Practical Approaches to Ace Regulatory and Accreditation Surveys

JUNE 13, 2022

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Simplify and Comply

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Our Mission

To materially improve patient safety, quality and outcomes.

Lisa Eddy
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Vice President – Clinical Compliance & High Reliability Practice

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DNP, RN, NE-BC

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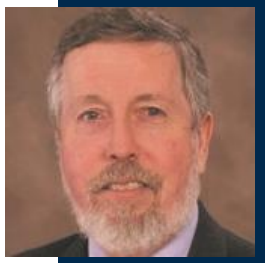

Bud Pate

Vice President - Content

“

Simplify and comply.

“

Complex is easy. Simple is hard.

Polling Question

How concerned are you about your next State, CMS, or Accreditation survey?

- Very concerned
- Somewhat concerned
- Not very concerned
- Not concerned at all
- Other (let us know in the chat box)

Key Learning Points

1. **The current focus of state survey agencies,** CMS, The Joint Commission, and other accreditors/regulators

2. **Practical approaches to addressing the most common pain points across the industry** aimed at reducing waste and maximizing simplicity, safety, value, and sustainability

3. **How to apply these specific approaches to improve patient safety** and develop long-term, sustainable compliance

Compliance with standards and regulations becomes a byproduct of high quality, safe, and efficient processes.

Objective

Avoid re-creating chaos in the name of compliance following the pandemic surges that broke healthcare at the weak points.

Agenda

The Current Situation: Broken at the Weak Spots

State of the Survey “Art”

Playing the Long Game

Key Takeaways

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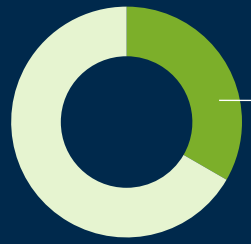
The Great (Healthcare) Resignation

1 in 5 healthcare workers left the field during the pandemic



30%

of nurses left the profession

The Impact on "Normal" Operations

The Great Resignation—the mass exodus of unsatisfied workers—has hit few industries harder than healthcare. According to some reports, the field has lost an estimated 20% of its workforce, including 30% of nurses.

Forbes

This year alone, nearly 1.7 million people have quit their healthcare jobs—equivalent to almost 3% of the healthcare workforce each month, according to the U.S. Bureau of Labor Statistics.

And a recent survey of 1,000 healthcare professionals showed that 28% had quit a job because of burnout.

Healthcare second largest sector hit by Great Resignation

Healthcare IT News

Staff shortages throw a wrench in hospitals' compliance standards

BECKER'S HOSPITAL REVIEW

"As a result, these care providers are having to balance time spent on non-nursing work with providing direct patient care and saving lives," Dr. Dabrow Woods said. The heavier workloads have left less time for healthcare providers to focus on infection control efforts.

These shortages have led to a lack of familiarity with standard processes and procedures among travel workers or providers covering new shifts.

"When APPs are unavailable, providers don't always know the resource to contact in their place, which opens the communication doors and often breaks protocol."

Safety-Related Metrics Suffer

Hospital infection rates rose and fell with COVID-19 surges in 2021: 5 findings

Mackenzie Bean - Wednesday, May 25th, 2022

BECKER'S HOSPITAL REVIEW

CDC data shows healthcare-associated infection rates rose significantly in 2020 after years of decline, and many kept climbing in 2021.

Similar findings for CLABSI, CAUTI, for MRSA

Ventilator-associate events rose 51% 1Q2021 and 60% in 3Q2021

Leapfrog urges CMS not to suppress hospital safety data

HEALTHCARE FINANCE

Leapfrog said the information CMS is seeking to curtail is critical

" … 'These findings highlight the continued challenges experienced in hospital infection prevention during the second year of the COVID-19 pandemic and underscore the need to establish resilient approaches to reducing infections during times of system stress,' lead author Lindsey Lastinger, an epidemiologist at the CDC, said in a news release the Society for Healthcare Epidemiology of America shared with Becker's.

CMS Seeks More Authority Over Accreditors

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS's Controls Related to Hospital Preparedness for an Emerging Infectious Disease Were Well-Designed and Implemented but Its Authority Is Not Sufficient for It To Ensure Preparedness at Accredited Hospitals

