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Inside Accreditation & Quality

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In this Issue

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Survey tips

AAAHC Quality Roadmap outlines 2021 deficiencies, tips for compliance

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

Find a detail-oriented person at ambulatory healthcare sites to review credentialing and privileging procedures to ensure primary source verification is carried out and that records and licenses for practitioners are not outdated.

Appoint a rotating "secret shopper" among your staff to audit daily hand hygiene so you don't lose all the progress you made on that simple infection control measure during the COVID-19 pandemic.

Check and back-check vendors, maintenance contractors, or other workers performing repairs or installations that may require holes to be made in walls designed for smoke and fire protection, to ensure any openings are sealed properly.

And as you prepare for survey, use the compliance tips gathered in the Accreditation Association for Ambulatory Health Care (AAAHC) *2021 Quality Roadmap*, reporting on accreditation survey results.

That map, paired with the accreditation organization's standards manual, is the best way to stay prepared for AAAHC survey and provide the safest care for your patients, says **Cheryl Pistone, RN, MA, MBA,** clinical director of accreditation services at AAAHC.

"The standards handbook is really an open-book test," she says, because it lays out the requirements. "The Quality Roadmap is the answers to the open-book test that people aren't getting right."

The map offers a look at not only common problems that surveyors found, but also compliance tips. "We're giving you tidbits—here's the things that surveyors are finding over and over, here are some things to fix your issues."

Credentialing, privileging, and peer review

For instance, under standards for credentialing, privileging, and peer review, AAAHC surveyors were finding problems with:

- Missing reappointment application and supporting documentation
- Lack of evidence that personal information is updated, including incomplete disclosure question forms or privilege lists, and authorization forms that aren't consistently signed or dated

- Credentialing policy not addressing the requirement for attestation questions
- Misdated signed applications/attestations
- Credentialing files missing required attestation questions (i.e., release of liability signature)
- Credentialing files missing or containing expired board certification

Hints for compliance offered by the Quality Roadmap are:

- Keep explicit written procedures for requests and approvals and follow them consistently; this includes adding documentation on updated attestations and personal information to credentialing files during the reappointment process
- Do not exclude contract and allied health providers from the credentialing process
- Keep up-to-date with time-sensitive information (e.g., state license, DEA registration, medical liability coverage) by reviewing it at least at expiration, appointment, and reappointment

Under privileging, some of the surveyor findings included:

- Approval of an unspecified "other" privilege with no explanation or description
- Privileges for anesthesiologists that did not contain the supervision of CRNAs, as required by regulations, and the use of ultrasound during regional nerve blocks
- Approved privilege sheets that did not contain a specified time period
- Provider requests for privileges but no documentation that the privileges were approved by governing body

Help is available

Among problems surveyors found were such things as peer review information not being used by the governing body to approve credentialing or reappointment, and no documentation that the organization was tracking or reporting peer review trends or results to the governing body.

All of those things require a lot of time and attention to detail, but they must be done, says Pistone.

"It needs a detail-oriented person," she says. While credentialing, privileging, and peer review are separate processes, they are related, with each one necessary to inform the others.

"This is a vital and important function … that needs to be done, and done correctly," Pistone emphasizes.

But there is help for ambulatory health organizations struggling with these things. "We do a lot of teaching, we have a toolkit on how to do credentialing and privileging, and we spend a lot of time on questions," she says.

Other common areas with deficiencies outlined in the Quality Roadmap include documentation of a patient's history and physical, documentation of a patient's allergies, medication reconciliation, and quality improvement efforts.

Infection prevention, safe injection practices

One of the main sections of the Quality Roadmap dealt with deficiencies concerning infection prevention and control (IPC) and safe injection practices (SIP).

