The Joint Commission to Include Patient Satisfaction Data on Quality Check®

Web Site Provides New Information to Help Patients Make Decisions

People seeking information about how patients perceive the care they received at a particular hospital can now find this information on The Joint Commission's Quality Check Web site, http://www.qualitycheck.org.

The Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) data from the Centers for Medicare & Medicaid Services' (CMS) Hospital Compare Web site (http://hospitalcompare.hhs.gov) is posted on Quality Check beginning January 2009. This information will be updated quarterly.

HCAHPS information comes from patient ratings of communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of the hospital, pain management, communication about medications, and discharge information. In addition to information about patient satisfaction, Quality Check also includes data from CMS on 30-day mortality rates for heart attack, heart failure, and pneumonia.

Thousands of people use Quality Check each month to find information about the more than 15,000 accredited health care organizations that have earned The Joint Commission “Gold Seal of Approval.” Quality Check provides details about an organization’s accreditation status, efforts to prevent medical mistakes by complying with National Patient Safety Goals, and comparison information about how hospitals comply with National Quality Improvement Goals such as giving heart attack patients aspirin within a specified time frame.

http://www.jointcommission.org
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In Sight

This column informs you of developments and potential revisions that can affect your accreditation and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they were rejected at some point in the process.

Accepted
- Modifications to standards for the critical access hospital program corresponding to recently revised Medicare Conditions of Participation
- Modifications to standards for suppliers of durable medical equipment, prosthetics, orthotics, and supplies corresponding to recently revised Medicare Quality Standards

Joint Commission Field Review
Field review notifications are sent out electronically as well as posted on The Joint Commission Web site. If you would like to be added to the electronic notification list, please contact the Division of Standards and Survey Methods at 630/792-5912.
- Standards Improvement Initiative: Revised “Document and Process Control” (DC) chapter for the laboratory program
- Standards Improvement Initiative: Revised “Emergency Management” (EM) chapter for the behavioral health care, laboratory, long term care, and Medicare/Medicaid certification-based long term care programs
- Standards Improvement Initiative: Revised “Medication Management” (MM) chapter for the behavioral health care program
- Standards Improvement Initiative: Revised “Provision of Care, Treatment, and Services” (PC) chapter for the behavioral health care, long term care, and Medicare/Medicaid certification-based long term care programs
- Standards Improvement Initiative: Revised “Quality System Assessment for Non-waived Testing” (QSA) chapter for the laboratory program
- Standards Improvement Initiative: Revised “Record of Care, Treatment, and Services” (RC) chapter for the behavioral health care, long term care, and Medicare/Medicaid certification-based long term care programs
- Standards Improvement Initiative: Revised “Rights and Responsibilities of the Individual (RI) chapter for the behavioral health care, long term care, and Medicare/Medicaid certification-based long term care programs

In Committee or Board Review
- Modifications to standards for ambulatory surgical center deemed status corresponding to recently revised Medicare Conditions for Coverage

Currently in Development
- Comprehensive Standards Improvement Initiative encompassing the behavioral health care, laboratory, long term care, and Medicare/Medicaid certification-based long term care programs
- Potential standards related to Health Information Technology
- Proposed standards on culturally competent patient-centered care for the hospital program

Joint Commission International
Field review notifications are sent out electronically as well as posted on the Joint Commission International (JCI) Web site. For JCI standards questions, please contact the associate director, International Accreditation Services, at jciaccreditation@jcrinc.com.

In Development at JCI
- Revisions to international disease-specific care certification standards

In Committee Review
- Revisions to international ambulatory care standards
- Revisions to international laboratory standards
At its December 2008 meeting, The Joint Commission’s Accreditation Committee approved a policy that “unlinks” accreditation decisions in a tailored survey—that is, each organizational component’s* accreditation decision will neither directly affect another component’s decision, nor will an organization’s overall accreditation decision be generated as the result of surveys of each of the organization’s required components. This new policy is effective immediately.