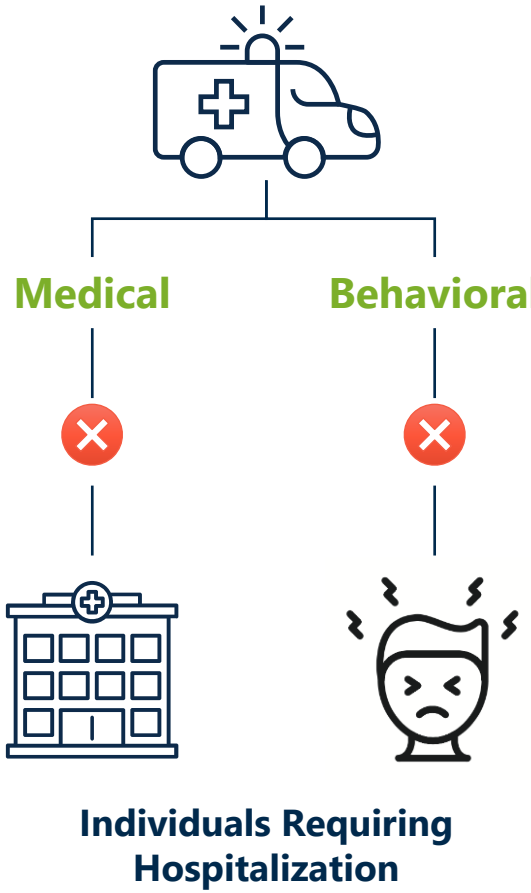
What OIG Found

CMS's controls were well-designed and implemented, but CMS's authority is not sufficient for it to fulfill its responsibility to ensure that accredited hospitals would maintain quality and safety during an emerging infectious disease emergency. Specifically, although CMS announced in February 2019 that it was critical for all hospitals to plan for emerging infectious diseases, CMS could not determine that all accredited hospitals updated their emergency preparedness plans to include this planning until 2022 due to accreditation organizations' quality and safety inspection cycles. Further, when COVID-19 emerged in the United States, CMS requested (but could not require) accreditation organizations to perform special targeted infection control surveys to help accredited hospitals prepare for COVID-19 patients. Accreditation organizations performed no such special surveys and, as of August 17, 2020, State survey agencies only performed these surveys at about 13 percent of accredited hospitals and had not performed any in 13 States because of CMS's limited authority over accredited hospitals. As a result of these limitations, CMS could not ensure that accredited hospitals would continue to provide quality care and operate safely during the COVID-19 emergency, and cannot ensure quality and safety at accredited hospitals when a future emerging infectious disease threatens the United States.

What OIG Recommends and CMS Comments

We recommend that CMS make regulatory changes to allow it to require accreditation organizations to perform special surveys after it issues new participation requirements or guidance and during a public health emergency to address the risks presented by the emergency.

Staff Shortages and Broken Processes are Evident in Crowded ED Waiting Rooms



For the Association of Academic Chairs of Emergency Medicine, Des Plaines, Illinois, USA

NEJM Catalyst

> *"The impact of ED crowding on morbidity, mortality, medical error, staff burnout, and excessive cost is well documented but remains largely underappreciated.*

ED Crowding and Harmful Effects

ED crowding is not an issue of inconvenience. There is incontrovertible evidence that ED crowding leads to significant patient harm,[6] including morbidity and mortality related to consequential delays of treatment for both high- and low-acuity patients,[11,12] ambulance diversion,[13] increased adverse events,[14] and preventable error.[15] Acutely ill ED patients requiring urgent intervention leave without being seen (LWBS) due to prolonged waits.[16,17] Outcomes are worse for patients with prolonged boarding in the ED, which results in longer inpatient stays and higher costs of care.[18-20] ED crowding has also been associated with more patients being classified as higher acuity and increased hospital admissions, further exacerbating the problem.[21] ED crowding leads to increased violence toward staff, high clinician and nursing staff turnover, decreased provider productivity, increased staff distraction resulting in human error, and consequent legal action.[22,23] Crowding is a key contributor to high ED physician burnout, approaching 75%.[24] Finally, patient experience is poor — regardless of quality of care — when patients are forced to remain in the ED waiting room in various states of discomfort.[25]

What would you do as a regulator?

Agenda

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Playing the Long Game

Key Takeaways

State Survey Agencies

Putting Pressure on State Agencies

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-22-12-ALL

DATE: **February 9, 2022**

TO: State Survey Agency Directors

FROM: Directors
Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

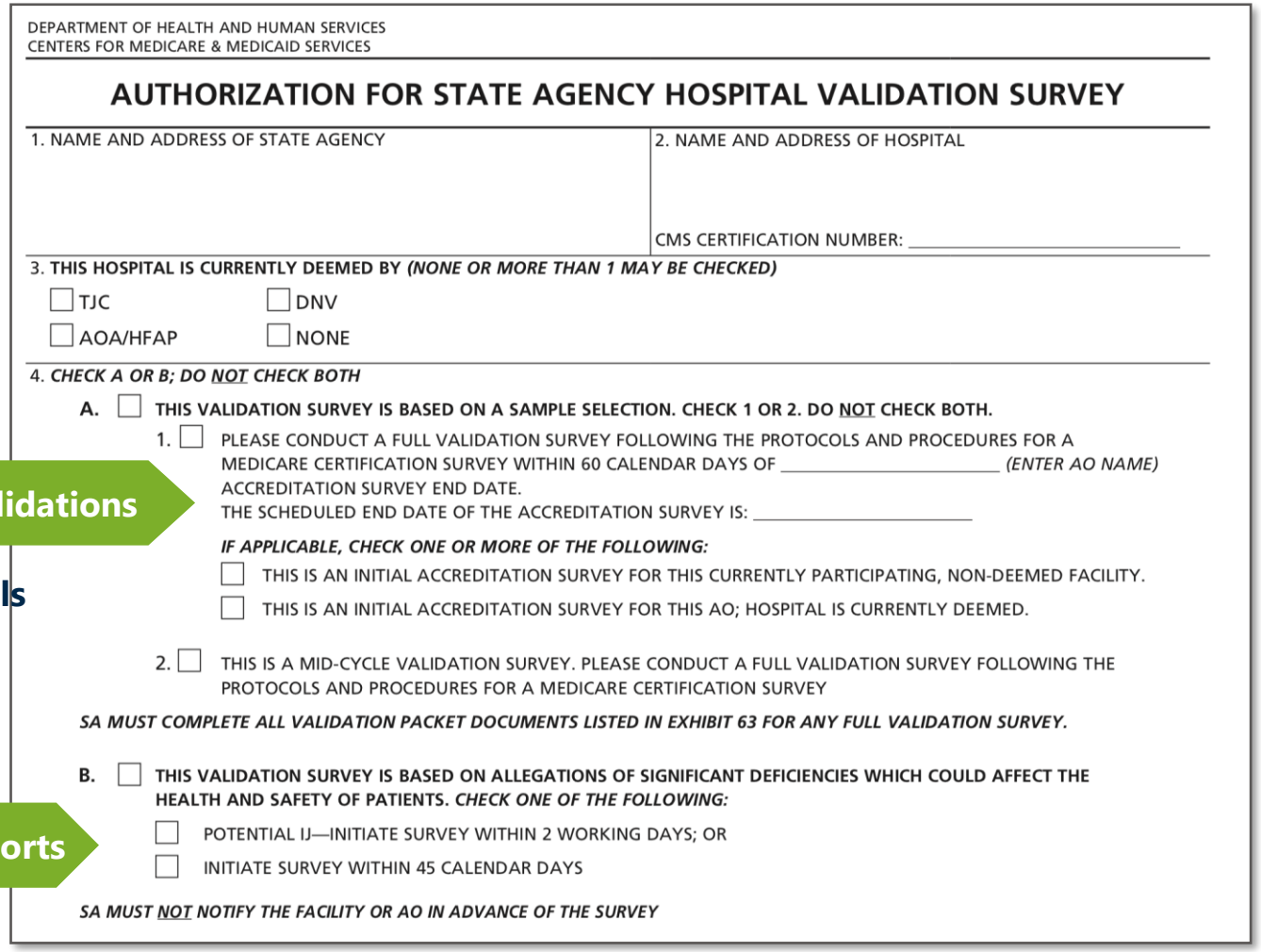
SUBJECT: State Obligations to Survey to the Entirety of Medicare and Medicaid Health and Safety Requirements under the 1864 Agreement

