

**Register Now for  
the 2010 C&A  
Annual  
Conference**

**"Partnering for  
Patient-Centered  
Care"**



This year's conference will be held in **Baltimore, Maryland**, from **April 26-28, 2010**.

Register by February 15, 2010, to lock in your "Early Bird Discount!"

[Visit our web site for more details and registration information.](#)

**2010 TJC & CMS  
Webinar Series**

**It's not too late to  
still join in...**

**The next webinar  
is February 8th so  
register now!**

**The Disparity Rate is Dropping**

**CMS Annual Report Update**

**By Marty Piepoli**

In the Fiscal Year 2009 Annual Financial Report to Congress, the Centers for Medicare and Medicaid Services (CMS) reported an 8% decrease in the disparity of findings between The Joint Commission (TJC) and CMS onsite hospital surveys. The disparity rate had been increasing annually over the past decade up to a high of 40% last year, causing increased concern for CMS and TJC. This is the first time the disparity rate has dropped and demonstrates that standards and survey process changes made by TJC in recent years have been effective in reducing the variance.

The disparity rate is identified through validation surveys. The Social Security Act authorizes the Secretary of Health and Human Services to conduct validation surveys of accredited facilities participating in Medicare as a means of validating the accreditation process. The Accreditation Validation Program, a significant component of CMS' oversight of accrediting organizations (AO), consists of two types of validation surveys: full surveys of a representative sample of deemed facilities and allegation surveys which are focused surveys based on complaints. Over the past nine years, the data collected by CMS demonstrated an increasing degree of disparity and identified multiple opportunities for TJC to improve its survey process, reduce the gap in assuring compliance in surveying the Conditions of Participation thereby providing deemed status for Medicare hospitals.

Deemed status means that if a hospital is compliant with TJC standards then they are "deemed to be compliant" with the CMS Conditions of Participation. You may recall that TJC had a longstanding, unique statutory deeming authority for hospitals that was revoked with the enactment of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA). In 2009 TJC was required to submit a deeming application to assure current survey process met CMS expectations in surveying the Medicare Conditions of Participation. TJC was successful in that application and received renewed deemed status effective July 15, 2010 through July 15, 2014.

The level of disparity between TJC findings and those found during CMS surveys reached its high point in FY2008, when a 40% difference in findings was identified between the TJC process and State Agency validation surveys. Seventy-three percent of that disparity was in the area of the Environment of Care. As TJC and CMS continued dialogue to close the gap, TJC implemented the Life Safety Specialist, embarked on a Standards Improvement Initiative (SII) to improve their standards, separated the Environment of Care chapter into three chapters, creating the Life Safety and Emergency Management chapters, provided Life Safety education for all surveyors and worked on survey process and

Call C&A at (704) 573-4535 to Register, [Register Online](#), or [Click Here to Download a Registration Form](#).

## Quick Links

[Consulting](#)

[Conferences](#)

[Webinars](#)

[Publications](#)

[Resources](#)

[About C&A](#)

scoring methodology to meet CMS expectations.

Prior to the enactment of MIPPA, the validation survey component of CMS' annual reporting to Congress was limited to those surveys conducted for The Joint Commission hospital program. As a result of MIPPA, expansion of the CMS annual report to Congress includes all accrediting organizations (AOs) and their approved accreditation programs. The validation survey program analysis will now be reported for all AOs and CMS-approved accreditation programs: critical access hospitals, home health agencies, hospice and ambulatory health care centers. The AO's include The Joint Commission, the Healthcare Facilities Accreditation Program (American Osteopathic Association), DNV Healthcare, Inc., Community Health Accreditation Program, Accreditation Association for Ambulatory Healthcare.

To learn more about the CMS annual report and the related implications for accrediting organizations, join C&A for a webinar on February 17, 2009 addressing the FY 09 CMS Financial Report to Congress and Disparity Results. Click here for more information.