Since all components will continue to be required in an applicant organization’s survey, if one of the components is denied accreditation, the organization will have six months to obtain accreditation again for that particular service/program. Failure to obtain accreditation for the particular component will result in the organization receiving a Requirement for Improvement (RFI). The organization will then be required to resolve the RFI through The Joint Commission’s regular Evidence of Standards Compliance (ESC) process.

Historically, The Joint Commission’s tailored survey policy has linked a component’s decision with that of the organization’s overall accreditation decision. However, this new approach is consistent with the action taken by the Accreditation Committee in October 2008, eliminating the direct impact that a Joint Commission–accredited laboratory’s decision would have on the organization’s overall accreditation decision. (See the December 2008 issue of The Joint Commission Perspectives® for more information.)

UPDATE: The Joint Commission’s Hospital Deeming Authority Application

In preparation for submission of its application to the Centers for Medicare & Medicaid Services (CMS) for continued hospital deeming authority, The Joint Commission began making necessary changes to its accreditation process in January 2009. Joint Commission–accredited hospitals are already meeting the spirit of many of these revised requirements. Some of these requirements add more specificity to existing Joint Commission standards, and others have led to entirely new Joint Commission requirements. Compliance with any requirements that are completely new are reviewed by Joint Commission surveyors beginning in January 2009, but will not be scored until July 2009 consistent with The Joint Commission’s policy to provide organizations with six-month’s notice of any changes to the requirements, whenever possible.

Changes Now Available Online

The new and revised standards and EPs are now available in a PDF on The Joint Commission’s Web site at http://www.jointcommission.org. The posted document contains text in two colors—black and grey, as illustrated here:

**Black text indicates new and revised standards and EPs developed to conform to CMS requirements. These requirements are scheduled for July 1, 2009, implementation but are subject to change pending further Joint Commission discussions with CMS. To further clarify: Organizations will not be scored on the standards and EPs indicated in black text until July 1, 2009.**

To provide context, grey text indicates current, unrevised Joint Commission requirements related to these new expectations. To further clarify: Organizations are scored on the standards and EPs indicated in grey text.

*(Note: The two colors are best distinguished if viewed at 100% on your screen.)*

The Joint Commission continues to work with CMS on some aspects of the application for hospital deeming authority. Please note that the posted document is a draft, and changes may be made over the next six months. Organizations with questions about the posted standards and EPs should call The Joint Commission’s Standards Interpretation Group at 630/792-5900. In March 2009, The Joint Commission will host a free audio conference on the deeming-related changes.
As of January 2009, reports of survey findings left with your organization after survey will no longer contain a preliminary accreditation decision based on reaching a defined threshold. As described in the December 2008 issue of *The Joint Commission Perspectives*, programmatic “bands” for “Direct Impact” Requirements for Improvement (RFIs) have been determined based on the number of survey days (as an indication of the size and complexity of the organization). See the table below for program-specific band information.

### Review Process and Criteria

The following information describes the review process and the criteria that will be considered during each review:

- These bands will serve as screening thresholds for Joint Commission Central Office review.
  - If the report meets or exceeds the screening “band” for Direct Impact RFIs, the report will stop for Central Office review.
  - This review will result in either a recommendation for Conditional Accreditation or Accreditation with RFIs if no other decision rule has been triggered.
- After an initial review to ensure that Direct Impact observations are correctly placed and the documentation supports the RFIs, the report will be reviewed to evaluate the effectiveness of systems and processes across the organization.
  - The identification of trends of noncompliance and the breakdown of systems and processes will be the focus of the review, rather than the volume of RFIs.
  - Conditional Accreditation will be recommended to The Joint Commission’s Accreditation Committee when it is determined that follow-up and monitoring by The Joint Commission would be beneficial to the organization.

