Joint Commission Update

Association of Health Facility Survey Agencies Annual Conference
Austin, Texas
August 22, 2016

Jennifer Hoppe, MPH
Senior Associate Director
State Relations
Today’s Topics

- Project Refresh
  - Review of new onsite scoring methodology: SAFER Matrix
  - Changes to the post-survey follow-up

- Redesign of Quality Check website

- Change in accreditation award terminology under the Early Survey Process
What is Project Refresh?

A series of 11 inter-related and/or inter-dependent process improvement initiatives underway at The Joint Commission

- Guiding principles: **Simplification, Relevancy, Innovation, Transparency**

Major initiatives to highlight at this time:
- Survey Analysis for Evaluating Risk™ (SAFER) Matrix
- Post-survey Follow-up
Survey Analysis for Evaluating Risk (SAFER) Matrix
History of Development

There are multiple different “taggings” that The Joint Commission uses for our Elements of Performance (EPs).

For example, we tag EPs as “Direct” versus “Indirect”, “A” category vs. “C” category, Measure of Success (MOS) required or not, Risk Icon or not, etc.

These multiple taggings were identified by different groups of staff, at different points in time, and are used for different reasons (ESC timeframe, decision rules, etc.).
Problem

- The existing multiple EP taggings require extensive upkeep, are confusing to our customers, and at times contradict each other.

- While the taggings attempt to prioritize those EPs that are most critical, they often result in “one size fits all” follow-up as the follow-up is determined by the EP itself rather than the context of the actual finding written under it.
A New Approach…

- A new model that recognizes that the potential for an EP to be related to a risk/safety issue depends on the context of the situation during a given survey/review and not pre-determined based on the EP itself.

- Develop one single, comprehensive method of categorizing the risk associated with standards.
A New SAFER Concept

Scope

Likelihood to Harm a Patient

Increasing Risk

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A New SAFER Model

Immediate Threat to Life (a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served)

Likelihood to Harm a Patient/Staff/Visitor

- HIGH (harm could happen at any time)
- MODERATE (harm could happen occasionally)
- LOW (harm could happen, but would be rare)

- LIMITED (unique occurrence that is not representative of routine/regular practice)
- PATTERN (multiple occurrences with potential to impact few/some patients, visitors, staff and/or settings)
- WIDESPREAD (multiple occurrences with potential to impact most/all patients, visitors, staff and/or settings)
IC.02.02.01 - The hospital implements infection prevention and control activities when doing the following:

**IC.02.02.01, EP 4 - Storing medical equipment, devices, and supplies.**

<table>
<thead>
<tr>
<th>Likelihood to Harm a Patient/Visitor/Staff</th>
<th>LIMITED PATTERN WIDESPREAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>A colonoscope used for the operating room was stored in an operating room cabinet with the tip of the colonoscope touching supplies stored in the bottom of the cabinet.</td>
</tr>
<tr>
<td>MODERATE</td>
<td>During an upper endoscopy procedure, a GI technician entered the endoscopy suite from the adjoining endoscope reprocessing room in order to place a processed endoscope into storage. This practice posed an unacceptable risk of cross-contamination. During an endoscopy procedure, the GI technician opened the endoscope storage closet to retrieve a CLOtest kit. This action had the potential to expose the stored endoscopes to aerosolized particles in the endoscopy suite.</td>
</tr>
<tr>
<td>LOW</td>
<td>“During a tour of the Endoscopy Department, note was made of the endoscope storage cabinets with the doors wide open with scopes stored in the cabinets. Staff explained that it was the practice in the department to leave the doors open during the work day. This resulted in an opportunity for airborne contaminants to deposit on the cleaned/stored scopes.”</td>
</tr>
</tbody>
</table>

In the supply room was an opened and partially used bottle of 0.9% normal saline used for dental irrigation. The bottle was not labeled with the open date, and the instructions on the bottle stated ‘discard unused portion’.

“During the building tour in the pediatric area, the intake room and two examination rooms were observed. Located under the sinks in all three areas were multiple boxes of gloves at risk of damage from water.”

