Frequently Asked Questions on Joint Commission Standards

by Mary Brandt, MBA, RRA, CHE, director of policy and research

---

Since January, AHIMA has cosponsored Management of Information (IM) seminars with the Joint Commission on Accreditation of Health-care Organizations. Taught by a Joint Commission surveyor and an HIM professional, these lively, interactive sessions have raised a number of questions about the practical application of IM and related standards.

Credentialing

Q: Does the Joint Commission still require verification of physician credentials with primary sources such as state licensing boards, medical schools, and residency programs? Can we use the American Medical Association's database instead?

A: The AMA's database of practicing physicians may be used by hospitals and other providers to meet accrediting standards. The Joint Commission is now accepting use of this database as a substitute for primary source verification.

The AMA collects detailed histories of every practicing physician in the US. Its staff tracks physician progress through medical school, residencies, fellowships, and states in which they are licensed to practice. It also gathers sanction information from the federal government and tracks all final actions taken by state licensing boards. It also contains information from the Drug Enforcement Agency regarding prescription of controlled substances.

Gone...or Just Moved?

Q: In reviewing *Volume I, Standards*, of the *Accreditation Manual for Hospitals*, I noticed that many of the old standards are no longer there. Have these old standards, like the requirement for an abbreviation list, been deleted?

A: In an effort to streamline the accreditation manual, the Joint Commission took many of the old requirements from the standards and incorporated them into the intent statements, scoring guidelines, and examples of implementation. These are found in *Volume II, Scoring Guidelines,* or in the *Comprehensive Accreditation Man-ual*. You'll need to have both *Volumes I* and *II* (or better yet, a *Comprehensive Accreditation Man-ual*) to get the complete picture. The requirement for an abbreviation list, for example, has been incorporated into the intent statement for IM.3 through IM.3.2.

New Standards for 1996

Q: I know the Management of Information standards haven't changed much for 1996, but are there significant changes in other chapters we need to know about?
A:There are significant additions in the *1996 Accreditation Manual for Hospitals* in the following chapters:

Patient Rights and Organizational Ethics

RI.1.2.1.1 through RI.1.2.1.5
RI.1.3.5
RI.1.3.6.1.1
RI.1.4
RI.1.5
RI.3.1

Assessment of Patients

PE.6

Care of Patients

TX.1.1.1
TX.1.2.1
TX.4.1.1
TX.7.4.1

Education

PF.1.2
PF.1.10

Improving Organizational Performance

PI.3.2.7
PI.4.5.2
PI.4.6

Leadership

LD.1.1.3

Management of the Environment of Care

EC.4.1, EC.4.1.1, EC.4.1.2
EC.4.2, EC.4.2.1, EC.4.2.2
EC.4.3, EC.4.3.1, EC.4.3.2
EC.4.3.2.1
EC.4.4, EC4.4.1, EC.4.4.2

Management of Human Resources

HR.4.1

Infection Control

IC.6.2

Medical Staff Standards

MS.2.1
MS.4.2.1.7 through MS.4.2.1.15 have been moved to the Leadership chapter where they are scored.

Problematic Standards in IM Chapter

Q: Which of the IM standards are getting the most recommendations during surveys?

A: Not surprisingly, standard IM.7.6 and its intent, which deal with delinquent medical records, is the most problematic standard in the IM chapter. In 1995, 21 percent of the hospitals surveyed received a score of 3, 4, or 5 in this area.

Other problematic IM standards in 1995 are included in Table 1.

Table 1
Problematic IM Standards in 1995

Standard Content	Standard	Percent receiving score 3,4, or 5
Entries are dated and authenticated within time frame defined in medical staff rules and regulations	IM.7.8	9.0
IM processes are planned, designed to meet organization's internal and external information needs	IM.1	8.7
Decision makers and others are educated and trained about information management	IM.4	8.7
Verbal orders for medications are accepted bypersonnel designated in medical staff rules and regulations and authenticated by the prescribing practitioner within stated period of time	IM.7.7 Internet	8.7
When operative note is not placed in the medical record immediately after surgery, an operative progress note is entered	IM.7.3.2.2	5.3

Quarterly Record Review

Q: Can we perform the quarterly record review required by IM.3.2.1 on a sample basis? We have too many discharges to review all of our cases.

A: The Joint Commission requires that a representative sample of records be reviewed. To be considered representative, your sample, on an annual basis, must include:

- Your organization's full scope of practice, including the most common diagnoses and procedures
- All high-risk procedures
- Records of patients who are currently hospitalized
- At least one record from each physician on the medical staff

Random Unannounced Surveys

Q: My organization is about midway through its survey cycle. How likely are we to get an unannounced survey, and what areas do those surveys cover?

A: A random sample of 5 percent of accredited organizations are selected for random unannounced surveys about midway through their three-year accreditation cycle. The survey focuses on the five grid elements that were the most problematic

during surveys done the previous year. Unannounced survey topics for 1996 are shown in Exhibit 1. Un-announced surveys will not be conducted for network or laboratory accreditation services in 1996.