### Considerations Before a Conditional Accreditation Recommendation

The following criteria will be considered before recommending Conditional Accreditation to the Accreditation Committee:

- The seriousness of the observations—the magnitude of the situation or issue observed
- Trends or systemic problems—the RFIs demonstrate or indicate a breakdown of systems and processes rather than isolated incidents
- Any leadership changes over the past 12 to 18 months that may have had a positive or negative impact on the organization
- Repeat issues from the previous full survey indicating either a failure to correct or an inability to sustain compliance

### Circumstances for a Preliminary Denial of Accreditation Recommendation

Preliminary Denial of Accreditation (PDA) will be recommended in the following circumstances:

- A Situational Decision Rule is triggered, which generates a PDA recommendation (for example, lack of license or certificate; practicing outside the scope of license and potentially causing harm; misrepresenting information to The Joint Commission)
- Immediate Threat to Health or Safety determinations
- The failure to correct RFIs within the defined time frames

Additional information will be provided in an upcoming issue of *Perspectives*.

### Surveyor Days Associated with Program-Specific “Bands”

<table>
<thead>
<tr>
<th>Surveyor Days–Band</th>
<th>AHC</th>
<th>BHC</th>
<th>CAH</th>
<th>HAP</th>
<th>LAB</th>
<th>LT2</th>
<th>LTC</th>
<th>OBS</th>
<th>OME</th>
<th>DSC</th>
<th>HCSS</th>
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<tr>
<td>Surveyor Days–Band 1</td>
<td>1–2</td>
<td>1–4</td>
<td>1–2</td>
<td>1–4</td>
<td>≥ 1</td>
<td>≥ 1</td>
<td>≥ 1</td>
<td>≥ 1</td>
<td>1–4</td>
<td>≥ 1</td>
<td>≥ 1</td>
</tr>
<tr>
<td>Surveyor Days–Band 2</td>
<td>3</td>
<td>≥ 5</td>
<td>≥ 3</td>
<td>5–6</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>≥ 5</td>
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<tr>
<td>Surveyor Days–Band 3</td>
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<td>Surveyor Days–Band 4</td>
<td>≥ 5</td>
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<td></td>
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<td>≥ 14</td>
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Key: AHC, ambulatory care; BHC, behavioral health care; CAH, critical access hospital; HAP, hospital; LAB, laboratory; LT2, Medicare/Medicaid certification-based long term care; LTC, long term care; OBS, office-based surgery; OME, home care; DSC, disease-specific care; HCSS, health care staffing services.
In December 2008, The Joint Commission's Board of Commissioners accepted revisions to the home care standards for home medical equipment services, effective January 1, 2009. These requirements are in alignment with the Centers for Medicare & Medicaid Services' (CMS) Quality Standards for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

These changes are located on The Joint Commission Web site at http://www.jointcommission.org and can be viewed in their entirety by selecting the "Accreditation Programs" tab and then the "Home Care" option. The direct link to these changes is as follows: http://www.jointcommission.org/AccreditationPrograms/HomeCare.

The Joint Commission is a CMS–approved accrediting organization for DMEPOS suppliers.

**ERRATA: 2009 Accreditation Manuals, All Programs**

This article contains Joint Commission–identified revisions to various standards requirements, elements of performance (EPs), and scoring information throughout the 2009 accreditation manuals, effective immediately. The revisions are noted in the box on pages 5–7 in strikeout and underlined text, as appropriate. Corrections are listed by standards chapter; program applicability is provided after each correction.

**Official Publication of Standards Errata**

**Official Publication of Standards Errata, Effective Immediately**

**APPLICABLE TO PROGRAMS AS INDICATED IN BLUE**

**Effective immediately**

From the “Environment of Care” (EC) Chapter:

EC.04.01.03, EP 2
The [organization] uses the results of data analysis to identify opportunities to resolve environmental safety issues. (See also EC.04.01.05, EP 1)

**Applies to:** Ambulatory care, critical access hospital (rehabilitation and psychiatric distinct part units), home care, hospital

EC.04.01.03, EP 3
Annually, representatives from clinical, administrative, and support services recommend to leaders one or more priorities for improving priority performance improvement activities for the environment of care.

