Operations

Hospital consolidation: Get ready for accreditation/compliance challenges

If you’re one of the many hospitals looking at some form of consolidation with another hospital, prepare for the new accreditation and standards compliance challenges consolidation brings. Smart quality directors who do their homework will not only make the transition smoother, but will show their value to the new hospital management.

Hospital consolidation, driven by market forces, is increasing. Hospitals face a variety of choices in how they move forward: acquiring, or being acquired by, another hospital; joining with another hospital to form a totally new entity; operating as separate entities with other hospitals after forming or joining an existing health care system; and aligning with other hospitals, (see consolidation, p. 6)

Infection control

AHRQ project on newborn CLABIs succeeds with data tracking, clinical culture changes

Employ a two-pronged strategy—technical approaches involving health IT, combined with cultural changes like fostering transparency—to decrease central-line-associated bloodstream infections (CLABIs) in newborns.

A project created for the federal Agency for Healthcare Research and Quality (AHRQ) by the Health Research and Education Trust of the American Hospital Association, the Johns Hopkins University Quality and Safety Research Group, and the Michigan Health and Hospital Association Keystone Center for Patient Safety and Quality helped reduce newborn CLABIs by 58% in participating institutions. The project and its results were detailed in a recent report released by AHRQ.

Addressing CLABIs has both a clinical and financial impact, with the report estimating that each CLABIs costs $70,696. Neonatal units and their delicate charges are especially vulnerable. (see infection control, p. 7)
Conditions of Participation

CMS tries again on reaffirming individual medical staffs

You may see more changes to The Joint Commission’s standards on medical staffs, depending on how the current discussion between CMS and some hospital industry leaders over single staff vs. unified staff plays out in the next few months.

At the heart of the discussion is an ongoing push, led by the American Hospital Association, to allow multi-hospital systems to have a single, unified medical staff serving all of the hospitals. They argue that resulting efficiencies both save money and improve patient care by facilitating consistent quality initiatives across a health system’s spectrum of care.

This has become especially true as hospitals have joined forces over the years, instituting in many cases single multi-system governing boards, and as improvements to patient care have taken a front seat in health care reforms, the argument goes.

Meanwhile, however, The Joint Commission’s Medical Staff standards have carried the clear caveat that CMS’ Conditions of Participation (CoPs) require one medical staff for each individual hospital.

Commission allows single staff work-around

Even as hospitals have joined multi-facility health systems, they in general have still retained their assigned CMS certification number (CCN), formerly known as the Medicare provider number, says Joe Gordon, technical adviser for Inside the Joint Commission, and founder of Survey Resources, LLC, in Manchester, N.J.

That’s important because in 2010, in accordance with requirements by CMS, The Joint Commission began accrediting organizations according to CCN, regardless of how many facilities, or campuses, are included under the same number or under individual numbers.

However, the commission has allowed the same individuals who make up the governing body and/ or the medical staff to be responsible for more than one hospital, “as long as the responsibilities for each hospital’s governing body and medical staff are performed independent of carrying out responsibilities for another hospital, and there is evidence of such,” according to the commission FAQ on CMS certification numbers.

What that means in practice is that such unified bodies can meet once, but the executive committee will have to convene and dismiss themselves several times so that the official minutes show that they met to represent each individual hospital, even while perhaps considering the same issues or quality initiatives, says Gordon.

The commission has been lobbying CMS to accept the unified staff concept for years, Gordon says, but to little avail.

Unified staff supporters continue effort

Organizations like the AHA, which represents almost 5,000 health care organizations, have made
similar efforts. CMS’ “focus should not be what the structure looks like, but what the effectiveness is,” says Nancy Foster, AHA’s vice president for quality and patient safety.

Calling unified medical staffs “the best opportunity to drive quality and safety forward,” Foster says AHA officials were pleased in October 2011 when a long-awaited proposal to update CMS’ CoPs included language saying that CMS seemed to support that position.

The proposed rule published in the Federal Register stated that CMS did “not believe that the current Medical Staff CoP language implies that we require a single and separate medical staff for each hospital within a multi-
hospital system. Therefore, we have retained the current requirement without revision.”

Dismay followed some months later when CMS published a final rule in May 2012 that indicated the exact opposite, and declared that CMS was retaining its interpretation that each hospital, “even those in a multi-hospital systems (sic), must have its own medical staff.” CMS did apologize for any confusion.

AHA considered it an about-face that amounted to changing federal regulations without proper review and comment, as mandated by law and upheld in several court decisions, according to a letter AHA sent to CMS Acting Administrator Marilyn Tavenner.