Among deficiencies cited under IPC were several themes common across various types of healthcare organizations:

- No evidence of IPC designee appointment, training, or competency
- IPC designee not trained in the cleaning and sterilization of surgical instruments
- No documentation of when multiple upper and lower endoscopes were reprocessed and by whom
- Guidelines on immediate use steam sterilization (IUSS) not being followed
- Linen found uncovered in a patient care area
- Insufficient (or no) monitoring and documentation of cleaning, high-level disinfection, and sterilization; and failure to follow national guidelines and/or manufacturer's instructions for use

Hints for compliance included:

- IPC training and competency testing should occur at hire and at least annually, or when there is an identified need, such as when guidelines or manufacturers' instructions change
- Devote resources to IPC designees to ensure adequate, ongoing training and competency testing
- Ensure new and existing staff (including providers) receive infection prevention training at regular

intervals, including as national guidelines change and with sufficient frequency for reinforcement

- Ensure compliance with OSHA regulations for bloodborne pathogens
- Perform competency testing on hire and at least annually or when equipment, guidelines, and/or manufacturers' instructions change
- Implement an active infection risk assessment and surveillance process

Under SIP, findings included:

- Not following CDC, APIC, or other requirements adopted as policy for hand hygiene and SIP
- No SIP or hand hygiene training or surveillance program
- Not treating a multidose medication opened and drawn in a patient treatment area as a single-dose vial (SDV)
- Opening, dating, and saving multidose vials (MDV) on anesthesia carts or in the OR or PACU for future use, as opposed to keeping MDVs in a designated clean area away from patient care or treating an MDV as an SDV because it has been in an unclean patient care area
- Syringes labeled, but not disposed of in the sharps container
- Open and undated vials of insulin in refrigerator in patient treatment area
- Syringe recapped with two hands, which could result in a needlestick
- Confusion on drug names

Hints for compliance included:

- Use AAAHC's Safe Injection Practices toolkit risk assessment form
- Use tall man lettering (TML) technique (e.g., fentanyl*/SUFentanil; epinephrine*/ePHEDrine) in lists of look-alike drug name medications
- Observe hand hygiene and SIP frequently using different staff as observers (similar to "secret shoppers") to get accurate data

The use of the "secret shopper" observer—someone designated to watch for hand hygiene and report problems—is especially useful when combined with a culture of safety that doesn't place blame but emphasizes identification and education, Pistone says.

Fire safety and emergency preparedness

Just because ambulatory health facilities, like clinics or surgical centers, close their doors at night does not exempt them from having problems with emergency preparedness and *Life Safety Code*® (LSC) standards.

Among the common findings in this area were:

- Fire drills not conducted quarterly as required or not scenario based
- Undocumented fire drills
- No disaster drills conducted
- A lack of exit signs, or having non-illuminated exit signs
- Drills that were not evaluated or evaluations that were short or missing

And like hospitals, one of the biggest problems facing ambulatory health centers is making sure fire wall penetrations are sealed appropriately to contain smoke or fire, says **Tarin English,** director of CMS & state compliance at AAAHC.

Deficiencies dealing with smoke and fire protections were among the most serious problems cited.

While many ambulatory health centers have their own on-site maintenance or facilities crews, others rely on the center's administrator, who may not be familiar with the NFPA's ambulatory occupancy requirements under the LSC.

English emphasizes, though, that accreditation professionals and administrators don't need to be well versed in the NFPA requirements to know to watch behind contractors, maintenance personnel, or vendors to ensure that wall or ceiling penetrations are sealed correctly.

"If they've punched a hole in a wall," she says, "they need to have used the correct fill" to maintain the integrity of the smoke or fire protection.

Identify your support systems within your organization or facility, even if that means reaching out to the building landlord.

And you can always call AAAHC.

Ask for help

If you're not sure of the exact LSC requirement, "organizations can call us whenever they have a question. We can help demystify some of this code language," English says.

She also urges administrators and staff in general to become familiar with their facility's emergency lighting and work with staff or cleaning vendors to make sure that certain light switches are not turned off at night, she advises.

It's not uncommon for someone to unknowingly turn off the switch to the emergency lighting, which becomes a problem during an emergency and is a citation waiting to happen, English says.

Also, "look at your center with brand-new eyes," she advises. Would you know where the exits are in an emergency? Are the exit signs leading you to a door that's locked or to a dead end?

