed status through accreditation is not a requirement for Medicare certification.

**Hospitals.** Since the enactment of the Social Security Amendments of 1965, hospitals with Joint Commission accreditation have been deemed as meeting the federal Conditions of Participation for the Medicare and Medicaid programs. The deemed status survey is unannounced.

CMS conducts random validation surveys and complaint investigations of organizations with deemed status through Joint Commission accreditation. In addition, The Joint Commission is obliged to provide CMS with a listing of, and related documentation for, organizations receiving conditional accreditation, preliminary denial of accreditation, and accreditation denied. The Joint Commission also provides CMS with accreditation decision reports for hospitals involved in CMS validation surveys and any other survey report CMS requests.

#### **Costs of deemed status survey allowable**

CMS has determined that fees for surveys by The Joint Commission are allowable costs and may be included in a health care organization's costs on its annual cost report for those organizations required to file cost reports.

#### **Recognition for state licensure and certification**

While federal deemed status does not typically provide an exemption from current state requirements for state licensure, The Joint Commission's various accreditation programs are recognized and relied on by many states in the states' quality oversight activities. Recognition and reliance refers to the acceptance of, requirement for, or other reference to the use of Joint Commission accreditation, in whole or in part, by one or more governmental agencies in exercising regulatory authority. Recognition and reliance may include use of accreditation for licensing certification or contracting purposes by various state agencies.

#### **For more information**

For information about deemed status, call The Joint Commission's Washington, D.C., office at (202) 783-6655. For information on state initiatives, call The Joint Commission's Division of Business Development, Government and External Relations, (630) 792-5269.