State Agency "Validates" Compliance with CoPs for Accredited Providers

SAMPLE Trial: Concurrent Validations

About 3% of accredited hospitals

Due to allegations or self reports



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AUTHORIZATION FOR STATE AGENCY HOSPITAL VALIDATION SURVEY

1. NAME AND ADDRESS OF STATE AGENCY	2. NAME AND ADDRESS OF HOSPITAL CMS CERTIFICATION NUMBER: _____

3. **THIS HOSPITAL IS CURRENTLY DEEMED BY** ***(NONE OR MORE THAN 1 MAY BE CHECKED)***

☐ TJC ☐ DNV
☐ AOA/HFAP ☐ NONE

4. ***CHECK A OR B; DO NOT CHECK BOTH***

A. ☐ **THIS VALIDATION SURVEY IS BASED ON A SAMPLE SELECTION. CHECK 1 OR 2. DO NOT CHECK BOTH.**

1. ☐ PLEASE CONDUCT A FULL VALIDATION SURVEY FOLLOWING THE PROTOCOLS AND PROCEDURES FOR A MEDICARE CERTIFICATION SURVEY WITHIN 60 CALENDAR DAYS OF _____ *(ENTER AO NAME)* ACCREDITATION SURVEY END DATE.
THE SCHEDULED END DATE OF THE ACCREDITATION SURVEY IS: _____

IF APPLICABLE, CHECK ONE OR MORE OF THE FOLLOWING:

☐ THIS IS AN INITIAL ACCREDITATION SURVEY FOR THIS CURRENTLY PARTICIPATING, NON-DEEMED FACILITY.

☐ THIS IS AN INITIAL ACCREDITATION SURVEY FOR THIS AO; HOSPITAL IS CURRENTLY DEEMED.

2. ☐ THIS IS A MID-CYCLE VALIDATION SURVEY. PLEASE CONDUCT A FULL VALIDATION SURVEY FOLLOWING THE PROTOCOLS AND PROCEDURES FOR A MEDICARE CERTIFICATION SURVEY

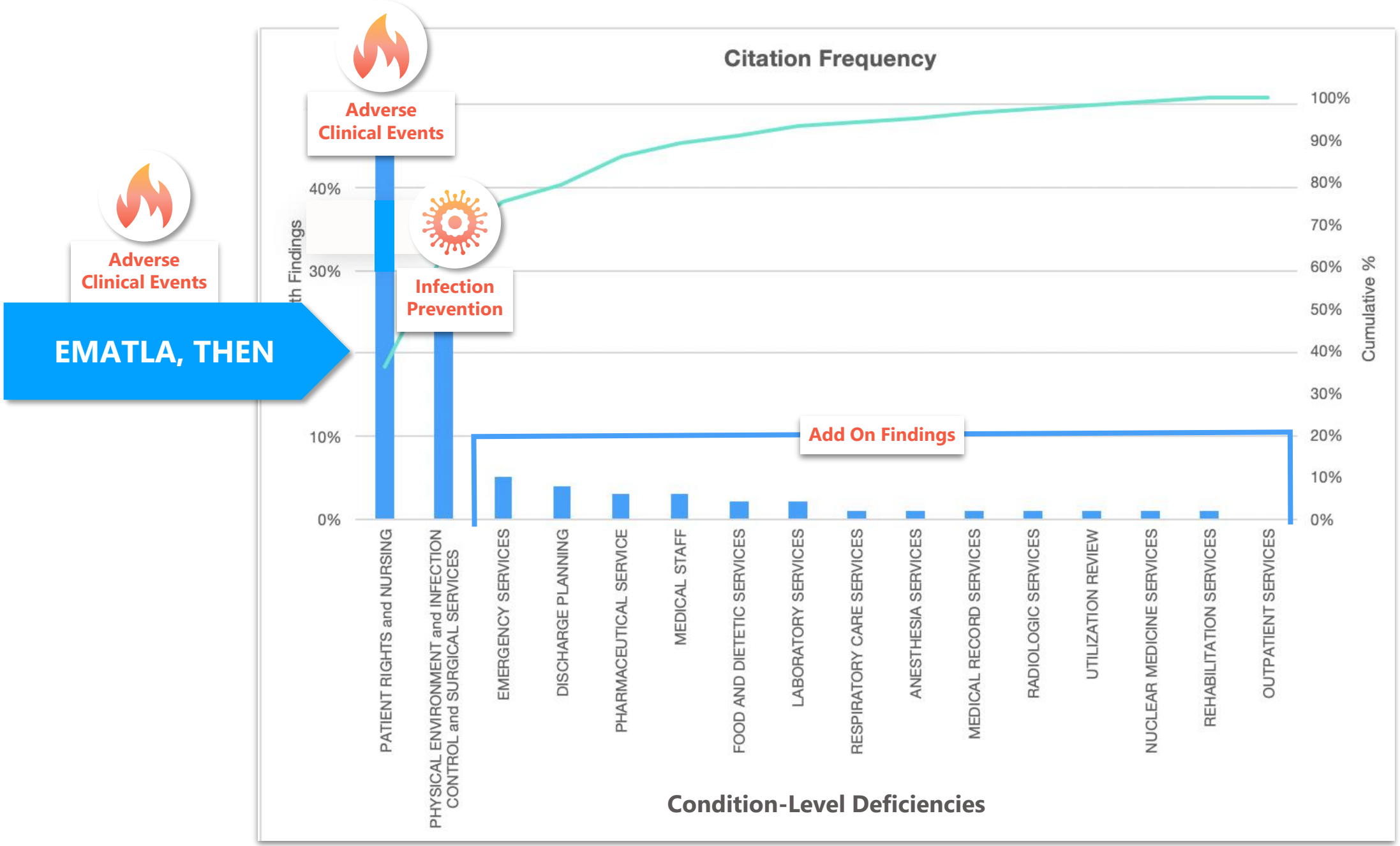
SA MUST COMPLETE ALL VALIDATION PACKET DOCUMENTS LISTED IN EXHIBIT 63 FOR ANY FULL VALIDATION SURVEY.

