Certified Professional in Healthcare Quality (CPHQ)

Chapter Review

Chapter 6: Accreditation, Licensure, & Surveys

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Objectives

Chapter 6: Accreditation, Licensure, and Surveys

1. Describe the functions of regulatory agencies.
2. Discuss the types of regulatory agencies (federal, state, and local) and recognize the impact of regulations on healthcare quality and safety.
3. Understand the different types of accreditation and process associated with different accreditation procedures, and explain the value proposition for quality and safety.
4. Identify the benefits and outcomes of continuous readiness, including leadership commitment, individual accountability, organizational assessment, and survey procedures.
5. Promote staff knowledge and competency to achieve the healthcare organization's goal of continuous readiness.

Regulation

Federal Regulation

- The healthcare industry is regulated by all levels of government – federal, state, and local
  - presenting challenges for healthcare quality professionals, such as being confident that they possess an understanding of regulatory requirements.
- Healthcare regulations create circumstances in which healthcare quality professionals spend inordinate amount of time responding to changing rules concurrently with demonstrating compliance with complex existing rules.

Federal Regulation Agencies

- **Occupational Safety and Health Administration –** The US Department of Labor's Occupational Safety and Health Administration (OSHA) is an agency healthcare professionals will be familiar with no matter where in the healthcare continuum services are provided. OSHA was created by Congress with the Occupational safety and Health Act of 1970 to ensure safe working conditions.
- **US Department of Health and Human Services –** The US Department of Health and Human Services (HHS or DPHHS) describes its roles as being the principal agency for protecting the health of Americans and providing essential human services for those who are least able to help themselves.
  - HHS is divided into the following operating divisions to administer the services impacting healthcare regulations: Administration for Children and Families (ACF), Administration on Children, Youth and Families (ACYF), Administration on Aging (AoA), Agency for Healthcare Research and Quality (AHRQ), Agency for Toxic Substance and Disease Registry (ATSDR), Centers for Disease Control and Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), Food and Drug Administration (FDA), Health Resources and Services Administration (HRSA), Indian Health Services (IHS), National Institutes of Health (NIH), National Cancer Institute (NCI), Office of Inspector General (OIG), and Substance Abuse and Mental Health Services Administration (SAMHSA).

Federal Regulation Agencies *(continued…)*

Healthcare quality professionals will want to become familiar with the following three laws and regulations among the many that CMS oversees:

- Clinical Laboratory Improvement Amendments (CLIA): In 1988, CLIA established quality standards for all laboratories (regardless of where the test was performed) to ensure the accuracy, reliability, and timeliness of patient test results.
  - CLIA regulations are stratified based on the complexity of the test method: waived complexity; moderate complexity, including the subcategory of provider-performed microscopy; and high complexity. The regulations specify quality standards for laboratories performing moderate- and/or high-complexity tests and require waived laboratories to enroll in CLIA and follow manufacturers' instructions (CMS, 2012a).
- Health Insurance Portability and Accountability Act (HIPAA): HIPAA provides federal protections for personal health information and provides patients with rights
- Emergency Medical Treatment and Active Labor Act (EMTALA): Any hospital participating in Medicare and offering emergency services must provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. The hospital is then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented (CMS, 2012b).

Federal Regulation Agencies *(continued…)*

Healthcare quality professionals should be familiar with two key systems:

- The National Practitioner Data Bank (NPDB)
  - Was established in 1987 and authorizes the government to collect information concerning sanctions taken by state licensing authorities and entities against healthcare practitioners. In 1990, Congress amended the law by broadening the language to include any negative action or finding by these authorities, not just sanctions.
- The Healthcare Integrity and Protection Data Bank (HIPDB).
  - Was created to also combat fraud and abuse in health insurance and health care delivery. It is a national data collection program for the reporting and disclosure of certain final adverse actions taken against healthcare practitioners, providers, and suppliers. It collects information regarding licensure and certification actions, exclusions from participation in federal and state healthcare programs, healthcare-related criminal convictions and civil judgements, and other adjudicated actions or decisions as specified in regulation.