“During the building tour it was noted that in the radiology area there were several cardboard boxes on the floor that appeared to be water logged. In addition, throughout this entire facility there were other cardboard boxes stored directly on the floor at risk for water damage.”

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Moderate/Widespread Example

“During a tour of the Endoscopy Department, note was made of the endoscope storage cabinets with the doors wide open with scopes stored in the cabinets. Staff explained that it was the practice in the department to leave the doors open during the work day. This resulted in an opportunity for airborne contaminants to deposit on the cleaned/stored scopes.”
In the supply room was an opened and partially used bottle of 0.9% normal saline used for dental irrigation. The bottle was not labeled with the open date, and the instructions on the bottle stated 'discard unused portion'.
IC.02.02.01 - The hospital implements infection prevention and control activities when doing the following:

IC.02.02.01, EP 4 - Storing medical equipment, devices, and supplies.

**Likelihood to Harm a Patient/Visitor/Staff**

**HIGH**

- "A colonoscope used for the operating room was stored in an operating room cabinet with the tip of the colonoscope touching supplies stored in the bottom of the cabinet."

**MODERATE**

- "During an upper endoscopy procedure, a GI technician entered the endoscopy suite from the adjoining endoscope reprocessing room in order to place a processed endoscope into storage. This practice posed an unacceptable risk of cross-contamination. During an endoscopy procedure, the GI technician opened the endoscope storage closet to retrieve a CLOtest kit. This action had the potential to expose the stored endoscopes to aerosolized particles in the endoscopy suite."

- "During a tour of the Endoscopy Department, note was made of the endoscope storage cabinets with the doors wide open with scopes stored in the cabinets. Staff explained that it was the practice in the department to leave the doors open during the work day. This resulted in an opportunity for airborne contaminants to deposit on the cleaned/stored scopes."

**LOW**

- "In the supply room was an opened and partially used bottle of 0.9% normal saline used for dental irrigation. The bottle was not labeled with the open date, and the instructions on the bottle stated 'discard unused portion'."

- "During the building tour in the pediatric area, the intake room and two examination rooms were observed. Located under the sinks in all three areas were multiple boxes of gloves at risk of damage from water."

- "During the building tour it was noted that in the radiology area there were several cardboard boxes on the floor that appeared to be water logged. In addition, throughout this entire facility there were other cardboard boxes stored directly on the floor at risk for water damage."

**LIMITED PATTERN WIDESPREAD**

**Scope**

- IC.02.02.01 - The hospital implements infection prevention and control activities when doing the following:

- IC.02.02.01, EP 4 - Storing medical equipment, devices, and supplies.
How is Risk Determined?

- Operational definitions and “anchors”
- Surveyor experience and expertise will provide the support to determine the “scope” and “likelihood to harm” for the finding
- Based on the context of the finding
- Discussion among team (if applicable), SIG and/or peers (as needed)
An Overall Picture of Survey Findings

- Immediate Threat to Life
- High
- Moderate
- Low
- Limited
- Pattern
- Widespread

Likelihood to Harm a Patient/Visitor/Staff

MS.08.01.01, EP1
RC.01.03.01, EP1
RC.03.05.15, EP1
RC.01.03.01, EP3
IM.02.02.01, EP3
PC.02.03.01, EP1
EC.02.06.01, EP1
MS.12.01.01, EP4

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Post Survey Follow-up
Follow-up Actions

Lesser Intensity

Greatest Intensity
## Prioritized Follow-up Action

<table>
<thead>
<tr>
<th>SAFER Matrix Placement</th>
<th>Required Follow-Up Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOW / LIMITED</strong></td>
<td>• 60 day Evidence of Standards Compliance (ESC)</td>
</tr>
<tr>
<td></td>
<td>- ESC will include Who, What, When, and How sections</td>
</tr>
<tr>
<td><strong>MODERATE / LIMITED, LOW / PATTERN, LOW / WIDESPREAD</strong></td>
<td>• 60 day Evidence of Standards Compliance (ESC)</td>
</tr>
<tr>
<td></td>
<td>- ESC will include Who, What, When, and How sections</td>
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<td></td>
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<td><strong>MODERATE/PATTERN, MODERATE/WIDESPREAD</strong></td>
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<td><strong>HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD</strong></td>
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</tr>
</tbody>
</table>