Sources:

The Joint Commission Standards Improvement Initiative  
([www.jointcommission.org](http://www.jointcommission.org))

CMS Financial Report, Fiscal Year 2009

## Excerpts from a Patient Diary - Part II

### Linking Patient Experiences to Accreditation Requirements

**By: Darlene Christiansen, Ed.D (candidate) and Sharon Dills, MSN**

In the August edition of C&A News, Judy Courtemanche, President and CEO, shared her experiences as a patient in the hospital in "Excerpts from a Patient Diary." She expressed concerns related to patient identification, pain management, medication administration and others. Unfortunately, all of the issues that Judy expressed concerns about are standards that frequently result in a Requirement for Improvement (RFI) for hospitals during surveys by The Joint Commission (TJC). In this follow-up article, we will specifically discuss each concern as related to the standards and provide you with compliance solutions.

**"There was no handoff of information about me. I am afraid because no one knows about the breathing problems [after receiving Morphine], and I don't have the pulse ox anymore."**

Consider PC.02.02.01, EP2 (dialogue during handoff communication) and LD.03.04.01, EPs 1 and 5 (communication related to safety and quality).

Compliance Planning:

- The organizational policies reflect effective handoff communication processes between care providers and between the care providers and the patient and/or the family.
- The organization identifies what information must be communicated when transferring the care of the patient from one health care provider to another health care provider.

- Staff is aware of the safety reasons for appropriate, active handoff communication.
- Patients are educated to be participants in their care and to request handoff communication.
- Handoff communication processes are effectively implemented.

Also consider PC.02.01.05, EP1 (interdisciplinary care, treatment and services).

Compliance Planning:

- Best practice is to implement rounding and include all healthcare professionals involved in the patient's care.
- Educate all disciplines where to document education/services provided.
- Assure that all disciplines can access other disciplines notes.
- If information is documented in multiple places, educate staff on how to speak about interdisciplinary care.

**“OK. Isn’t Morphine a wonderful drug? I’m at peace with the universe. I don’t think I’m breathing. No, I guess not, as the pulse ox is dropping.”**

Consider MM.07.01.01, EP2 (monitoring response to medications).

Compliance Planning:

- The organization processes require that staff consider: clinical information from the medical record, relevant lab values, clinical response, and medication profile.
- The educational records of staff document that staff have been educated in clinical information to be reviewed in monitoring patients to determine the effects of their medication.
- Staff is knowledgeable about the elements which are to be considered in monitoring of patients and can verbalize this information.
- Staff implements appropriate processes to monitor patients to determine the effects of their medication.

Also consider RC.02.01.01, EP2 (medical record contains assessment and patient response information related to pain management).

Compliance Planning:

- Create/implement/educate hospital policy regarding timeframes for documentation, especially when related to pain assessment and reassessment.
- Require documentation to occur in one place to eliminate confusion/redundancy and increase compliance.

**“Did she check my two identifiers? I don’t remember.”** Consider NPSG.01.01.01, EP1 (patient identification).

Compliance Planning:

1. The organization has identified which patient identifiers are to be used when providing care, treatment, and services.
2. The educational records of staff document that staff have been educated in patient identification and the use of patient identifiers.
3. Staff is knowledgeable about the use of patient identifiers and, at a minimum, when they must be used.
4. Staff implements the process of using the two patient identifiers when required.
5. Patient education empowers patients and families to request that the identification process be consistently used.

**“. . . pain medication was ordered. Someone asked if I was allergic to anything.”** Consider NPSG.08.04.01, EP1 (medication reconciliation – modified process for short-stay situations). Note this NPSG is not in effect at this time, but this EP should be considered in the provision of safe, quality care.

Compliance Planning:

- The organization has identified the patient care locations or settings where medications are used minimally or prescribed for a short duration.
- The organization has identified which medications would fall into the categories, minimally used and/or prescribed for a short duration.
- The educational records of staff document that staff have been educated that a modified medication reconciliation process is to be performed in these identified patient care locations.
- The educational records of staff document that staff have been educated on which medications fall into the categories, minimally used and/or prescribed for a short duration.
- The modified medication reconciliation process is implemented.

**“Describing my pain was difficult.” “It felt really bad to me, but was it a 10 or could it get worse? What if I think it is a “10,” but it gets worse? What exactly did a “9” feel like? Can I use 12? I thought I should play it safe in case it gets worse, so I said an “8.”** Consider PC.01.02.07, EPs 1 and 2 (pain assessment).