What did CMS say, and when did it say it?

Here are the disputed sections of what CMS published over the last two years in the Federal Register regarding medical staff requirements in the Conditions of Participation, styled under Health and Human Services regulations section 482.22:

**Oct. 24, 2011, proposed rule:** “The current language of § 482.22 states that the hospital ‘must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.’ We do not believe that the current Medical staff CoP language implies that we require a single and separate medical staff for each hospital within a multi-hospital system. Therefore, we have retained the current requirement without revision. However, based on the anecdotal evidence and input provided by stakeholders on this issue, we request comment on whether we need to propose any clarifying language.”

**May 16, 2012, final rule:** “We appreciate all of the comments received on this issue and apologize for any confusion that may have been caused by the ambiguous statement in the preamble to the proposed rule. We continue to agree with the commenters who opposed any changes to the current requirement that might allow for a single medical staff to oversee all hospitals within a multi-hospital system. We believe that the concerns of the commenters are valid, particularly with regard to medical staff self-governance, peer review, and accountability for patient care, and agree with the commenters that such a change in current requirements and interpretation could negatively impact the health and safety of patients. Therefore, as we previously stated in the preamble discussion of the proposed rule, we are retaining the current Medical staff requirement without revision and maintain our historical position that each hospital, even those in a multi-hospital systems (sic), must have its own medical staff with the authority and responsibility for the quality of patient care provided in that hospital.”

**Feb. 7, 2013, proposed rule:** At the end of a lengthy section under “Medical Staff” that noted the confusion apparent among various commenters on the May 16, 2012, publication, CMS stated, “We continue to believe that it is important and in the best interest of patient care for each hospital to have its own medical staff. For example, a large multi-hospital, multi-regional system that only has a single medical staff may not appropriately be able to address the needs of each individual hospital in each local area. We did not receive public comments on the prior rule that would have adequately addressed this issue. The mixed response from public commenters regarding our confirmation of the requirement and its interpretation has led us to consider proposing changes to the regulatory language of § 482.22 that would more explicitly communicate our longstanding policy that each hospital must have its own medical staff. Therefore, we propose to clarify the introductory paragraph of § 482.22 to require that each hospital must have an organized and individual medical staff, distinct to that individual hospital, that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by that individual hospital.”

Resources:
CMS apologizes, maintains stance

CMS, meanwhile, claims it was merely pointing out ambiguous language and asking for comment on whether it needed to be clarified, and decided in the final rule that it did not. But in response to an immediate uproar from hospital leaders who supported unified medical staffs, in February, in the most recent proposed changes to Medicare CoPs, CMS has restated its intent to stick with single medical staffs for each individual hospital. However, it is seeking comment on that proposed language.

AHA says “we still firmly believe” in the necessity and benefits of a unified medical staff if that’s how multi-hospital systems want to organize their operations, Foster says.

If CMS reaffirms the single medical staff concept in the next final rule, there could be changes to commission medical staff standards to reflect that, Gordon says. However, Gordon, a former commission surveyor, says his personal belief is that there will be some compromise between the commission and CMS that will alleviate the need for a unified staff to convene and dismiss several times over the same issues.

Could LSC update finally happen?

On an up note, another change on the horizon will likely be welcomed by just about everybody. Evelyn Knolle, AHA’s senior associate director for policy, says that CMS appears to be near to accepting a change that many have sought for more than a decade – revising the CoP that requires hospitals to adhere to the 2000 edition of the National Fire Prevention Association’s Life Safety Code. CMS has been considering changing to the 2012 edition.

The LSC has been revised numerous times since the 2000 edition, which the NFPA considers to be out of date, says Ron Cote, the NFPA’s principal safety engineer, adding that the group has provided CMS a side-by-side comparison of the two editions to show the changes.

The 2012 LSC edition offers hospitals much-needed flexibility, Gordon says. “The 2012 NFPA code recognizes some conditions that frequently exist in hospitals today,” and allows hospitals to better manage resources. For instance, the later code version recognizes the need for some fixed seating in corridors, for the use of the end of hallways for some types of storage, and for the temporary storage of transportation equipment, such as gurneys and wheelchairs, he says.

While the AHA said it expects a rule proposal to switch to the 2012 edition of the LSC within the next several months, it should be noted that that expectation has been around since at least late 2011.