**Applies to:** Ambulatory care, critical access hospital (rehabilitation and psychiatric distinct part units), home care, hospital

EC.04.01.05, EP 1
The [organization] takes action on the identified opportunities to resolve environmental safety issues. (See also EC.04.01.03, EP 2)

**Applies to:** Ambulatory care, critical access hospital (rehabilitation and psychiatric distinct part units), home care, hospital

EC.04.01.05, EP 2
The [organization] evaluates changes to determine if they resolved environmental safety issues. (See also EC.04.01.03, EP 2)

**Applies to:** Ambulatory care, critical access hospital (rehabilitation and psychiatric distinct part units), home care, hospital

Continued on page 6
Standards Errata, Effective Immediately (Continued)

From the “Equipment Management” (EQ) Chapter:

EQ.01.01.01, EP 12 (text revised to better align with Centers for Medicare & Medicaid Services’ interpretation)
The organization verifies that the patient received the medical equipment and supplies. Verification of delivery is documented.

Note: Verification is a written, verbal or electronic acknowledgement by the patient, family, or caregiver of receipt of the medical equipment or supplies. A UPS or common carrier tracking number alone without a signature does not constitute verification. Some examples of methods for verifying delivery include, but are not limited to the following: contacting the patient to confirm that delivery occurred, providing the patient with a return receipt to complete upon delivery, and retaining a copy of the delivery service’s tracking slip as well as the supplier’s own invoice. Proof of delivery can also be demonstrated by verifying a sample of deliveries and using the data collected for a performance improvement indicator.

Applies to: Home care

From the “Infection Prevention and Control” (IC) Chapter:

IC.01.01.01, EP 1—Remove MOS designation, C

Applies to: Critical access hospital, hospital

IC.01.06.01, EP 1—Remove MOS designation, C

Applies to: Ambulatory care, critical access hospital, home care, hospital

IC.02.02.01, EP 2—Scoring category change, from “C” to “A”, C

Applies to: Ambulatory care, critical access hospital, hospital, office-based surgery

From the “Life Safety” (LS) Chapter:

LS.02.01.30, add EP 25 (add inadvertently omitted EP) C

25. In buildings, exit stairs connecting three or fewer floors are fire-rated for 1 hour; exit stairs connecting four or more floors are fire-rated for 2 hours. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.3.2.1.)

Note: Vertical openings include, but are not limited to, stairways, elevator shafts, escalator openings, and other vertical openings.

Applies to: Behavioral health care, critical access hospital, home care, hospital, long term care

LS.03.01.30, EP 2
In existing buildings, exit stairs connecting three or fewer floors are fire-rated for 1 hour; exit stairs connecting four or more floors are fire-rated for 2 hours. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.3.2.1.)

Note: Vertical openings include, but are not limited to, stairways, elevator shafts, escalator openings, and other vertical openings.

Applies to: Ambulatory care, critical access hospital, hospital, office-based surgery

From the “Medication Management” (MM) Chapter:

MM.01.01.03, EP 4
The [organization] minimizes risks associated with managing hazardous medications. (See also EC.02.02.01, EPs 1 and 8)

Applies to: Ambulatory care, critical access hospital, hospital, office-based surgery

MM.2.20, EP 15 (add inadvertently omitted EP) C

15. All medication storage areas are periodically inspected according to the organization’s policy to make sure medications are stored properly.

Applies to: Behavioral health care

From the “National Patient Safety Goals” (NPSG) Chapter:

NPSG.01.01.01, EP 1
Prior to any specimen collection, medication administration, transfusion, or treatment, the organization actively involves the client and, as needed, the family in the identification and matching process. When active client involvement is not possible or the client’s reliability is in question, the organization will designate the caregiver responsible for identity verification.