Compliance Planning:

- Ensure that RNs assess the patient’s pain per hospital policy.
- Documentation of pain must occur per hospital policy.
- Educate RNs to help the patient understand what “rating” their pain means. Give examples to the patient of different severities. Although pain is subjective, also include physical indicators. For example, increased blood pressure.
- Physicians should make sure that parameters exist for mild, moderate and severe pain so that RNs are not making medication decisions. For example, for mild pain give have Percocet 1 tab PO every 4 hours. For moderate pain, Percocet 2 tabs PO every 4 hours. For severe pain, give morphine 2 mg IV every 2 hours.
- Do not use range orders. For example, give 1-2 tabs Percocet PO every 4 hours.

- Best practice idea is to implement rounding every 2 hours to assess patient's pain. This does not have to be done by the RN.

**"It is as though I know what is happening, but am powerless to do anything about it. I can hear everything they do and don't say, and suddenly realize that no one told the x-ray tech about my recent medication."**

Consider PC.02.01.09, EPs 1 and 2 (recognition and response to deteriorating patient condition).

Compliance Planning:

- Create a rapid response team.
- Educate all staff in the organization about the rapid response team and how to activate the team.
- Make sure that staff knows it is better to call the team than not to call and that no one will be reprimanded.
- Educate patients and visitors that they have the right to call the rapid response team.
- Post how to contact the rapid response team throughout the hospital.

The healthcare environment presents many challenges for health care organizations, individual practitioners, patients, and families. Healthcare organizations and practitioners are challenged to meet regulatory and accreditation requirements while working to improve clinical outcomes. Being in the hospital is a stressful and scary experience. It is each practitioner's responsibility to minimize this stress for the patient. The implementation of strategies that increase compliance with TJC standards can support best practices in patient care and result in improved patient care outcomes.

Source: The Joint Commission Comprehensive Accreditation Manual for Hospitals, 2010



## Were You Aware?

1. The Joint Commission (TJC) has released the 2010 Survey Activity Guide. Download the document from [www.jointcommission.org](http://www.jointcommission.org). This version includes, for all programs, updated document lists, survey readiness notes and a survey activity list. In an effort to continue to improve customer and surveyor satisfaction, TJC has implemented a new process for developing the survey agenda. The survey team will work with the organization, while onsite, to develop an agenda that

meets survey requirements and the needs of the organization. (See the January 2010 edition of The Joint Commission Perspectives for more information.)

2. Just another reminder about “pre-charting.” Any orders for post-procedure medications, treatment and other care that are written pre-procedure must be activated post procedure for use with the patient. This means, for example, if an anesthesiologist completes a pre-anesthesia evaluation and writes post-procedure orders at that time, prior to the procedure, the orders would have to be activated after the procedure or should be signed, dated and timed after the procedure to indicate they are now active for use with the patient. (Courtesy of TJC’s Standards Interpretation Group (SIG) 12/30/10.)

3. The Centers for Medicare & Medicaid Services (CMS) have published revised Anesthesia Services Interpretive Guidelines to clarify which anesthesia services fall under this Condition of Participation (COP) and provide further details on pre, intra, and post-operative anesthesia requirements. See a future edition of C&A News for a summary of the revisions to these Interpretive Guidelines.

4. TJC has published revised interim staffing effectiveness requirements that become effective July 2, 2010. These revisions are applicable to the Hospital and Long Term Care programs and focus on the adequacy of staffing based on number, skill mix and staff competency. (See the January edition of Perspectives.) These requirements are expected to help organizations focus on assuring appropriate staffing to provide safe care without the onerous burden of the previous prescriptive staffing effectiveness data requirements.

[Click here to download 2009 "Were You Aware?" year in review](#)

Courtemanche & Associates  
Charlotte, NC | Parsippany, NJ  
Phone 704-573-4535 | Fax 704-573-4538  
[info@courtemanche-assocs.com](mailto:info@courtemanche-assocs.com) | [www.courtemanche-assocs.com](http://www.courtemanche-assocs.com)