AAAHC standards require quarterly drills, and a drill is a good time to put those new eyes into action. "That can be a neat way to learn new things about your facility—nominate someone to be your patient," she says.

Other AAAHC Quality Roadmap hints for compliance with fire safety and emergency preparedness include:

- Create a template form or checklist for drills that includes who is participating, a description of the scenario, an evaluation of the drill, and steps to improve.
- Have an impartial party view drills while they are being performed and conduct an evaluation.
- Include supporting documents, including completed AAAHC Emergency Drill toolkit forms.
- Check state and local building code requirements for exit sign and emergency preparedness requirements.

To download a copy of the AAAHC Quality Roadmap, go to AAAHC's website: *https://www.aaahc.org/quality-institute/quality-roadmap/* ■

Questions Comments & Ideas

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Survey results

AAAHC report also offers pandemic-stressed organizations applause

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

The Accreditation Association of Ambulatory Health Care (AAAHC) released its *2021 Quality Roadmap*—but it wasn't entirely bad news.

Besides offering tips on how to get the most value out of the report—such as comparing surveyor findings to your last on-site survey and your annual self-assessment, and leveraging AAAHC patient safety toolkits and resources—the Quality Roadmap also offered a "word about the findings and COVID-19."

Noting that a few new areas related to infection prevention and safe injection practices reached the 10% threshold of citations, which AAAHC uses as a marker of the most serious deficiencies, the report also opened with this note:

"However, it is important to recognize that during the pandemic, organizations worked hard and often developed innovative approaches to ensuring compliance with AAAHC Standards. These include:

- Ensuring credentialing files were up-to-date and emergency equipment was checked even when the facility was officially closed
- Prioritizing pandemic-related QI studies such as proper use of Personal Protective Equipment (PPE) and hand hygiene
- Reviewing written discharge instructions to the patient/caregiver curbside to comply with social distancing protocols
- Adding COVID-19 risk acknowledgment consent forms and COVID-19 test results to clinical records
- Adding pandemic-specific emergency drills to policies and procedures

"AAAHC commends health care organizations for their efforts. All organizations should continue their heightened focus on infectious disease protocols and emergency plans, including preparing for disasters and treating patients with COVID-19." ■

Standards

Review workplace violence prevention programs against new TJC standards

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

Take another look at your workplace violence prevention (WVP) policies and procedures now that The Joint Commission (TJC) has formally published *new and revised standards* that will be effective January 1, 2022.

Not unexpectedly, the new WVP requirements require a workplace analysis, staff education and training, and a designated leader to oversee creation of policies, implementation of the program, analysis of reported incidents, and reports to the hospital governing body.

The new Leadership WVP element of performance (EP) under standard LD.03.01.01 also requires the designated leader to ensure that someone follows up with workplace violence victims and witnesses and provides them with support if necessary, including trauma and psychological counseling.

Another EP requires a review of your existing WVP policies and procedures be done via a multidisciplinary team. That team must be made up of representatives from all departments in your facility, including physicians and nurses, other clinical and laboratory staff, physical plant operations and cleaning crews, and security teams.

That's because they are going to provide the best view of your organization. But that team needs "to be prepared to ask the uncomfortable questions" to provide a real analysis of your hospital, says **AlGene Caraulia, MBA,** vice president of Integration and Sustainability with the *Crisis Prevention Institute* (CPI). CPI works to provide educational, behavioral health, security, and healthcare professionals with training on verbal and nonviolent crisis intervention.

An organization like CPI can help guide you through the analysis, but ultimately your WVP team will have to do the hard work of it because every organization has its own challenges, says Caraulia.

"We'll never know a hospital like the hospital does," he says.

Be able to ask hard questions

While the multidisciplinary team will be asking the hard questions about the blind spots in your organization and who needs training, an organization like CPI can provide a complimentary risk assessment of employees and their roles, as well as how to start training and how to sustain the program throughout the facility, he says.

To be effective, your program must have both leadership support and the ability to sustain itself.