Federal Regulation Resources

- The Federal Register:
  - Is the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as presidential executive orders.
- The Code of Federal Regulations (CFR):
  - Is the codification of these rules published in the Federal Register, which is divided into 50 titles that represent broad areas subject to federal regulation. It is updated by amendments that appear daily in the Federal Register. Each volume of the CFR is updated once each calendar year.
- Regulatory Agenda:
  - Published by Federal Agencies, twice a year. Helpful for healthcare organizations to understand the direction for the agency in the coming year.
    - For example: HHS plan provides not only the annual priorities for the fiscal year as an overview but also the detailed information about each of the priorities

Federal Role in Quality Healthcare

- The Social Security Act: mandates the establishment of minimum health and safety standards that must be met by providers and suppliers participating in the Medicare and Medicaid programs.
  - The providers and suppliers are subject to federal healthcare quality standards; thus the federal government has a large role in setting quality standards and oversight of compliance to these standards for Medicare beneficiaries.
- CMS developed 'Conditions of Participation' (CoPs) and 'Conditions for Coverage (CfCs) that healthcare organizations must meet to participate in the Medicare and Medicaid programs and receive reimbursement for services.

State Regulation

- State governments maintain state health departments that operate licensing programs for healthcare providers and organizations.
- Licensing requires organizations, providers, and practitioners to meet legal requirements to practice or provider services.
- These departments usually operate enforcement programs for both state licensing requirements and federal certifications requirements.
- State regulations vary greatly in content, detail, and organization of regulations. This requires regulatory professionals to have state-specific knowledge to guide organizations within a given state.

Health Plan Regulators

- Regulations of health plans and insurance is s difficult to understand and is best described by documents from the Library of Congress Congressional Research Service (1997).
- Healthcare quality professionals working with health plans will want to understand the regulations specific to their situation in the state where business is conducted and healthcare delivery occurs.
- The federal government regulates managed care and other health plans sponsored by the private sector.
  - However, the states regulate the business of insurance, which includes managed ere organizations (MC()s) such as HMOs that offer managed care policies to individuals, employers, or other purchasers.
  - This complex division of regulatory responsibilities between the federal and state governments resulted from provisions of several federal laws and subsequent decisions of federal courts.

Private Regulators

Although, regulation is primarily a government role, there are private regulators in healthcare

- The American Medical Association (AMA) may be the most well-known private regulator.
  - The AMA sponsored creation of organizations with oversight roles for the medical profession to supplement government regulators, such as organizations that accredit medical schools, administer licensure examinations, and certify specialists.
    - For example: State medical boards use privately administered examinations in granting medical licenses, and the Medicare program relies on specialty certification as an indicator of physician quality.

Accreditation Concepts

Accreditation

- A voluntary survey process used by various non-government, independent, external agencies to assess the extent of a healthcare organization's compliance with applicable pre-stabled performance standards set by the agency.
- Involves both self-assessment and external peer review, focusing on organizational, not individual practitioner, performance.
- The purpose is to improve the systems and process of care and, in so doing, improve patient outcomes.

Healthcare Accreditation

In the healthcare industry, the act of accreditation involves an objective or impartial review of an organization by an external agency against recognized and published standards or requirements.

- In competitive markets, accreditation or certification may be viewed by the public as an endorsement for providing a minimum level of quality or standard of care.
- It may also be accepted as evidence of meeting state and federal regulatory requirements.

Deemed Status

For a healthcare organization to participate in and receive payment from the CMS or Healthcare Insurance Marketplace programs, it must be certified as complying with the standards, called 'Conditions of Participation' (CoP), set forth in federal regulations.

- The certification is usually based on an onsite survey conducted by a state agency on behalf of CMS or the CMS regional office. However, if a national accrediting organization enforces standards meeting the federal Conditions of Participation, CMS may grant the organization "deeming" authority to conduct these types of surveys and "deem" each subsequently accredited health care organization as meeting the CMS certification requirements. The healthcare organization would have "deemed status" and would not be subject to a routine, separate survey and certification process conducted by the state or regional CMS office.
  - Surveyors for all accreditation agencies with deemed statuses are always **unannounced.**

Healthcare Licensure

Licensure is a mandatory act of granting and receiving a license to provide healthcare services in a state in the United States.