“We have no feel for when that might happen,” says Cote. “All we can continue to do is push for it.”
– A.J. Plunkett (aplunkett@decisionhealth.com)

Resource:

- The Joint Commission FAQ on CCNs:
  http://www.jointcommission.org/faqs_ccn/

HIPAA

Emphasize HIPAA compliance with hospital’s rookies from day 1

Are hospital rookies – those freshly graduated residents and nurses, interns, medical students and volunteers – giving you HIPAA nightmares? Ease your concerns over potentially costly violations by setting up an ongoing protected-health-information (PHI) education program that begins with their orientation on the first day.

Better yet, team them with veterans on improving both hospital compliance as well as patient safety, and you could very well see them not only learn more but take leadership roles in ensuring that others also comply, say medical education experts.

“Make them part of the process instead of just recipients of rules and regulations,” says Linda R. Archer, PhD, associate dean of graduate medical education at Eastern Virginia Medical School (EVMS) in Norfolk, Va.

The more you can engage and integrate newcomers into a hospital environment that recognizes they may need extra help, the more likely they are to remember PHI or at least remember to ask for clarification, says Frank Ruelas, who is the compliance and privacy officer for Gila River Health Care, as well as principal of the consulting firm HIPAA College in Casa Grande, Ariz.

Use hands-on compliance to educate, engage

Often interns and others at Ruelas’ health facility come in with only minimal training, he says, and many don’t even know what HIPAA stands for as an acronym. (It’s the Health Insurance Portability and Accountability Act.)

On the other hand, schools like EVMS have made it an annual part of their undergraduate and graduate training,
including requirements that students at both levels take online training and pass a test, which is tracked by the school, say Archer and associate dean of medical education, Dr. Ronald Flenner.

As the years go by, the school is seeing fewer PHI infractions because students have been exposed to HIPAA, first passed in 1996, earlier in their lives and “are growing up in the system,” Archer says.

Still, violations do occur. Flenner says undergraduates must constantly be reminded to “de-identify” patients when presenting cases in class. Likewise, graduate students must remember to destroy case notes, Archer says.

So how can you reinforce PHI rules with your newcomers?

Follow these tips from the experts

• **Start with orientation.** It’s important to include PHI with the very first personal interaction, all the experts say. It lays a good groundwork and works to reinforce later one-on-one training.

• **Emphasize patient care.** The first thing Ruelas tells newcomers is that HIPAA is not intended to “impede important or necessary communications ... patient care and safety is primary.” He advises them that when faced with a question about PHI, do whatever it is they believe is necessary.

If they remember that core theme – that it’s all about what information is necessary – that can help drive the decision making, he says. For instance, just because someone asks for information about a family member or friend doesn’t mean they need the information. “There’s nothing wrong with telling family members to ask the patient.”

At EVMS, there are programs at both the undergraduate and graduate level that emphasize compliance issues as part of patient care.

• **Involve your veterans.** Make sure your staff understands that newcomers may have questions, and that they not only should want to help, it’s a responsibility to help ensure health information is protected, Ruelas says. And most coworkers appreciate being asked, he says, “because it shows you respect my opinion.”

It also helps build relationships, which is key to a successful education program, says Archer. One EVMS program at a partner teaching hospital aligns residents with veteran mentors on a team focused on patient safety and quality improvement, Archer says. That both engages the residents in making the initiatives work, and helps them understand why rules and regulations exist.

• **Have your staffers quiz the newcomers during their down time.** Provide staff with scenario-sharing points. “You have to make it alive and breathing,” Ruelas says.

• **Get out there and interact.** You shouldn’t see that person just once when they get there – get out and see how they’re doing, Ruelas advises.

• **When PHI problems do occur, have the staff address them immediately.** Train staffers to keep the situation positive, to explain to the newcomer what the problem is, why it’s a problem and how to address it. If someone is not comfortable in that role, have them report it to the compliance officer “so it can get fixed,” Ruelas says. That both emphasizes that there is a process and that compliance is taken seriously.

• **Bring your newcomers back in for a refresher session after 30 days.** “That first 30 days you’re seeing a lot of new things,” Ruelas says. “After that, it’s just rerun experiences. I pull those people back in – quick review, this is what we expected in terms of HIPAA.” Ask them to share experiences where they have seen it working and not working – it helps them, and helps the compliance officer learn about problems. “I’ve heard people say they don’t have time. I say, ‘Make time. You owe it to those folks.’ ”

• **Let everyone know that protecting health information is serious business.** On the first offense, make it clear what the problem is, and why they dropped the ball, Ruelas says. But set a limit. “If they don’t get it right, get rid of them. If someone is a repeat offender despite your best efforts to get them educated, some people just need to be taken out of the pool.”