B. ☐ **THIS VALIDATION SURVEY IS BASED ON ALLEGATIONS OF SIGNIFICANT DEFICIENCIES WHICH COULD AFFECT THE HEALTH AND SAFETY OF PATIENTS.** ***CHECK ONE OF THE FOLLOWING:***

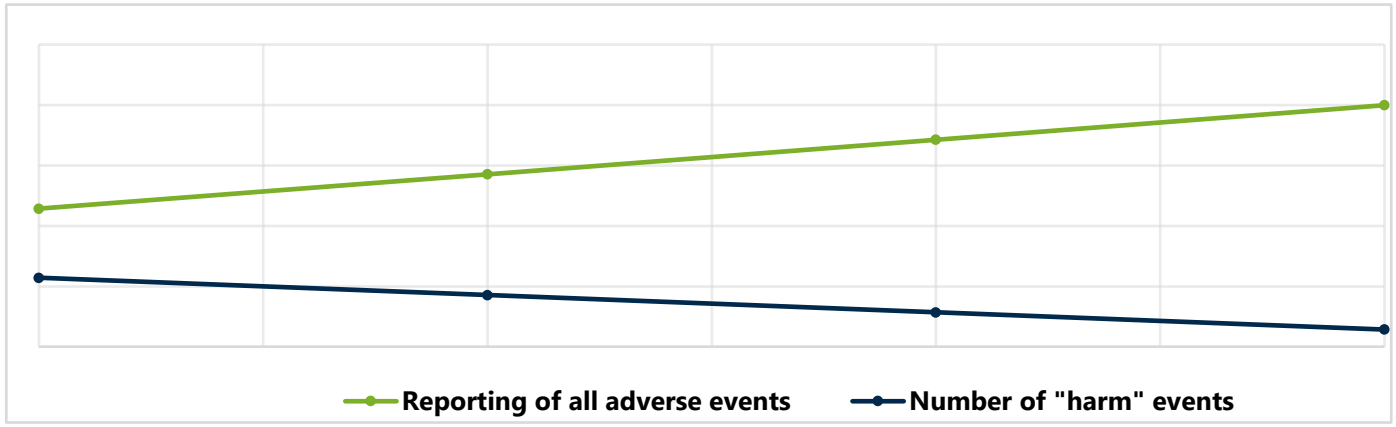
☐ POTENTIAL IJ—INITIATE SURVEY WITHIN 2 WORKING DAYS; OR

☐ INITIATE SURVEY WITHIN 45 CALENDAR DAYS

SA MUST NOT NOTIFY THE FACILITY OR AO IN ADVANCE OF THE SURVEY



Most CMS termination actions are triggered by one or more adverse clinical event involving patient harm



Identify Harm Events

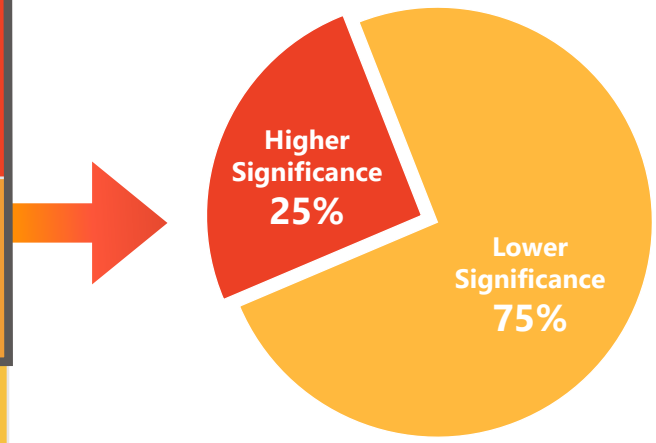
- Understand the true causes of Harm Events
- Focus on and fix the flaws in systems that cause Harm Events
- Sustain improvements

An effective patient safety program is essential to avoid adverse actions by CMS/State Agencies

The Joint Commission

Higher-Significance Findings

	Limited	Pattern	Widespread
	Immediate Threat to Life: 0.22%		
HIGH Likelihood to Harm	1.56%	1.59%	1.55%
MODERATE Likelihood to Harm	16.38%	14.02%	7.00%
LOW Likelihood to Harm	38.59%	13.84%	5.24%
Scope			