**Note:** If an Immediate Threat to Life (ITL) is discovered during a survey, the organization immediately receives a preliminary denial of accreditation (PDA) and, within 72 hours, must either entirely eliminate the ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL). Please see the Accreditation Process Chapter within the Comprehensive Accreditation Manual for more information.
Evidence of Standards Compliance (ESC) Changes

- All Requirements for Improvement (RFIs) due in a 60 day ESC
  - 45 day ESC no longer applicable

- All findings will require an ESC
  - Opportunities for Improvement (OFI) section of the report no longer applicable

- Findings of higher risk will require 2 additional ESC fields
Current ESC Fields

- WHO
- WHAT
- WHEN
- HOW

*These are required for all RFIs cited during the survey*
New ESC Fields

- Only for findings cited within the higher risk areas (dark orange and red areas of SAFER matrix)

- Includes 2 new fields:
  1. Leadership Involvement
  2. Preventive Analysis
Leadership Involvement

- The measure of the success of change is in its sustainability within organizations
- Success and sustainability are highly influenced by support from the top level of leadership
Types of Leadership Involvement

- Providing resources (e.g. staff, money, expertise)
- Serving as a champion of the change
- Direct participation on teams
- Motivating employees
- Establishing intervals for communication and/or reporting
- Direct oversight of change

*This list provides examples of leadership involvement. It is not an exhaustive or prescriptive list as to how organizations should incorporate leadership involvement into the corrective action plan.*
Leadership Involvement - ESC

In order to achieve the goal of reducing risk, which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

- President
- Chief Executive Officer
- Vice President
- Chief Quality Officer
- Chief Medical Officer
- Chief Nursing Officer
- Chief Operating Officer
- Medical Director
- Director of Nursing
- Facilities Director
- Director of Clinical Services
- Other

Please describe how the above leadership involvement is helping to sustain compliance with this Element of Performance in the future.

For example: “Our Chief Quality Officer directly participated in meetings where Infection Control Policy #123 was revised and approved. The Chief Quality Officer is serving as the champion for implementing the revised policy, including communicating the changes to leadership across the organization and establishing a monitoring system to ensure all staff are educated on the policy. Additionally, as part of the Chief Quality Officer’s monthly leadership meeting, a standing agenda item will be added related to compliance with the revised policy.”
Preventive Analysis

- Ensures the corrective action does not simply fix the issue at hand
- Focuses on identifying and addressing underlying reasons that caused the issue
- Efforts also focused on preventing future occurrences of the high risk issue
Preventive Analysis Questions

- What went wrong?
- Why did this happen?
- What process(es) failed?
- What is the underlying reason why this went wrong?

*This list provides examples of questions surrounding Preventive Analysis. It is not an exhaustive or prescriptive list as to what questions organizations should incorporate within their analysis.
Preventive Analysis - ESC

What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution) but also any underlying reasons for the failure were addressed as well?

Example: “A group of staff including members from the quality improvement team, infection control and nursing met to discuss and understand why the hand hygiene compliance program was not effectively being implemented. It was determined that there had been numerous staff changes over the past year, leading to inconsistent responsibility for the program. Moving forward, there will be two co-owners for the program – one from nursing and one from infection control. This will help ensure consistency and continuation of the program in the event of future staff turnover.”
SAFER Matrix™ Examples
Example #1

It was observed that there was an entry in the record which had not been authenticated and/or dated and timed. The Intake assessment had been signed by the author but the entry was not dated and timed.
Example #2

It was observed that the grab bars posed a ligature risk because they were not continuous with the wall. The handicap grab bars were located on both sides of the hallways of both units currently in use. Additionally, handicap grab bars in use in the bath tub room on Unit 1072 and the bathroom in room 243 on Unit 1072 were not continuous with the wall and posed a ligature risk. The organization reported that all of the handicap grab bars in patient areas were similar to this. The handicap grab bars were not identified on the organization's "Annual Fixed Points Risk Assessment."
Example #3