EVMS takes the same hard-line approach, Flenner says. In the HIPAA module that students are required to take, Flenner says he uses the example of an incident involving pop star Britney Spears after she was hospitalized some years ago – hospital personnel who took a look at Spears’ records without a need to know were fired. Violate PHI and you could be terminated.

Similarly, students who can’t or won’t learn the rules will find themselves taken before the Student Progress
Committee, which “is not a pleasant experience,” Flenner says. Professionalism is at issue, he says, and the committee’s finding could significantly impact a student’s ability to get medical credentials or a residency.

—A.J. Plunkett (aplunkett@decisionhealth.com)

consolidation

(continued from p. 1)
as well as other health care providers, in any of several Accountable Care Organization (ACO) arrangements.

The choice on whether to consolidate, and how to consolidate, is largely a business decision. But you need to be aware of what this decision will entail in terms of Joint Commission accreditation and compliance. This knowledge can help you both guide management to the best consolidation choice and handle accreditation and compliance after a deal is complete.

“Mergers and acquisitions are considered major changes that must be reported to The Joint Commission within 30 days. Deals are happening faster and faster in health care these days,” says health care attorney Sarah Swank, a principal with the law firm Ober Kaler in Baltimore. “Prior to the closing of hospital mergers and acquisitions, I suggest informing the governing body of its roles and responsibilities for compliance with leadership, medical staff and other [Joint Commission] standards, as well as the Medicare Conditions of Participation.”

Consolidation options – and what you should do

Following are several hospital consolidation scenarios and the role accreditation and compliance plays in each, as well as what you, as the hospital quality director, should do:

• **One hospital is acquired by another.** The acquiring hospital tells The Joint Commission about its new acquisition and the commission quickly “extends accreditation” to the new site with the understanding that it will do a survey, usually within six months, to formally extend the acquiring hospital’s accreditation to the acquisition hospital, says Kurt Patton, CEO of Patton Healthcare Consulting, Glendale, Ariz., and The Joint Commission’s former executive director of accreditation services. This usually consists of a visit by one surveyor for one day. If the acquired hospital had open RFIs, “they disappear,” says Patton, “but the surveyor conducting the extension survey will have that information and check to verify that those were fixed.” If survey due dates between the two hospitals are widely different, the commission may move the next full survey earlier.

As the quality director, if you are with the acquiring hospital, you should analyze clinical performance at the hospital likely to be acquired, Patton says. “Too often, [management] looks only at finance. They need to determine if the new location is safe and compliant with CMS and Joint Commission requirements.” You should also speak with the commission while the merger is being considered, so it can help you plan accreditation requirements.

For the quality directors at both the acquiring and acquired hospital, be aware that, as in any merger, some jobs don’t survive. “I would say [that] both quality directors want to appear irreplaceable,” Patton says.

• **Hospitals join to form a totally new entity.** “This is the most difficult to plan and organize,” says Patton, because, in essence, a new hospital is being formed. The new entity will lose the history of its predecessor hospitals, which, if the history was problematic, the new hospital may consider a good thing. “If you retain the old Medicare provider ID and history, the new owners are at risk for a Medicare audit and retrospective disallowance,” Patton notes. “If you lose history, there is no one there to get the disallowance from.”

Nonetheless, the new hospital “will be unaccredited and not Medicare-certified,” Patton says. The role of the quality director in this kind of merger, other than making yourself appear irreplaceable, is to stress to senior leaders the need to get Medicare-certified and accredited as soon as possible, he adds. Like any new hospital, it will need to start the accreditation process, as well as the Medicare certification process, from scratch, which can be “a real stumbling block” in states that lack the money to conduct initial surveys.

Beyond the issue of accreditation, the new hospital board may need to adopt a board resolution which forms the medical staff and adopts compliant medical staff bylaws. It also will need to meet budget, quality assurance and other Joint Commission Leadership standards specifically required of the governing body, Swank says. “A way to get buy-in from senior leadership is by letting it know that meeting many of the accreditation requirements also satisfies certain CMS Conditions of
Participation, and without CMS certification, the hospital will be unable to bill Medicare.”

- Hospitals form or join a health care system, but continue to operate as separate entities, maintaining their own Medicare provider numbers and cost reports. In this case, you just continue what you were doing before joining the system, maintaining your own accreditation and survey history, says Patton. As the quality director, you should make a point of learning the new system’s policies, procedures and reporting requirements.