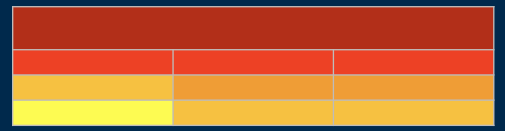
*N=8972 RFIs | 2019 Data

Joint Commission's Long Game

CONSISTENT INTERPRETATION

+

SAFER

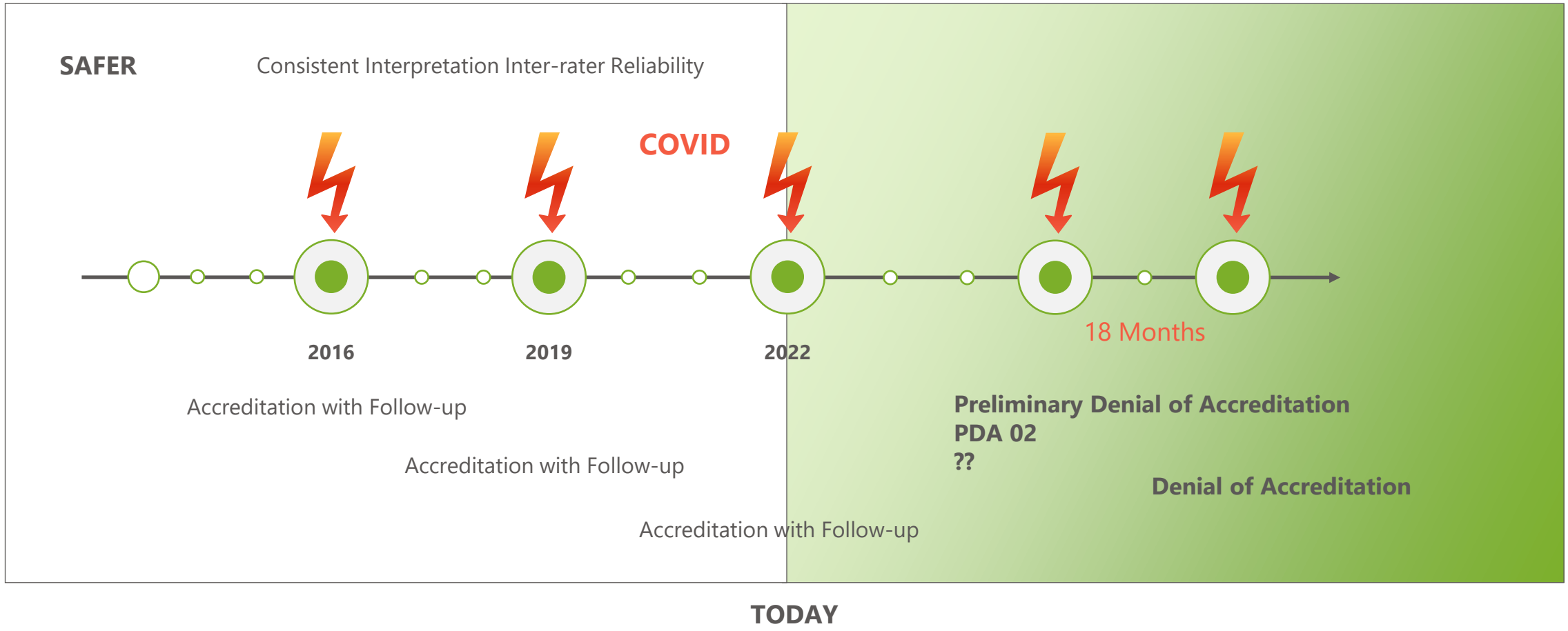


ADVERSE ACCREDITATION DECISIONS

- **Deeming authority**
- **Accreditation cannot be automatic**
- **Looking Forward**

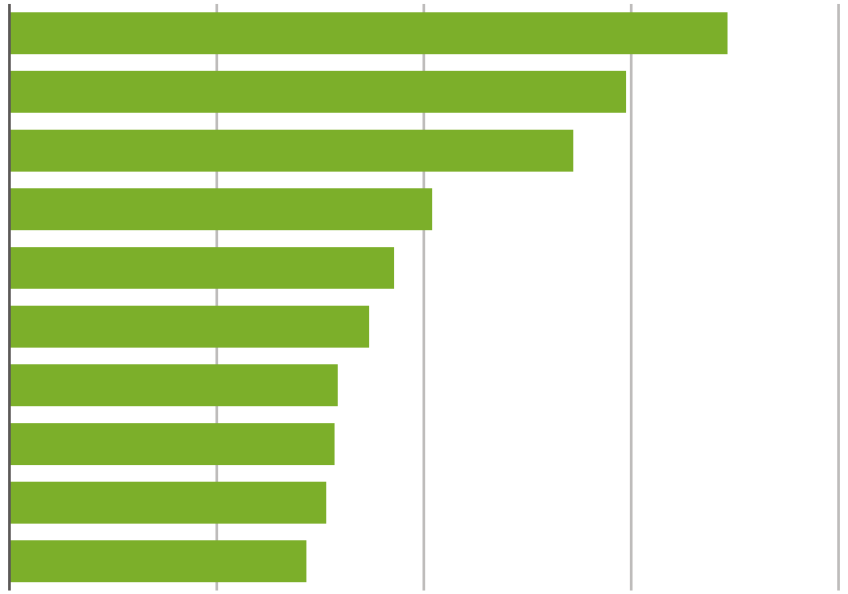
It is therefore essential that organizations permanently fix the truly significant issues instead of applying band-aid solutions to the mountain of less significant findings.

What happens to TJC accreditation if you don't permanently fix the "significant" issues?