Scoring and Capping

Q: Are the Management of Infor-mation standards still capped for 1996? If standards are capped, does that mean they won't generate a type I recommendation, even if you're not in compliance?

A: The Management of Information standards are capped at different levels for 1996. To see which ones are capped (and where they are capped), you'll need to check the IM chapter in the appropriate Comprehensive Ac-creditation Manual. This information is not included in Volume I, Standards, or Volume II, Scoring Guidelines; it is found only in the Comprehensive Manuals.

The cap is indicated by a bar above the scoring scale (see Exhibit 2). This bar stops above the number on the scoring scale at which the standard is capped. The cap for IM.7.1.1 is a score of 3, which means that the worst impact the score of this standard can have on the grid element score is a score of 3. Although a surveyor may score this standard a 4 or 5, the standard's score will not have an impact greater than a score of 3 on the grid element score. (Although the accreditation decision grid reflects the capped scores, your organization's Official Accreditation Decision Report shows your actual standard-level score, not the capped score.)

A word of caution: The standards within a grid element may be capped at different scores. The standards in each grid element affect the grid element directly; so the score of any one standard, by itself, can affect the overall score for the grid element.

For 1996, the following standards are still capped at 2:
IM.1 (all standards in this section)
IM.3.1
IM.5 and 5.1
IM.6
IM.10.1, 10.2, and 10.3

All remaining standards are capped at 3 or higher, which means you can get a type I recommendation for noncompliance.

Security Levels for Information

Q: We're trying to set up security levels for health information in the patient database we're developing. Do the IM standards address this issue, or are we free to establish our own policies?

A: In the *1996 Accreditation Manual for Hospitals*, standard IM.2.1 says "the hospital determines appropriate levels of security and confidentiality for data and information." But don't take this as a directive to simply give everyone access to all the information in the database.

When you're surveyed, you can expect the surveyor to ask what your security levels are and how you decided on them. Your system should allow users access based on their need to know. Physicians probably don't need access to all information on all patients; ideally, their access should be limited to the patients they are treating or consulting. A nurse should be able to access the patients currently hospitalized on his/her unit, but not on other units. Billing clerks should have access to demographic and billing information, but not clinical information.

Signature Cover Sheets

Q: Standard IM.7.8 re-quires medical records to be dated and authenticated. Under the examples of evidence of implementation, the scoring guidelines say it is acceptable to have "a system in which there is a cover sheet for each chart indicating the specific signatures within that chart." Instead of signing each individual entry, the author would just sign this cover page, which is permanently retained in the medical record. Are other hospitals doing this?

A: Some hospitals that have considered doing this checked with their regional HCFA office and were told HCFA will not accept this system for authentication of record entries. Before you decide to implement such a system, contact your regional HCFA office and get their agreement in writing. Check with your facility's legal counsel or risk manager, too, to see if they have any concerns about this system meeting legal requirements for medical records in your state.

Exhibit 1
Unannounced Survey Topics for 1996

Ambulatory Care

- Credentialing and Privileging
- Surveillance/Prevention of Infections
- Competency Assessment
- Management of the Environment of Care-Design
- Improving Organizational Perfor-mance-Effectiveness

Home Care

Home Health Services

- Care Planning Process
- Organizational Management
- Surveillance, Prevention, and Con-trol of Infection
- Human Resources Management
- Improving Organizational Perfor-mance-Plan

Home Medical EquipmentClinical Respiratory Therapy

- Organizational Management
- Care Planning Process
- Management of the Environment of Care-Implementation
- Human Resources Management
- Surveillance, Prevention, and Con-trol of Infection

Pharmaceutical Services

- Care Planning Process
- Organizational Management
- Preparation and Dispensing
- Improving Organization Perfor-mance-Plan
- Human Resources Management

Hospitals

- Special Treatment Procedures
- Patient Specific Data and Information
- Credentialing
- Medication Use
- Management of the Environment of Care-Design

Long Term Care

- Assessment of Residents-Assessment
- Resident Rights
- Improving Organization Perfor-mance-Improve

- Management of the Environment of Care-Design
- Management of the Environment of Care-Measurement Systems

Subacute Programs

- Credentialing and Privileging of Subacute Program
- Assessment of Residents-Assessment
- Planning and Providing Care
- Diagnostic Services
- Human Resources Planning

Mental Health

- Human Resources Qualifications, Competencies, and Privileges
- Management of the Environment of Care-Design
- Management of the Environment of Care-Implementation
- Treatment Planning
- Initial Screening and Clinical Assessments

Exhibit 2

_ _ _ 1 2 3 4 5 NA	IM.7.1.1 Only authorized individuals make entries in medical records.

Article citation:
Brandt, Mary D.. "Frequently Asked Questions on Joint Commission Standards" *Journal of AHIMA* 67, no.5 (May 1996): 34-37.