Note: The involvement of a single caregiver is acceptable as long as the other components of client identification are satisfied.

Applies to: Behavioral health care
**Standards Errata, Effective Immediately (Continued)**

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<tr>
<th>NPSG.01.01.01, EP 3</th>
<th>Remove MOS designation</th>
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<tbody>
<tr>
<td>Applies to: Ambulatory care, behavioral health care, critical access hospital, disease-specific care, home care, hospital, laboratory, long term care, Medicare/Medicaid certification-based long term care, office-based surgery</td>
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<th>NPSG.07.04.01, EP 8</th>
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<tr>
<td>As of January 1, 2010, the [organization] conducts periodic risk assessments for surgical site infections, measures central line–associated bloodstream infection rates, monitors compliance with best practices or evidence based guidelines, and evaluates the effectiveness of prevention efforts.</td>
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<tr>
<td>Applies to: Ambulatory care, critical access hospital, home care, hospital, long term care, Medicare/Medicaid certification-based long term care</td>
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<th>Scoring Tier change, from “Tier 4” (Indirect Impact Requirements) to “Tier 3” (Direct Impact Requirements)</th>
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<td>Applies to: Ambulatory care, behavioral health care, critical access hospital, disease-specific care, home care, hospital, long term care, Medicare/Medicaid certification-based long term care, office-based surgery</td>
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<th>UP.01.01.01, EP 2</th>
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<thead>
<tr>
<th>From the “Provision of Care, Treatment, and Services” (PC) Chapter:</th>
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<tbody>
<tr>
<td>PC.01.03.01, EP 5</td>
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<tr>
<td>Applies to: Critical access hospital, home care, hospital</td>
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<tr>
<th>PC.02.02.03, EP 11</th>
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<tbody>
<tr>
<td>The [organization] stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.</td>
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<tr>
<td>Applies to: Ambulatory care, critical access hospital, home care, hospital</td>
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<thead>
<tr>
<th>PC.04.02.01, EP 3</th>
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<tr>
<td>The organization provides a written discharge summary to the patient’s physician in accordance with law and regulation. Note: Medicare regulations require that the home health agency must inform the attending physician of the availability of a discharge summary. The discharge summary is provided to the physician upon the physician’s request and includes the patient’s medical and health status at the time of discharge.</td>
<td></td>
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<tr>
<td>Applies to: Home care</td>
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<tr>
<th>From the “Rights and Responsibilities of the Individual” (RI) Chapter:</th>
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<tbody>
<tr>
<td>RI.01.02.01, EP 18</td>
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<tr>
<td>---------------------</td>
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<tr>
<td>The organization provides the patient with options for renting or purchasing equipment and items.</td>
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<tr>
<td>Applies to: Home care</td>
</tr>
</tbody>
</table>

* “Tier 4” indicates Indirect Impact Requirements. These requirements are typically applied to planning and evaluation of care processes; the risk to patient safety increases if these requirements are not resolved over time.

† “Tier 3” indicates Direct Impact Requirements. These requirements are based on the implementation of care processes that are likely to create an immediate risk to patient safety or quality of care if they are not adhered to.
CORRECTION: 2009 Disease-Specific Care Certification Manual and Update
Replacement Pages Posted Online

Following publication of the 2009 Disease-Specific Certification Care Manual and Update in October 2008, Joint Commission staff identified errors in some of the standards chapters. The pages containing errors have been corrected and posted online, for download and insertion into your manual. These corrections, applicable to the disease-specific care certification program, are effective immediately.

The corrections are also published in the box on page 9, listed by chapter. To see the corrections incorporated into the manual, please refer to the replacement pages posted online.

To download a PDF of the corrected pages, please visit http://www.jcrinc.com/Joint-Commission-Requirements/Disease-Specific-Care/. The pages posted online apply to both the manual and Update, and include only the pages that contain corrected information.