Top 10 “Higher Importance” Requirements for Improvement: 2020

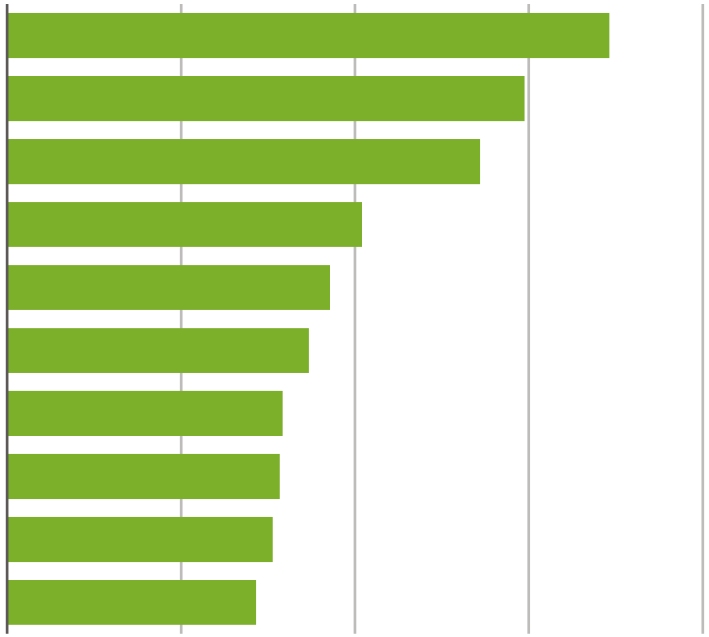
	Subject	Moderate Risk	High Risk	Immediate Threat	Total	% of Highest
NPSG. 15.01.01 EPO1	Suicide	107	99	1	207	17%
IC.02.02.01 EP02	Infections	73	120	1	194	16%
IC.02.01.01 EP01	Infections	110	33	0	143	12%
MM.06.01.01 EP03	Medications	68	70	0	138	12%
EC.02.05.01 EP15	Infections	54	53	0	107	9%
EC.02.06.01 EP01	Infections	72	29	0	101	9%
EC.02.02.01 EP05	Infections	24	57	0	81	7%
NPSG 15.01.01 EP05	Suicide	39	34	1	74	6%
NPSG 15.01.01 EP04	Suicide	20	52	1	73	6%
IC.02.02.01 EPO4	Infections	48	18	0	66	6%
Total		615	565	4	1184	100%
Percent		52%	48%	0%	100%	



Source: Joint Commission Perspectives, May 2021: 1,104 Hospital Surveys Conducted in 2020

Top 10 "Higher Importance" Requirements for Improvement: 2022

	Subject	Moderate Risk	High Risk	Immediate Threat	Total	% of Highest	Change in Rank
IC.02.02.01 EP02	Infections	136	277	20	433	17%	Up 1
NPSG. 15.01.01 EP01	Suicide	167	204	1	372	14%	Down 1
MM.06.01.01 EP03	Medications	107	233		340	13%	Up 1
EC.02.06.01 EP01	Infections	204	51		255	10%	None
EC.02.05.01 EP15	Infections	101	131		232	9%	None
EC.02.02.01 EP05	Infections	68	149		217	8%	Up 1
IC.02.01.01 EP01	Infections	133	64	1	198	8%	Down 4
IC.02.02.01 EP04	Infections	142	54		196	8%	Up 2
NPSG 15.01.01 EP05	Suicide	80	110	1	191	7%	Down 1
NPSG 15.01.01 EP04	Suicide	44	135		179	7%	Down 1
Total		1182	1408	23	2613	100%	
Percent		45%	54%	1%	100%		



2020: 1184 Citations in 1104 Surveys
2021: 2613 Citations in 1363 Surveys 120% more Citations in 23% more Surveys

Source: Joint Commission Perspectives, May 2021: 1,104 Hospital Surveys Conducted in 2020

What are these persistent highest-risk issues?

The "Short List"

1. **IC.02.02.01 EP02**: Disinfection, Sterilization Cycle
2. **NPSG.15.01.01 EP01**: Ligature Resistance
3. **MM.06.01.01 EP03**: Medication Administration … especially titrations
4. **EC.02.06.01 EP01**: Unsafe Environmental Conditions: USP 797
5. **EC.02.05.01 EP15**: Temperature, Humidity, and Air Flow in "critical" locations
6. **EC.02.02.01 EP05**: Hazardous Materials and Waste, including eye-wash stations
7. **IC.02.01.01 EP02**: Environmental Infection Prevention Issues (e.g., sanitation and maintenance)
8. **IC.02.02.01 EP04**: Storage of Equipment and Supplies and other infection prevention issues.
9. **NPSG.15.01.01 EP05**: Suicide Risk Screening and Assessment
10. **NPSG.15.0101 EP04**: Suicide Precautions

- Other Historical
  - Emergency Power
  - Food Sanitation
  - Leadership: Conditions Level Deficiencies
- Other Projected
  - Psychiatric Hospitals
  - Workplace Violence
  - Maternal Safety
  - Emergency Management
  - Health Equity

Agenda

The Current Situation: Broken at the Weak Spots

State of the Survey "Art"

Playing the Long Game

Key Takeaways

Top Strategies

- Oversight
- Nursing Documentation Simplification
- Adverse Events / Patient Safety
- Managing Crowded ED Waiting Rooms
- Process Maturity (Infection Prevention, Quality, Safety, Etc.)
- Suicide Prevention

Oversight

Manage Quality and Safety as Tightly as the Budget

- **Different approaches to oversight**
  - The **Business** of Healthcare (budgeting, capital, growth, etc.)
    - Regular meetings
    - Clear accountabilities
    - Follow-up
  - **Quality and Safety**
    - Large committees
    - A LOT of information sharing
    - Takes a long time to get things done
- **Step 1:** Manage quality, safety, and compliance as if it were the hospital's budget
- **Step 2:** Have fewer meetings and get more done (Greeley's oversight management improvement)
- **Step 3: Prioritize**: don't get distracted by the small issues.
- **Step 4: Do more with less**: do not allow needless complexity back into your clinical processes

Does your leadership team use the same oversight and accountability tools for budgeting, growth, and human resources that is uses for quality and safety?

