New Joint Commission Standards Ahead: Improvement Initiative Takes Effect January 1

by Gina Rollins

New Joint Commission standards and processes go into effect at the start of the new year. For HIM professionals, the revisions won't spell major change.

Effective January 1, 2009, HIM professionals will see updated Joint Commission accreditation standards and elements of performance, a new scoring and decision process, and a slightly different post-survey process.

The changes are the culmination of a two-year standards improvement initiative, which included feedback from both accredited and nonaccredited organizations, several advisory groups, healthcare quality experts, and others, says Kevin Hickey, MSA, director of survey scheduling and management support at the Joint Commission. The August 2008 issue of *The Joint Commission Perspectives* offered an overview of the entire standards improvement initiative, and a section of the Joint Commission Web site is devoted to the effort.

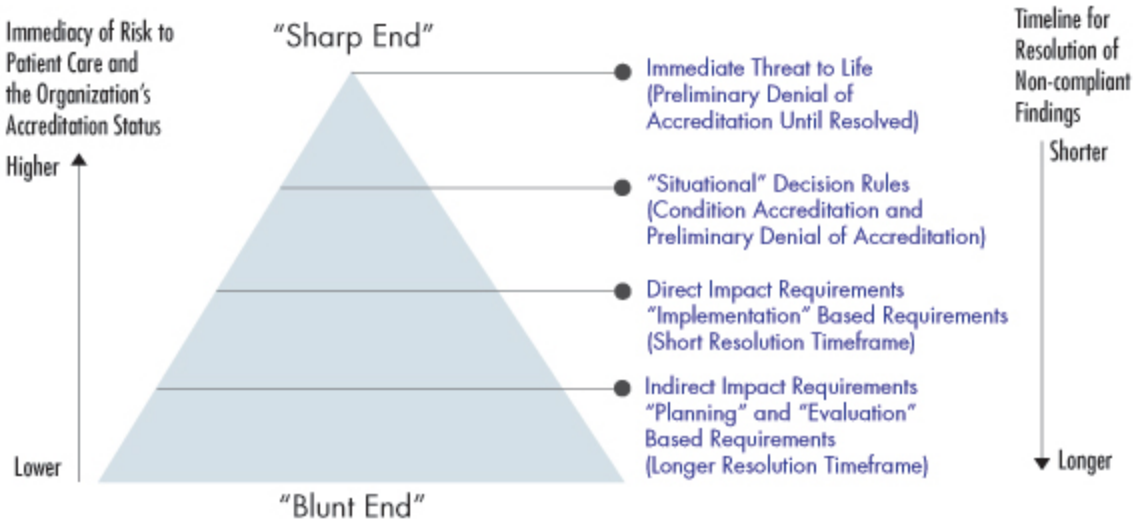
The overall aims of the standards revision were to make them "clearer, eliminate redundancies, and create a simpler and more logical order," according to the Joint Commission. The initiative did not introduce new requirements. It does delete redundant or nonessential standards, revise accreditation manual chapters, eliminate jargon, and consolidate similar standards. In addition, hard-to-measure words such as "adequate," "appropriate," "sometimes," and "timely" have been eliminated. The revisions also introduce a new chapter numbering system.

In the case of HIM, the bulk of health record-related standards have been moved from the "Information Management" chapter to the "Record of Care, Treatment and Services" chapter.

"It brings almost all the medical records information together," says Kathy Sauer, MBA, RHIA, director of HIM at Mount Sinai Hospital and Schwab Rehabilitation Hospital in Chicago. "It had been in a lot of different places, but the majority in the information management section, which was huge, and a lot of it had to do with information systems rather than elements of the medical record and the type of information required," she explains. Sauer serves as an AHIMA representative on the Joint Commission's professional and technical advisory committee.

In concert with these changes, the Joint Commission for the first time will make available electronic editions of the accreditation manual. The new e-versions will include an interactive "history tracking" feature. By clicking on a particular standard or element of performance, users will be able to see how it changed from 2008 to 2009.

Joint Commission Patient Care Impact Scoring/Accreditation Decision Model



The Joint Commission illustrates the criticality concept as a pyramid. At the top, or "sharp end," are immediate threats to life (criticality level 1), which have the most immediate risk to patients and require the shortest timeline for resolving noncompliant findings. The base, or "blunt end" represents indirect impact requirements (criticality level 4). Issues at the base pose less immediate risk to patient care and the organization's accreditation status; they have a longer timeline for resolving noncompliant findings.

A New Scoring Process

Another significant part of the standards improvement initiative is a redesign of the scoring and decision process to better capture an organization's performance in relation to the safety and quality of care. At the heart of the new decision model is the concept of criticality—the immediacy of risk to patient safety or quality resulting from noncompliance with a requirement.

"We want organizations focused on elements of performance where noncompliance will have the greatest impact on patient care," explains Hickey. However, he stresses, "No one is saying the indirect impact requirements are not important, because planning and evaluation activities could have a long-term impact on patient care."