CORRECTION: Health Care Staffing Services Certification Criticality Designations

This article corrects erroneous criticality* (“Tier”) designations for several elements of performance (EPs) in the 2009 Health Care Staffing Services Certification Manual, effective immediately.

* Criticality The immediacy of risk to patient safety or quality of care as a result of noncompliance with a Joint Commission requirement.

† “Tier 4” indicates Indirect Impact Requirements. These requirements are typically applied to planning and evaluation of care processes; the risk to patient safety increases if these requirements are not resolved over time.

‡ “Tier 2” (△) indicates that Situational Decision Rules apply. Based on specific situations at the time of an on-site review, some issues will generate a recommendation to the Board of Commissioners for Conditional or Preliminary Denial of Certification.

§ “Tier 3” (▽) indicates Direct Impact Requirements. These requirements are based on the implementation of care processes that are likely to create an immediate risk to patient safety or quality of care if they are not adhered to.

The following requirements were incorrectly labeled as “Tier 4”† (Indirect Impact Requirements); the correct designation is “Tier 2”‡ (Situational Decision Rules) or “Tier 3”§ (Direct Impact Requirements), as indicated:

- From the “Certification Participation Requirements” (CPR) Chapter:
  - CPR 3, EP 1—“Tier 2” △
  - CPR 7, EP 1—“Tier 2” △
  - CPR 9, EP 1—“Tier 2” △
  - CPR 12, EP 1—“Tier 2” △

- From the “Human Resources Management” (HR) Chapter:
  - HR.1, EP 1—“Tier 2” △
  - HR.2, EP 2—“Tier 3” ▽
  - HR.2, EP 3—“Tier 3” ▽
## Effective immediately

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<thead>
<tr>
<th>Chapter</th>
<th>Correction Information</th>
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<td>Certification Participation Requirements (CPR)</td>
<td>● Scoring “Tier 2” *( ▲ ) added at CPR 3, EP 1; CPR 7, EP 1; CPR 9, EP 1; and CPR 12, EP 1</td>
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<td>Program Management (PR)</td>
<td>● Scoring “Tier 3” † *( ▲ ) added at PR 7, EP 2</td>
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<tr>
<td>Delivering or Facilitating Clinical Care (DF)</td>
<td>● Scoring “Tier 3” *( ▲ ) added at DF.1, EP 6; DF.2, EPs 4 and 5; DF.3, EPs 2, 3, 5–7; and DF.4, EPs 1–4</td>
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<td>DSC Certification Requirements for Chronic Kidney Disease (CKD)</td>
<td>● MOS designation *( ▲ ) added at PR.9, EP 1</td>
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<td>● MOS designation *( ▲ ) added at SE.1, EP 1</td>
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<td>● Scoring category “C” *( ▲ ) added at CT.3, EPs 1 and 2</td>
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<td>● Scoring category “A” *( ▲ ) added at CT.5, EP 5</td>
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<td>DSC Certification Requirements for Chronic Obstructive Pulmonary Disease (COPD)</td>
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<td>● Scoring category “A” *( ▲ ) added at PM.1, EP 6 and PM.3, EP 3</td>
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<tr>
<td>DSC Certification Requirements for Inpatient Diabetes Care (IDC)</td>
<td>● MOS designation *( ▲ ) added at SE.1, EP 1</td>
</tr>
<tr>
<td>DSC Certification Requirements for Lung Volume Reduction Surgery (LVRS)</td>
<td>● MOS designation *( ▲ ) added at SE.1, EP 1</td>
</tr>
<tr>
<td>DSC Certification Requirements for Primary Stroke Center (PSC)</td>
<td>● Scoring “Tier 3” *( ▲ ) added at PR.7, EP 2</td>
</tr>
<tr>
<td></td>
<td>● Scoring “Tier 3” *( ▲ ) removed from PR.7, EPs 8 and 10</td>
</tr>
<tr>
<td></td>
<td>● MOS designation *( ▲ ) added at DF.2, EP 4</td>
</tr>
<tr>
<td></td>
<td>● Scoring category “C” *( ▲ ) added at DF.3, EP 3</td>
</tr>
<tr>
<td></td>
<td>● MOS designation *( ▲ ) added at SE.1, EP 1</td>
</tr>
<tr>
<td>DSC Certification Requirements for Ventricular Assist Device Destination Therapy (VAD)</td>
<td>● MOS designation *( ▲ ) added at DF.3, EP 3 and at SE.1, EP 1</td>
</tr>
</tbody>
</table>