Simplify Nursing Documentation

Question

What documentation is required during triage in the emergency department?

Restore the emphasis on **TRIAGE**

Free resources for medical screening and stabilization

- Travel Screening
- Vaccination
- **Triage Note**
- **Chief Complaint**
- **Vital Signs**
- **ESI Level**
- Airway, Breathing, Circulation, Disability
- Stroke
- Severe Sepsis
- **Suicide Screen (Behavioral health only)**
- Falls Risk Scale
- Homeless
- Domestic Violence
- Safety: Weapons, Belts, Shoestrings

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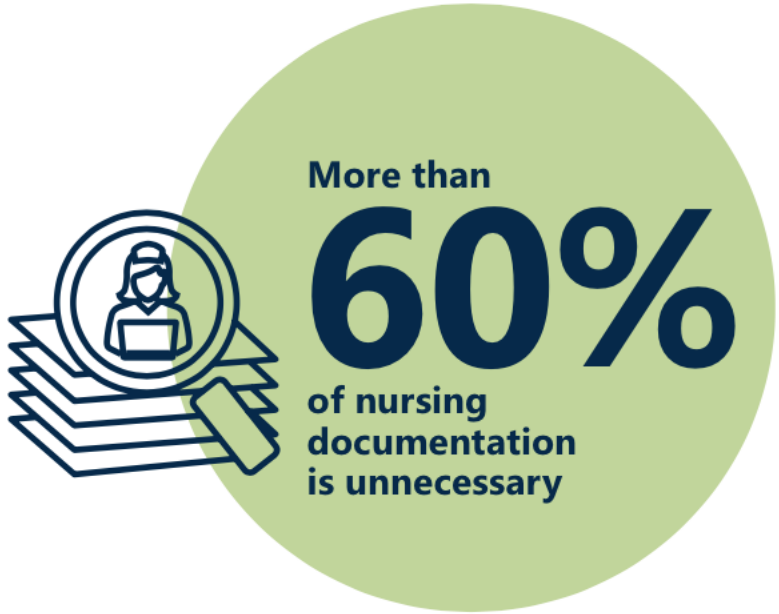
Doing More With Less

HOW SIMPLIFYING DOCUMENTATION HELPS STREAMLINE NURSING PROCESSES AND RETAIN SCARCE CLINICAL RESOURCES

Improve patient care, reduce caregiver frustration, and increase communication efficacy throughout the healthcare team—it's all possible by eliminating unnecessary nursing documentation.



Adverse Events/Unsafe Conditions

Patient Safety Essentials

- Meet frequently (daily) to identify “harm” events
  - Effective Radar communication
- Don’t get distracted: identify the true underlying causes and fix them.
  - **DON’T** generate 100 demands for actions about issues that are not true safety issues.
  - **DO** focus on the true issues and resolve them
- Live Just Culture
- Use your leadership tools to address safety concerns.

Managing Crowded ED Waiting Rooms

Process Maturity (Infections, Quality, Etc.)

Elements of a Strategic Assessment

Example: Infection Prevention Program

Executive Sponsorship

The degree to which the infection control program has access to executive leadership and its support is demonstrated through the dedication of resources and accountability through the operational chain of command

Program Effectiveness

The degree to which the eight essential functions of infection prevention are realized:

Risk Assessment
Surveillance
Process Design / Implementation
Meeting Management
Data Collection and Reporting
Survey Readiness
Antimicrobial Stewardship
Emergency Preparedness

Staffing and Organization

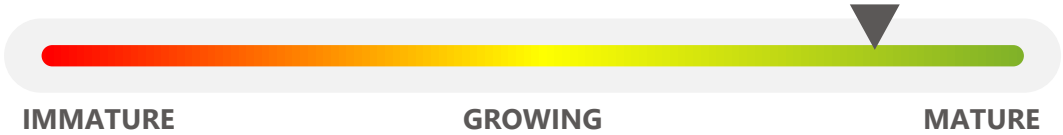
How departmental functions are staffed and organized and where the department sits within the organizational structure

Sample Hospital

The organization's Infection Prevention program was well supported by executive leadership and middle management. The single Infection Control Practitioner was knowledgeable and effective. The organization remains vulnerable to significant infection prevention challenges but is well positioned to mature by streamlining meeting and oversight management and supplementing the current practitioner with either an ICP in training, administrative support, or both.