- A governmental regulatory entity, usually the state Department of Health Services or Division of Insurance, grants the license for the healthcare entity.
- State and federal laws determine the type of facilities that must be licensed to operate.

Compliance with Standards

Compliance with standards has become two-pronged with the advent of performance measures in addition to the traditional written standards, as ways to measure accreditation appropriateness.

- The current prescribed, approved, and written standards, as ways to measure accreditation appropriateness and certification have become or are becoming more practical in the sense of assessing *actual* performance, rather than just the capacity to perform.
- They also focus on processes and outcomes, not simply structure, patient care issues related to quality and safety, and the organization's efforts to manage patient care and to support process improvements that result in good patient outcomes.
- Achieving compliance with the accreditation/regulatory standards and then maintaining survey readiness is the goal for healthcare organizations.

Value of Accreditation

As a healthcare industry faces ongoing pressure for cost containment, questions surface as to the “value” of accreditation in relation to cost.

- External Credibility- Accreditation was cited as improving an organization’s reputation end-users and enhancing awareness and perception of quality care.
- Improved Quality – Accreditation was cited as leading to improved patient outcomes.
- Organizational Learning – Accreditation was cited as promoting capacity building, professional development, and organizational learning.
- Staff Effectiveness – Accreditation was cited as contributing to the effectiveness of organization’s staff in the following ways: strengthening interdisciplinary team effectiveness, promoting an understanding of how each person’s job contributes to the organization, providing team building, and increased job satisfaction.
- Reduced Costs - Accreditation was cited as decreasing liability costs and mitigating the risk of adverse events, which would ultimately reduce costs.

Polling Question(s)

Question #1- #5

Accreditation Survey Readiness

Accreditation Process

Accreditation and certification standards are published and available to organizations that are submitting an application for review.

- Review Cycles – vary by agency, most are 2-3 year cycles. Cycles begin with application requesting an initial or follow up review or re-accreditation.
- Performance Measures – are often a required element of accreditation and are frequently publicly reported. They may be an ongoing review for accreditation, with quarterly or annual performance ratings.
- Onsite accreditation surveys are completed by professionals from within the filed of review. The length of the review is dependent on the size of the organization and the complexity of the services offered.
- Following review of all the data sources, an accreditation decision is determined for the organization. The decision usually includes an overall assessment of the organization or service that reflects the full accreditation decision, or a decision with limitations or restrictions that the organization must resolve with a designation time frame.

Accreditation Process

- Cited deficiencies or requirements for improvement must be corrected and documentation submitted to the reviewing organization within pre-determined time frames.
  - An organization is offered an opportunity to discuss areas of noncompliance, to submit documentation to demonstrate compliance or progress, and, with some accrediting agencies, to request a face-to-face interview or even a validation resurvey.
- Following a survey, Corrective Action Plan, are improvements to an organization's processes taken to eliminate causes of non-conformities or other undesirable situations.
- If CMS determines that patients are not being cared for properly by a healthcare facility, and they find actual or potential harm, they have the power to declare an immediate jeopardy situation. This is serious because it means that there is a severe safety condition.

Preparedness/Continuous Readiness

The goal of continuous readiness programs is to break crisis management cycles and just in time cultures to provide continuous safe, quality patient care and sustained compliance with evidence-based practices, professional standards, and regulations.