The revised scoring system will retain the current three-point scoring scale. As is the case now, a 0 will indicate insufficient compliance with a particular requirement, a 1 will reflect partial compliance, and a 2 will represent satisfactory compliance.

New in 2009 is the requirement that organizations provide a post-survey response and resolution to all findings of insufficient or partial compliance. This is a change from the existing system, where supplemental findings noted by the Joint Commission do not require official documentation of how they are addressed, according to Hickey.

Under the new scoring method the elements of performance will be divided into two, rather than three, categories. Category B will be discontinued. Instead, elements of performance will either be classified as A or C.

Category A elements of performance generally involve structural requirements such as policies or plans that either do or do not exist; they will thus be scored as either 0 (insufficient compliance) or 2 (satisfactory compliance). Some are related to Medicare Conditions of Participation, and full compliance is expected at all times.

Category C elements are based on the number of times an organization does not meet a particular requirement. A score of 2 means there is one incident of noncompliance; a 1 indicates there are two occurrences of noncompliance; a 0 means there are three or more incidents of noncompliance.

Criticality

The criticality of a requirement will overlay the scoring scale and elements of performance categories. Criticality is divided into four categories.

A criticality rating of 1 indicates that noncompliance could pose an immediate threat to life; for example, maintaining adult-strength medications in a pediatric crash cart. When noncompliance with elements of performance are found that pose an immediate threat to life, the Joint Commission will issue an expedited decision of preliminary denial of accreditation. This will remain in effect until corrective action is validated during an on-site, follow-up survey.

Criticality level 2 is a situational decision rule, based on specific circumstances found during a Joint Commission survey. Examples include unlicensed facilities or individuals. Surveyors can recommend either a preliminary denial of accreditation or conditional accreditation when they find situational decision rules.

The third level of criticality involves direct impact requirements. Noncompliance with these performance standards is likely to create an immediate risk to patient safety or quality of care. Examples include failure to reassess or respond to a patient's pain, based on the facility's criteria, and a lack of emergency medications and supplies readily accessible in patient care areas.

Indirect impact requirements, which generally involve planning and evaluation of care processes, represent the fourth level of criticality. Noncompliance with indirect impact requirements may not pose an immediate risk to patient safety or quality of care, but if not attended to, could over time become more risky than direct impact requirements. Examples include not orienting staff members to a key safety measure before they provide care, or not documenting the orientation.

The Joint Commission illustrates the criticality concept with a pyramid (see page 59).

The revised 2009 accreditation manuals will have "tags"—triangles with numbers inside—that will make it easy to identify whether a particular element of performance falls under a situational decision rule (level 2 criticality) or direct impact (level 3 criticality). All other elements of performance are considered to have an indirect impact, although they will not be tagged with a 4. There will be no level 1 tags per se, because noncompliance that poses an immediate threat to life usually involves a combination of level 2, 3 and 4 requirements.

Organizations must provide documentation of resolution of any noncompliance with situational decision rules and direct impact requirements (criticality levels 2 and 3) within 45 days, and within 60 days for indirect impact requirements (criticality level 4).

The overall accreditation decision will depend on a combination of the standards the organization is found to be out of compliance with, based on thresholds, which were still being finalized at the time this story was written, according to Hickey.

An example of how the criticality levels could play out in the HIM realm involves medical record delinquencies. The existing element of performance related to the rate of medical record delinquencies (IM.6.10) provides specific parameters for determining whether a provider is fully, partially, or insufficiently compliant with the requirement. For instance, a rate that is 200 percent above the average monthly discharge rate is considered insufficient compliance and can result in a recommendation for conditional accreditation. These specific cut-offs have been eliminated in the new element of participation effective January 1, 2009 (RC.01.04.01), in recognition that this requirement generally will have only an indirect impact on patient care (criticality level 4).

"This is not an area of direct impact to the quality of care and safety, but an organization shouldn't take it that they can have an unlimited medical records deficiency rate," explains Hickey. "If an organization is found to have an exceedingly high rate it doesn't mean a surveyor won't make a recommendation of conditional accreditation."

New Survey Procedures

The standards improvement initiative also will bring changes to the survey process, most notably in the way organizations receive notice about accreditation decisions. Surveyors still will convene a closing interview to discuss their findings, but they will no longer provide a preliminary accreditation decision, Hickey says. Rather, the decision will be posted on the organization's extranet link with the Joint Commission, typically within two days of the survey, unless further review by the Joint Commission is necessary.

The new standards and scoring process are not expected to spell major changes for HIM, according to Lou Ann Schraffenberger, MBA, RHIA, CCS, CCS-P, manager of clinical data at Advocate Health Care in Oak Brook, IL, and another AHIMA representative on the Joint Commission technical and professional advisory committee. "I don't think it will have a

huge impact on HIM. The Joint Commission tried to make the standards make more sense, and HIM appreciates the idea of criticality," she says.

Resources Online

The Joint Commission has devoted a section of its Web site to the initiative at www.jointcommission.org/Standards/SII/default.htm. The site includes a link to an August 2008 special issue of The Joint Commission Perspectives devoted to the new process.

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