The leader involved should be high up in the organization's hierarchy—preferably vice president level or its equal. If leadership gets relegated to mid- or low-level managers, you run the risk of sending the wrong message about the importance of the workplace violence initiative.

"It has to be more than just the flavor of the day," he says.

Having a culture of safety throughout the hospital when it comes to reporting potential problems—and potential problem employees—or encouraging an open dialogue about domestic violence and handling trauma should be a key component of a successful WVP program.

The standards also require training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents.

TJC also published an accompanying *R3 Report* at the same time as the new WVP requirements that includes a key element of any good WVP program: a definition of workplace violence.

TJC defines workplace violence as: "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors."

TJC will add WVP definition to manual glossary

The definition will be added to the accreditation manual's glossary of terms, said TJC. Such a definition is a good place to start, but it shouldn't be the only guide, says Caraulia.

Remember that workplace violence doesn't only originate from patients or visitors; it could also be in the

form of cyberbullying, or involve bullying or violence from one colleague to another, he says.

One of the most important aspects of training is that your program must include training for physicians, nurses, and other clinicians, no matter how busy they may say they are, he advises.

"When a provider is going through med or nursing school, they've never exposed to the training we provide regarding workplace violence," explains Caraulia.

Everyone, including patients and practitioners, should feel safe in the healthcare environment. That's an issue not just of security, but patient safety.

"If I don't feel safe, there is a measurable rise in bad outcomes," he notes.

The kinds of education and duration of training will vary from person to person, depending on the role they play at your facility.

Whatever program you develop, understand that it will need to change over time, especially as people become more familiar with procedures.

It will need to be flexible and responsive to changes, especially as the review of workplace violence incidents becomes more formalized, as required under the Leadership EP.

But this effort will likely be worth it. The Bureau of Labor Statistics reports that 73% of reported workplace injuries and illnesses due to violence nationwide were from healthcare workers. And those were just the reports involving nonfatal injuries.

CPI notes on its *website* that the cost of dealing with an incident of workplace violence—or in replacing a nurse or someone else who can no longer work because of it—can run more than $100,000. ■

We're seeking experts

Contact me and let me know your areas of expertise and interests in publishing or training.

– AJ Plunkett, Editor
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Life safety

Update SOCs for off-campus buildings as TJC targets business occupancies

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

Be sure your facility electronic Statement of Conditions™ (eSOC) and Basic Building Information (eBBI) are up to date with accurate business occupancy information. Expect life safety (LS) surveyors to start inspecting many of your off-campus sites now that The Joint Commission (TJC) has a new LS section on business occupancies.

Starting with LS.01.05.10, the five new standards, with a total of 28 elements of performance (EP), were announced earlier this year and came into effect on July 1. However, TJC officials have been warning for years, including at last fall's national American Society for Health Care Engineering (ASHE) *conference*, that it was going to be adding days to the LS survey so surveyors could do inspections at business occupancies with healthcare components.

That could include such off-campus sites as ambulatory care clinics or buildings with physician offices that are included under the hospital Medicare certification number. It may also include any central utility plants shared by healthcare facilities and other buildings.

"Compliance with the *Life Safety Code® (LSC)* for off-site business occupancies is found in chapters 38 and 39, and healthcare organizations have always had to comply with these standards," says **Brad Keyes, CHSP,** founder of Keyes Life Safety Compliance and a former TJC LS surveyor.

The first new EP states that when such buildings undergo rehabilitation, the hospital must now incorporate LSC chapters 38 and 39, as well as Chapter 43, which is on building rehabilitation.

Expect LS surveyors to go into any building or area within a building where some type of activity takes place that touches patient care—such as a laboratory or laundry room that's in a separate building from the main hospital, or even a restaurant within the hospital that can serve patients food, said TJC officials at the ASHE conference.

While LS surveyors could always be called upon to survey sites away from the main hospital, the job in

recent years has often fallen to the nurse or physician surveyor, say accreditation consultants.

Those clinicians were often focused on other areas of the survey or not as conversant in Environment of Care or LS requirements and missed many problem areas.