- Key components of successful continuous readiness programs include:

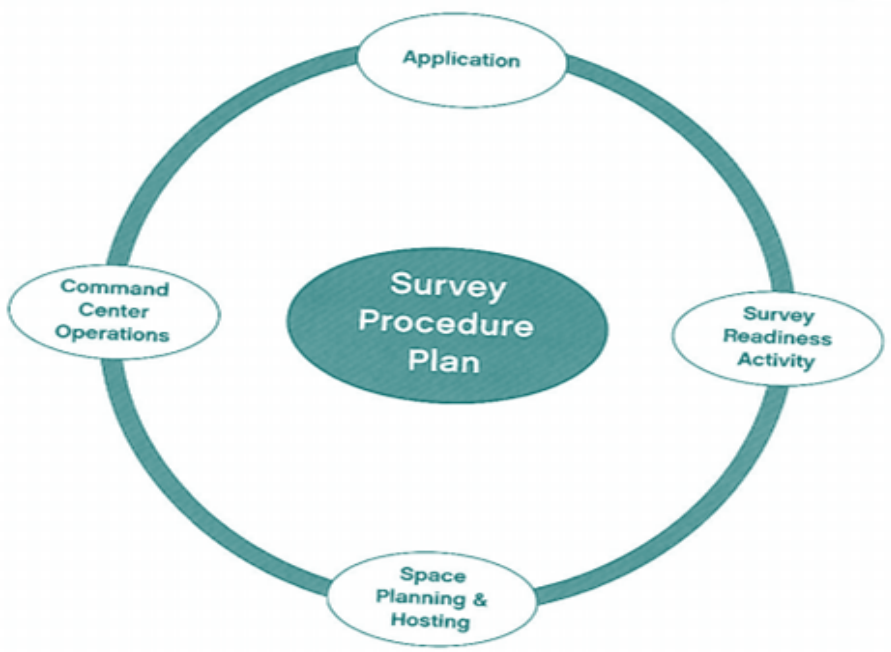
Preparedness/Continuous Readiness

- Leadership Commitment – must be in place for the programs to be successful and sustained. Leaders must be willing to change their organization's culture.
- Manager Accountability – compliance is evaluated by what happens at the point of care delivery, which managers are accountable for. Policies and procedures provide the guidance and structure for those providing or supporting care delivery, but actual practice and policies must be aligned to achieve compliance.
- Requirement Oversight – a defined process to ensure the organization is aware of changes and emphasis in standards or regulations.
- Routine Self-Assessment – the ability to evaluate compliance of key regulatory and accreditation requirements is a critical step in this process.
  - Tracers are often used to assess the movement of a patient through the health system.
- Staff Education – require solid organization wide education programs with staff participation from all levels within the organization.

It is key that all the team members must have decision-making authority in the organization.

Preparedness/Continuous Readiness

- Staff Recognition –staff members are experiencing ever-increasing lists of tasks they must accomplish and documentation they must complete while trying to meet organizational expectations for efficiency and customer service. Helps to build increased job satisfaction and pride in work.
- Survey Procedure plans – should be planned in advance based on what is expected with anticipated surveys.



Polling Question(s)

Question #6 - #11

Accrediting Agencies

CMS Approved Accreditation Organizations

- **The Joint Commission –** The Joint Commission (TJC) is an independent, not-for-profit organization that accredits and certifies healthcare organizations and programs in the United States and its certification is recognized as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
- **Det Norske Veritas (DNV) Healthcare –** A global risk management accrediting foundation.
- **The Healthcare Facilities Accreditation Program (HFAP) –** is authorized by the Centers for Medicare and Medicaid Services (CMS) to survey all hospitals for compliance with the Medicare Conditions of Participation and Coverage and also provides certification reviews for Primary Stroke Centers.
- **The Center for Improvement in Healthcare Quality (CIHQ) –** is a privately held accreditation company approved by CMS, to deem acute care hospitals as meeting Medicare Conditions of Participation, plus areas of patient safety and quality care.

Additional Accreditation Organizations

- **The International Organization for Standardization (ISO) –** is a worldwide certification agency that focuses on the quality management systems of an organization
- **The National Committee for Quality Assurance (NCQA) –** is a private, not-for-profit organization that works to improve healthcare quality via evidence-based standards, measures, programs, and accreditation.

Polling Question(s)

Question #12 - #17

THANK YOU!

Questions ? ? ?

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Answer Key

1. C	10. C
2. A	11. C
3. B	12. A
4. C	13. B
5. D	14. C
6. A	15. A
7. D	16. B
8. B	17. A
9. A	