While observing the process for cleaning instruments after a surgical procedure it was observed that the tech did not spray the used instruments with an enzymatic cleaner prior to transporting them to the decontamination room. Staff indicated that this was not a process in place at this facility.
Beginning January 1, 2017

- The SAFER matrix will be implemented for the organization as a whole (including tailored programs)
- The SAFER matrix will be generated and embedded within the survey process and the final report
- Matrix data will be shared with the organization
- Matrix data will drive the updated written post-survey process

*The SAFER matrix will not drive the adverse decision process, determination of CLDs during survey, or declaration of an ITL. These 3 processes will remain the same as they do today.
## Report Example

**Survey Analysis for Evaluating Risk (SAFER)**

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of a RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

**Likelihood to Harm a Patient/Staff/Visitor:**
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

**Scope:**
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most patients, staff, visitors and/or settings

All Evidence of Standards Compliance (ESC) forms, which outline corrective actions, will be due in 60 days. For those findings of a higher risk, two additional fields will be required within the ESC for the organization to provide a more detailed description of leadership involvement and preventive analysis to assist in sustaining the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

<table>
<thead>
<tr>
<th>SAFER Matrix Placement</th>
<th>Required Follow-Up Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Limited</td>
</tr>
<tr>
<td>Moderate/Limited, Low/Pattern, Low/Widespread</td>
<td>60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, Where, and How sections</td>
</tr>
<tr>
<td>Moderate/Widespread</td>
<td>High/ISW, ISW</td>
</tr>
<tr>
<td>High/ISW</td>
<td>High/ISW, ISW</td>
</tr>
</tbody>
</table>

Note: For Improvement to the RFI be strengthened during a survey, the organization immediately outlines an improvement action that results in improved performance on a timeline, by a specific date, to achieve the expected outcome of a rapid corrective action to ensure sustained compliance.
Report Example

Survey Analysis for Evaluating Risk (SAFER) Matrix

Hospital Accreditation:

<table>
<thead>
<tr>
<th>ITL</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR.09.04.01 EP1</td>
<td>EM.02.01.01 EP1</td>
<td>EM.02.01.01 EP3</td>
<td>LD.01.01.01 EP2</td>
</tr>
<tr>
<td>APR.01.01.01 EP1</td>
<td>EC.02.03.01 EP2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Limited | Pattern Scope | Widespread
Report Example

Chapter: Emergency Management
Program: Hospital Accreditation
Standard: EM.02.01.01


Element(s) of Performance:

3. The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

![Highlighted text: Likelihood to Cause Harm: Moderate, Scope: Pattern]

Observation(s):

EP3
Observed in Individual Tracer at ABC Medical Center (1000 North Main Street) site. The plan was not available at the time of the survey.
Final Impacts:

- No more Direct and Indirect EP designations
  - Consolidated ESC into one 60-day timeframe*

- No more A and C EP categories
  - No more Opportunities for Improvement (OFIs)
  - No more Measures of Success (MOS)

*exception for findings that result in adverse accreditation decisions: The ESC timeframe will remain 45 days
Quality Check Redesign
Types of Information that can be found on Quality Check:

- The date of the most recent, full on-site survey
- The organization’s current accreditation decision
- The date of the most recent on-site survey, if not a full survey
- Whether or not a provider is deemed for Medicare Certification
- Accreditation history
- Sites and services included in the accreditation survey
- Disease-specific care certification(s) and the effective date
- Standards areas with requirements for improvement (RFIs) related to an organization that has an adverse accreditation decision
- The receipt of special quality recognition awards, as recognized by the Board of Commissioners
- Compliance with National Patient Safety Goal requirements
- **New in 2016: Download/export list of all accredited providers**
Previous website:

The Joint Commission

Quality Report

Summary of Accreditation Quality Information

<table>
<thead>
<tr>
<th>Accreditation Programs</th>
<th>Accreditation Decision</th>
<th>Effective Date</th>
<th>Last Full Survey Date</th>
<th>Last On-Site Survey Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>Accredited</td>
<td>3/30/2010</td>
<td>2/19/2010</td>
<td>2/19/2010</td>
</tr>
</tbody>
</table>