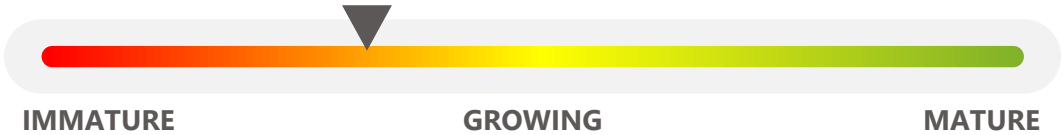
Operational Effectiveness: 2.07

Executive Sponsorship: 2.75



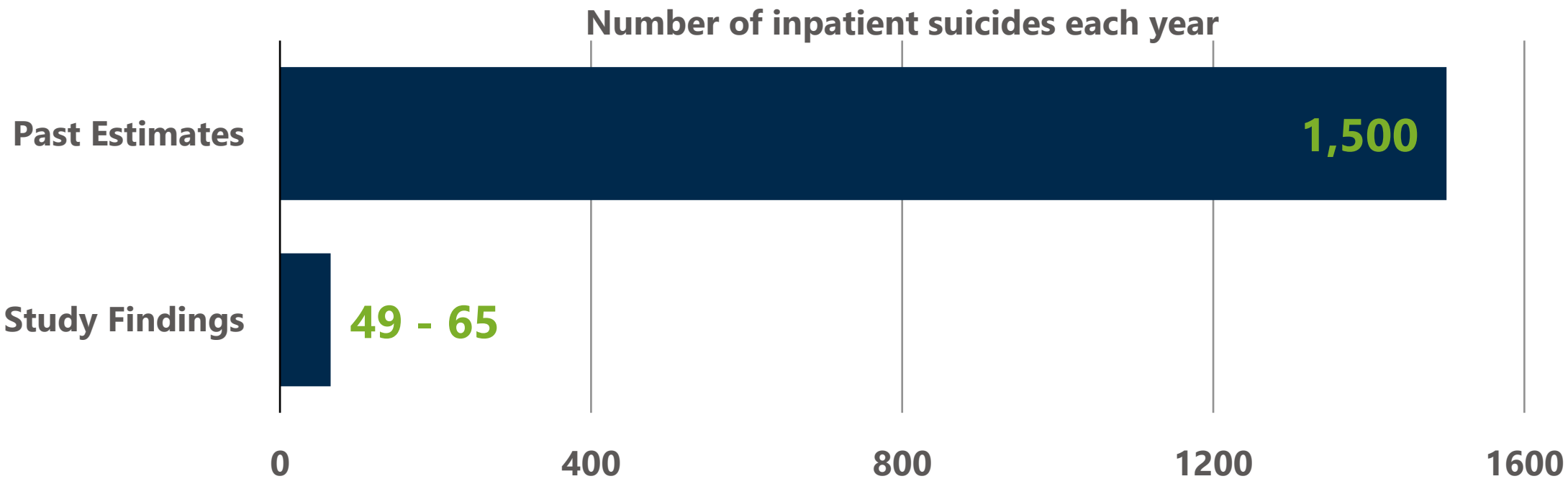
Staffing and Organization: 2.22

Observed Practices: 1.75



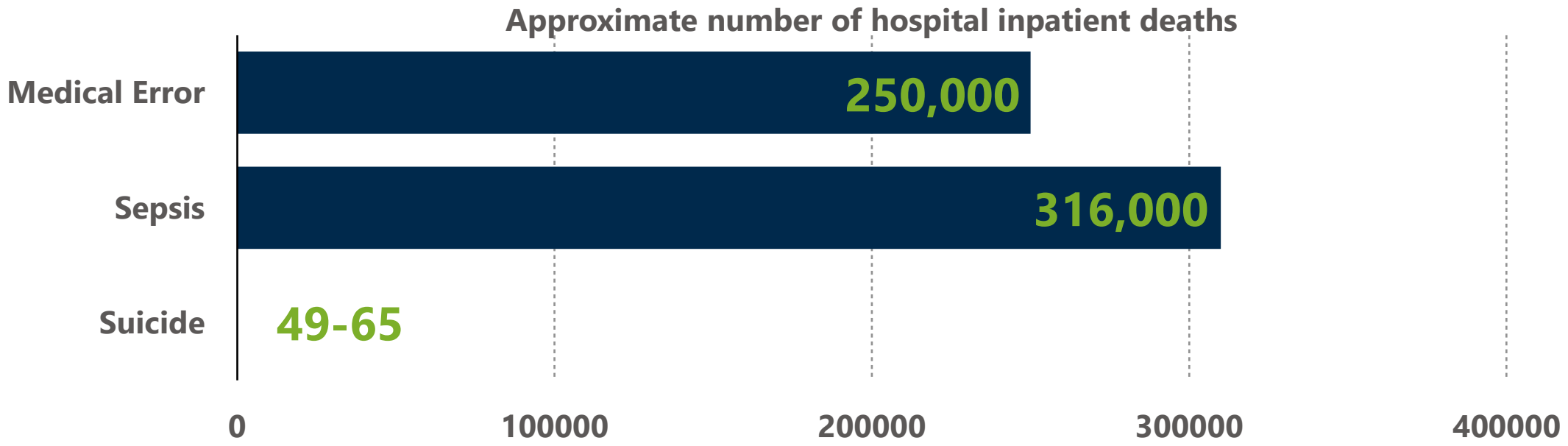
Suicide Prevention

Frequency of Suicides by Hospital Inpatients



Source: "Incidence and Method of Suicide in Hospitals in the United States," by Scott C. Williams, PsyD; Stephen P. Schmaltz, PhD, Gerard M. Castro, PhD, MPH; and David W. Baker, MD, MPH. The article appears in The Joint Commission Journal on Quality and Patient Safety, September 2018.

Causes Associated with Death in the Hospitals



Sources:
Johns Hopkins
CDC
"Incidence and Method of Suicide in Hospitals in the United States," by Scott C. Williams, PsyD; Stephen P. Schmaltz, PhD, Gerard M. Castro, PhD, MPH; and David W. Baker, MD, MPH. The article appears in The Joint Commission Journal on Quality and Patient Safety, September 2018.

Suicide Failure Points

- Perform and maintain a credible ligature resistance assessment
  - Solid plan
  - Include non-behavioral health areas
- Screen (using an approved tool) only patients with primary behavioral health complaints.
  - Don’t forget the standard psychosocial assessment
- Tie suicide screening and assessment to 3 levels of precautions:
  - 1:1 for high risk only (may be less if ligature resistant environment)
  - Intermittent observation
  - General observation
- Clarify your expectations and reality check at the bedside

The main reason suicide prevention remains problem prone is the perfect storm of misplaced priorities and excessive expectations.

It will therefore take extra effort to truly have a system that makes clinical sense and works.

Agenda

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Key Takeaways

Takeaways

We must do

more with less

- **State Survey Agencies and Accreditation Organizations are on notice that patient safety through compliance with the Conditions of Participation and EMTALA is a high priority.**
- **Hospitals must play the long game by focusing on THE most important problems and taking the time to solve them.**
- **Preparing for and responding to survey results must become proactive rather than reacting to the noise of inaccurate or minor issues that accumulate day by day.**

Questions?