* “Tier 2” *( ▲ ) indicates that **Situational Decision Rules** apply. Based on specific situations at the time of an on-site review, some issues will generate a recommendation to the Board of Commissioners for Conditional or Preliminary Denial of Certification.

† “Tier 3” *( ▲ ) indicates **Direct Impact Requirements**. These requirements are based on the implementation of care processes that are likely to create an immediate risk to patient safety or quality of care if they are not adhered to.
The Joint Commission has updated its policies on accreditation and certification fees, including the deposit for initial customers and general fee information, for all accreditation and certification programs. The revised fee policy information is provided in the box on page 11.

For the accreditation programs, the information published below replaces the “Forfeiture of Survey Deposit” and “Survey Fees” sections in “The Accreditation Process” (ACC) chapter of the 2009 accreditation manuals. For the certification programs, this revised fee information replaces the “Forfeiture of Certification Deposit” and “Certification Fees” sections of “The Joint Commission Certification Process” chapter of the 2009 certification manuals.

For questions about accreditation or certification fees, please contact The Joint Commission’s Pricing Unit by phone at 630/792-5115 or e-mail at pricingunit@jointcommission.org.

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**CMS Continues to Recognize Joint Commission Ambulatory Surgical Center Accreditation**

*Deeming Authority Renewed for Six Years*

The Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS) has again granted The Joint Commission deeming authority for ambulatory surgical centers for its maximum six-year period.

The CMS designation means that ambulatory surgical centers accredited by The Joint Commission will be “deemed” as meeting Medicare certification requirements. CMS found that The Joint Commission’s standards for ambulatory surgical centers meet or exceed those established for the Medicare and Medicaid programs. CMS estimated in 2007 that approximately 4,600 ambulatory surgical centers participate in Medicare.

“The Joint Commission is pleased to once again receive this recognition of its accreditation of ambulatory surgical centers,” says Michael Kulczycki, executive director, Ambulatory Care Accreditation Program, The Joint Commission. “This public-private collaboration between CMS and The Joint Commission provides quality oversight for ambulatory surgical centers, which are increasingly important as patients undergo surgical procedures in freestanding clinics outside the traditional hospital setting. It is also significant that this is the third time CMS has granted The Joint Commission’s ambulatory surgical centers program deeming authority for the maximum six-year term, sending a strong signal about their confidence in our accreditation process.”

The federal government’s Final Notice granting deeming authority to The Joint Commission for its accredited ambulatory surgical centers was published in the Federal Register on November 14, 2008. The Joint Commission has been granted deeming authority for ambulatory surgical centers since 1996.

For more information on recent policy and requirement changes for ambulatory surgical centers using The Joint Commission deemed status option, please see the October 2008 issue of The Joint Commission Perspectives®, page 7.