Accreditation programs recognized by the Centers for Medicare and Medicaid Services (CMS)

- Top -

National Patient Safety Goals and National Quality Improvement Goals

Symbol Key

- The organization has met the National Patient Safety Goal.
- The organization has not met the National Patient Safety Goal.
- The goal is not applicable

Home Care

2010 National Patient Safety Goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Nationwide</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

See Detail
New Website:
# Quality Report

## Health at Home, LLC

**DBA:** Health at Home LLC  
**HCO ID:** 493284  
**6451 Far Hills Ave.**  
**Dayton, OH, 45439**  
(937) 456-7700  
[www.graceworksathome.org](http://www.graceworksathome.org)

## Summary of Quality Information

### Accreditation Programs

**Home Care**  
- **Accreditation Decision:** Accredited  
- **Effective Date:** 11/28/2013  
- **Last Full Survey Date:** 11/27/2013  
- **Last On-Site Survey Date:** 11/27/2013

### Deemed Programs

- Home Health Agency

### Sites

- **Health at Home LLC**  
  - **DBA:** Health at Home LLC  
  - **6451 Far Hills Ave.**  
  - **Dayton, OH, 45439**

### Available Services

- Home Health Aides  
- Home Health, Non-Hospice Services  
- Medical Social Services  
- Occupational Therapy  
- Physical Therapy

### National Patient Safety Goals and National Quality Improvement Goals

[Show Keys →](#)
Alliance Home Healthcare Services LLC

DBA: HomeSite Home Health Care
HCO ID: 522932
266 Brubaker Drive
New Carlisle, OH, 45344
(937) 845-1486
www.homesitehc.org

Summary of Quality Information

Accreditation Programs

<table>
<thead>
<tr>
<th>Accreditation Decision</th>
<th>Effective Date</th>
<th>Last Full Survey Date</th>
<th>Last On-Site Survey Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation with Follow-up Survey</td>
<td>4/15/2016</td>
<td>4/14/2016</td>
<td>6/24/2016</td>
</tr>
</tbody>
</table>

The following information provides a general description of the areas in which performance issues were found. Each of these areas typically has many specific requirements. The area is listed if one or more of the specific requirements were determined to require improvement.

- Any individual who provides care, treatment, or services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.
- Governance is ultimately accountable for the safety and quality of care, treatment, or services.
- Reduce the risk of falls.
- The organization assesses and reassesses the patient and his or her condition according to defined time frames.
- The organization audits its patient records.
- The organization compiles and analyzes data.
- The organization effectively manages the collection of health information.
- The organization evaluates the effectiveness of its Emergency Operations Plan.
- The organization has policies and procedures that guide and support patient care, treatment, or services.
- The organization identifies risks for adverse and adverse drug effects.
New Website:
Data Download

The Joint Commission is committed to the public reporting of some information on accredited and certified health care organizations. The options below allow requesters to obtain aggregate information already available on each organization's Quality Report.

**Accreditation**

Download demographic information on all our accredited customers.

- See All

**Certification**

Download demographic information on all our certified customers.

- See All

**Performance Measure Data**

See our Quality Data Downloads.

- Not sure what types of data sets are available?
  - View All Data Sets

**Data Mart**

Need more? The Joint Commission can customize data delivery for you.