You can no longer expect to slide through those problems now that LS surveyors will be on-site as well, say consultants.

Hospitals have always been required to include business occupancies in their SOC and BBI, notes **Steven A. MacArthur,** a senior consultant with The Greeley Company in Danvers, Massachusetts.

He pointed to a note in the overview for TJC's LS chapter that reads: "The first two standards, LS.01.01.01 and LS.01.02.01, apply to all occupancy types."

LS.01.01.01 requires that a hospital manage its physical environment to meet the *LSC* and includes, among other things, the requirement to maintain current BBI within the hospital's eSOC.

LS.01.02.01 requires hospitals to protect occupants when the LSC cannot be met or during construction.

Check with your business occupancies to ensure that any changes to the building are included and up-to-date in your SOC and BBI, advises MacArthur.

"One of the challenges facilities folks sometimes face is that it's typically the accreditation manager or other compliance person who is responsible for completing the application for survey, but if there are changes to care locations, the facilities folks don't always find out," he says.

"I've certainly seen instances of organizations being cited because they didn't have a completed eBBI entry for a care location—and it's usually because the facilities person didn't realize there had been a change," he says.

Also remember that LS surveyors will be looking for all the same things they always have under the EC chapters, notes **Ernest E. Allen, ARM, CSP, CPHRM, CHFM,** a former patient safety executive with The Doctors Company and now a life safety consultant with HealthTechS3.

For some tips on business occupancy compliance and common problems, see the article below.

Life safety

Beware these common problems with business occupancies

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

Update your inspection, testing, and maintenance documentation and check your exit signs when preparing to host life safety surveyors from The Joint Commission (TJC) at your business occupancies. (For more information on the new standards, see page 6.)

Effective July 1, there are five new standards with a total of 28 elements of performance (EP), starting at LS.01.05.10. They were announced earlier this year.

While TJC always had the option to survey business occupancies, this marks the first formal set of specific standards for those areas.

CMS has been pushing TJC and other accreditation organizations for years to get tougher on *Life Safety Code*® compliance on areas not part of the main hospital facility or campus, say consultants. This includes clinics, laboratories, and other buildings that touch on patient care like laundry rooms or central utility buildings.

Hospital Safety Leader asked three consultants—**Ernest E. Allen, ARM, CSP, CPHRM, CHFM; Brad Keyes, CHSP;** and **Steven A. MacArthur**—for what to expect on survey and common problems to look for as facility managers brush up on their business occupancy requirements.

Allen is a former patient safety executive with The Doctor's Company and now a life safety consultant with HealthTechS3. Keyes is founder of Keyes Life Safety Compliance. MacArthur is a senior consultant with The Greeley Company in Danvers, Massachusetts. All three have conducted mock surveys across the country and agreed to share their insights to help compliance managers get ready.

Q: Should hospitals be calculating their square footage with business occupancies?

In general, the square footage of healthcare occupancies counts only toward the total used to determine survey days, MacArthur says. But it is supposed to be part of your electronic Statement of Conditions™ (eSOC) and Basic Building Information (eBBI), as set out in the overview of the Life Safety chapter.

Remember also, says MacArthur, that you might be asked for life safety drawings for those business occupancies.

Q: What do surveyors usually look for in a business occupancy, and what are the most common citations or common mistakes?

"One of the most common questions I receive regarding compliance with the *Life Safety Code* at off-site business occupancies is, 'do we have to inspect, test, and maintain (ITM) the features of life safety at the same frequency as we do for the hospital?' And the answer is, for the most part yes," says Keyes.

"The requirements for ITM for fire alarm systems are found in NFPA 72-2010, and that applies to all occupancies. Similarly, the requirements for ITM for sprinkler systems are found in NFPA 25-2011, which also applies to all occupancies. Nearly the same can be said for all other features of life safety," says Keyes.

"One notable exception is NFPA 80-2010 regarding fire dampers, and NFPA 105-2010 regarding smoke dampers. The testing requirements for non-hospital locations of these devices is once every four years, rather than the once every six years for hospitals. Another difference is the frequency of fire drills."