For more information on the ambulatory care program, please visit [http://www.jointcommission.org/AccreditationPrograms/AmbulatoryCare/](http://www.jointcommission.org/AccreditationPrograms/AmbulatoryCare/).
Forfeiture of Survey or Certification Deposit

A nonrefundable, nontransferable deposit toward accreditation or certification fees is required for initial customers only. Organizations seeking certification that are currently accredited by The Joint Commission are not required to pay a deposit. The Joint Commission applies the deposit to the organization’s open invoices until the deposit is exhausted. An organization scheduled for an initial survey or review forfeits its deposit if its survey or review is not conducted within one year of submitting its application. The organization must then reapply and submit a new deposit to begin the accreditation or certification process again. Customers reapplying for certification are not required to pay a deposit if their organization is still accredited by The Joint Commission at the time of re-application.

Survey and Certification Fees

The Joint Commission uses a subscription billing system for all programs. Fees are determined annually and are based on the need to secure sufficient resources to cover the costs of operations. The Joint Commission generally bases individual organization fees on the volume and type of services provided and the sites to be included in the organization’s accreditation survey. Certification fees are based on variables within Disease-Specific Care or Health Care Staffing Services. Questions about all fees can be directed to the Pricing Unit (pricingunit@jointcommission.org) or by calling 630/792-5115.

The Joint Commission’s fee structure includes a nonrefundable, nontransferable annual fee, which recognizes the provision of substantial accreditation or certification related services on a continuous basis between on-site surveys and reviews. The annual fees are billed each January. The annual fee level for an organization is determined by the organization’s size and complexity. The annual fee for organizations applying for accreditation or certification for the first time will be prorated, based upon the quarter in which the application is submitted.

In addition to annual fees, organizations are also billed an on-site fee after the survey or review has been performed. The on-site fee is designed to cover the costs of performing a survey or review. If an ambulatory health care specialist or a chemical dependency specialist is required to be on the survey team, the organization’s invoice will reflect the additional fees to cover the costs of having these surveyors. Organizations requiring out-of-cycle surveys, such as in response to a sentinel event, will be assessed a separate survey fee.

Electronic invoices will be posted to the organization’s secure The Joint Commission Connect™ extranet site and are due upon receipt. The Joint Commission accepts checks, money orders, wire payments, and credit cards for all fees:

- Checks and money orders must be sent to the remittance address listed on the last page of the invoice to expedite payment processing to the organization’s account.
- To obtain wire transfer information, contact the Pricing Unit at 630/792-5115.
- To make a credit card payment by telephone, call Accounts Receivable at 630/792-5662. We accept Visa®, Mastercard®, American Express®, and Discover Card®.

Failure to provide timely payment of any Joint Commission fees may result in the loss of accreditation or certification status. The Joint Commission notifies an organization with significant standards compliance problems of either a Conditional Accreditation/Certification or a Preliminary Denial of Accreditation/Certification decision as soon as possible, whether or not payment has been received.
This book, an update to the successful Patient Safety Essentials for Health Care, 4th edition, is the complete guide to The Joint Commission's patient safety standards for ambulatory care, behavioral health care, critical access hospitals, home care, hospitals, and long term care organizations. It includes the standards, rationales, elements of performance, and scoring information in one handy resource. This book also identifies the commonalities among the standards to help readers understand which standards apply to which settings.

This book also discusses The Joint Commission’s program-specific 2009 National Patient Safety Goals and offers compliance and monitoring suggestions. It also describes how patient safety plays a key role in The Joint Commission’s accreditation process, particularly in tracer activities and safety-related priority focus areas.

This book also offers practical advice for creating a culture of safety, conducting proactive risk assessment through the use of failure mode and effects analysis (FMEA), and informing patients about unanticipated outcomes.

This edition also includes an explanation of The Joint Commission’s Standards Improvement Initiative, the new system for scoring elements of performance based on criticality, and how these changes affect the standards and National Patient Safety Goals.

Features:
- All safety standards for multiple accreditation programs in one convenient resource
- Handy matrix identifies which standards and EPs apply to which settings
- Tips for practical implementation of the safety standards and the 2009 National Patient Safety Goals
- Updated information on how safety plays a key role in The Joint Commission’s accreditation process

Item Number: PSE09
Price: $89.00

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