- Learn More
Select program...
<table>
<thead>
<tr>
<th>Organization</th>
<th>Accreditation Program</th>
<th>Accreditation Decision</th>
<th>Accreditation Decision Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 Hospital</td>
<td>VA Southern Nevada Healthcare System</td>
<td>Accredited</td>
<td>03/24/2014</td>
</tr>
<tr>
<td>70 Hospital</td>
<td>Puerto Rico Medical Services Administration (ASEM)</td>
<td>Accredited</td>
<td>02/28/2015</td>
</tr>
<tr>
<td>389 Hospital</td>
<td>Methodist Ambulatory Surgery Hospital - Northwest</td>
<td>Accredited</td>
<td>05/13/2015</td>
</tr>
<tr>
<td>444 Hospital</td>
<td>Aurora Charter Oak - Los Angeles, L.L.C.</td>
<td>Accredited</td>
<td>04/11/2015</td>
</tr>
<tr>
<td>469 Hospital</td>
<td>New York State Psychiatric Institute</td>
<td>Accredited</td>
<td>06/21/2013</td>
</tr>
<tr>
<td>487 Hospital</td>
<td>UHS of Fairmount, Inc.</td>
<td>Accredited</td>
<td>05/14/2016</td>
</tr>
<tr>
<td>498 Hospital</td>
<td>Fort Lauderdale Hospital, Inc</td>
<td>Accredited</td>
<td>08/14/2013</td>
</tr>
<tr>
<td>503 Hospital</td>
<td>Shadow Mountain Behavioral Health</td>
<td>Accreditation with Follow-up Surveys</td>
<td>03/19/2016</td>
</tr>
<tr>
<td>505 Hospital</td>
<td>Connecticut Mental Health Center</td>
<td>Accredited</td>
<td>09/06/2014</td>
</tr>
<tr>
<td>507 Hospital</td>
<td>CenterPointe Hospital</td>
<td>Accredited</td>
<td>11/22/2013</td>
</tr>
<tr>
<td>513 Hospital</td>
<td>Mountain View Hospital</td>
<td>Accredited</td>
<td>03/20/2015</td>
</tr>
<tr>
<td>514 Hospital</td>
<td>The BridgeWay, LLC.</td>
<td>Accredited</td>
<td>02/13/2016</td>
</tr>
<tr>
<td>549 Hospital</td>
<td>State of Ohio Office of Budget and Management State</td>
<td>Accredited</td>
<td>10/25/2013</td>
</tr>
<tr>
<td>567 Hospital</td>
<td>BHC Intermountain Hospital</td>
<td>Accredited</td>
<td>12/05/2014</td>
</tr>
<tr>
<td>578 Hospital</td>
<td>John J. Madden Mental Health Center</td>
<td>Accredited</td>
<td>08/10/2013</td>
</tr>
<tr>
<td>598 Hospital</td>
<td>Mental Health Services for Clark and Madison Counties</td>
<td>Accredited</td>
<td>09/24/2015</td>
</tr>
<tr>
<td>601 Hospital</td>
<td>Butler Hospital</td>
<td>Accredited</td>
<td>07/18/2015</td>
</tr>
<tr>
<td>603 Hospital</td>
<td>Central Louisiana State Hospital</td>
<td>Accredited</td>
<td>11/12/2015</td>
</tr>
<tr>
<td>604 Hospital</td>
<td>Greystone Park Psychiatric Hospital</td>
<td>Accredited</td>
<td>12/20/2014</td>
</tr>
<tr>
<td>619 Hospital</td>
<td>Seton Shoal Creek Hospital</td>
<td>Accredited</td>
<td>05/02/2015</td>
</tr>
<tr>
<td>622 Hospital</td>
<td>Choate Mental Health and Developmental Center</td>
<td>Accredited</td>
<td>01/07/2016</td>
</tr>
</tbody>
</table>
Change in Accreditation Award Terminology under the Early Survey Process (ESP)
Background on ESP process

- Optional two part survey process
  - First survey conducted prior to services being offered
    - limited set of standards
  - Following submission of corrective action
    Preliminary Accreditation* awarded
  - Second survey (full) conducted within 6 months of the award.
    - Must meet minimum patient eligibility requirements

* Term valid through July 31, 2016
Background…

Several state regulatory agencies rely on ESP process in the oversight authority

- Requirement for accreditation in order to obtain licensure
- Requirement for accreditation for provider to perform specific services (ex: OBS)
New Terminology: Effective August 1, 2016

- Award after successful ESP event will now be termed:
  - Temporary, Limited Accreditation

- Reflected in the accreditation reports, award letters, and the Joint Commission’s Quality Check website.

- While the name of the award has changed, nothing about the standards or survey process applied to an ESP event have changed.
Questions?

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