- A hospital aligns with an ACO. The Joint Commission does not yet take ACOs into consideration when making accreditation decisions. There are no specific rules for ACOs, Patton says. Individual hospitals, whether within an ACO or outside an ACO would, as always, need to be accredited. – Robert Sperber (sperber1@aol.com)

Editor’s note: Look to future issues of Inside the Joint Commission for more details on how different types of hospital alignment will affect your hospital’s accreditation and your job duties as the quality director.

infection control

(continued from p. 1)

“We push the limits in neonatology,” says Barbara S. Edson, vice president of clinical quality with the Health Research and Education Trust, one of the project co-leaders. “Viability used to be at 28 weeks or 29 weeks. Now we’re at 23 weeks. We put lines in the umbilical area and we maintain those lines for 10 to 14 days. That’s a long time. A good portion of this population needs longer-term IV fluid and nutrition. Neonates don’t have mature immune systems, so they’re ripe for infections. They are a particularly vulnerable population.”

CLABIs were once viewed as unavoidable, collateral damage in the neonatology unit and elsewhere in the hospital.

“It used to be a cost of doing business,” Edson says. “But that’s not the case anymore.”

The AHRQ project report found five key factors to reduce CLABIs:

- Have well-defined, evidence-based interventions;
- Build a solid implementation structure and project plan;
- Collect and use timely, accurate and actionable data to improve performance;
- Tailor national programs for local and unit audiences; and
- Evolve project strategies and emphases over time.

Technology can help with CLABIs reduction

Drilling farther down into the nuts and bolts of successful CLABIs reduction in newborns reveals two distinct halves of the effort: the technical and the cultural.
On the technical side, track central line use and CLABI-related data, and make that data readily available to those working at the bedside.

“Know what your [CLABIs] rates are,” Edson says. “Everyone in the unit should know them, especially if [the rates are] not where you want them to be.”

Health information technology can help distribute and process those data points.

“You can use IT to track process measures,” says Elizabeth Monsees, clinical safety officer for Kansas City, Mo.-based Children’s Mercy Hospitals and Clinics. “Using electronic medical records to pull that data can really help.”

Other specific technical tips from Edson and Monsees include:

• Insert central lines only when truly appropriate, and discontinue as soon as possible. General guidelines and best practices on central line use are available through the federal Centers for Disease Control and Prevention.

• Create a central line utilization equation based on risk group. This can standardize central line protocols and reduce the possibility of error or unnecessary variation.

• Develop a mathematical formula for when to remove the line, based on factors like weight or milestones like oral feeding;

• Equip clinicians with real-time reminders at the bedside, informing them about proper central line maintenance and relevant patient information.

• Stay current with and follow best practices for proper hand hygiene and sterilization (including chlorhexidine).

Culture changes are necessary, too

On the cultural side, neonatal units should find advocates within their own ranks and seek buy-in both from hospital leaders and front-line providers.

“Put together a team interested in this,” Edson says. “We don’t function independently, we function as a team. We can empower staff to work together to solve problems.”

Ultimately, any effort will need to be sustainable at the provider-to-patient level, and be workable for all relevant health care professionals.

“It should be multidisciplinary,” Monsees says. “Find a physician champion or leader. Allow clinicians to be advocates and hold them accountable. Nurses, physicians and all front-line clinicians can help drive practice changes. There needs to be engagement at the sharp end and the unit level, rather than just the regulatory or compliance level.”

Part of this engagement process should mean creating an environment in which front-line clinicians feel comfortable pointing out specific problems and larger process deficiencies. They are especially important in family situations.

“It is important for clinicians to have the ability to speak up when something doesn’t fall into evidence-based practice,” Monsees says.

Extend this sense of empowerment beyond the hospital walls, particularly in cases where the central line itself will remain inserted outside those walls.

“Nurses can sense where the needs are from the family, especially if they’re going to be discharged with the lines,” Monsees says. “They can act on that.”

Treat mistakes as opportunities to get better, not just opportunities to punish.

“Learn from defects,” Edson says. “Walk through why an error happened, ask questions, and improve the teamwork.”

One way to formally accomplish this, according to Monsees, is creating a multidisciplinary central-line rounds team, in which clinicians assess each active central-line case.

Other specific cultural tips from Edson and Monsees include:

• Raise awareness among staff about safety issues by holding regular discussions or training or posting informational signage, as appropriate.

• Conduct regular debriefings and meetings to identify defects and anticipate and prevent potential future errors.

• Network with peers both inside and outside the hospital to share best practices and exchange successes and lessons learned. – Scott Harris (mscottharris@yahoo.com)

Resource:

› For more information on the project, go to www.onthecuspstophai.org.
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