Remember that when a surveyor tours an off-site business occupancy, they are looking for anything that is noncompliant, warns Keyes.

"The amount of time they spend at the location will typically reveal how many items they find noncompliant. For me, when I survey a business occupancy, I first look at the 'EXIT' signs and see where they lead me. In one facility, the 'EXIT' signs led me around in a circle and never did point the way to the egress," says Keyes. "That's a problem."

"Other obvious issues are locked doors in the means of egress, hazardous storage, and the movement of patients. Occasionally, I find the healthcare organization bringing inpatients into a business occupancy on gurneys for diagnostic or treatment purposes, which is a violation of the healthcare occupancy chapter," says Keyes.

"But it is important to remember that all of the features of life safety (i.e., fire alarm system, sprinkler system, fire dampers, medical gas system, generator, interim life safety measures, fire extinguishers, etc.) must be inspected, tested, and maintained the same way and frequency (with the exception of fire dampers) as they are at the hospital. And now, surveyors will be asking to look at your documentation for all of those ITM activities," says Keyes.

Allen says to pay attention to the business occupancy standards, which include "specific requirements for fire alarm systems being installed depending on the building size, number of floors, number of occupants, etc. For example, if a fire alarm system is installed, are pull stations by the egress doors? Hazardous storage areas are now required to be one-hour rated unless the building is sprinklered. The doors to hazardous storage rooms require door closures."

Remember also, says Allen, that "depending on the locations and building approval process of the state or city, requirements vary widely, and especially physician-owned practices recently purchased by the hospital frequently do not comply. The life safety surveyor will request inspection reports for fire alarm inspections including smoke detectors, sprinkler system reports," and emergency generator testing records, if the building is so equipped.

If the business occupancy has battery-powered lights, surveyors will also expect to examine documentation of the monthly and annual testing, notes Allen.

Common citations Allen has seen in business occupancies include the lack of testing of fire alarm and sprinkler systems. If the occupancy is in a rental space, "try to obtain copies from the building owner."

Also look for dead batteries for egress exit lighting, fire extinguishers not inspected, fire extinguishers blocked, and exits blocked, says Allen. ■

What does The Joint Commission say?

A frequently asked question (FAQ) on TJC's website asks whether a floor plan is required for business occupancies. TJC's response is that if the entire building meets the Life Safety Code® definition of a business occupancy, then "life safety drawings are not required. For mixed occupancy buildings where portions of the building are business occupancy, and other portions are either health care occupancy or ambulatory health care occupancy, life safety drawings are required for the whole building, including the sections that are business occupancy."

According to the same FAQ, noting that hospitals and ambulatory healthcare facilities are required under LS.01.01.01, element of performance 7, to have a Statement of Conditions™ (SOC) and maintain current Basic Building Information (BBI), TJC adds that "organizations that have free-standing business occupancy buildings shall list them in the SOC under 'Sites and Buildings.'"

Credentialing and privileging

Tips on compliance, querying with National Practitioner Data Bank

by Dom Nicastro, Credentialing Resource Center Journal

The National Practitioner Data Bank (NPDB) was created to help hospitals vet physicians and keep problem physicians from traveling from hospital to hospital. Hospitals are required to check the NPDB when they add a new physician to the medical staff.

According to its website, the NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to healthcare practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving between states without disclosure or discovery of previous damaging performance.

Keeping up with compliance

Medical staffs need to recognize their requirements and compliance expectations when it comes to the NPDB—they remain as strict as ever. During the COVID-19 pandemic, the U.S. Department of Health and Human Services (HHS) presented no waivers or relaxed compliance requirements surrounding NPDB reporting and querying like it did for many other credentialing and privileging regulations.

"There were so many things that changed during COVID, in terms of the law," says **Libby A. Snelson, Esq.,** legal counsel for the Medical Staff, PLLC, based in St. Paul, Minnesota. "So much changed on the state level and the federal level. There were all these emergency declarations that said doctors don't need to do that anymore, they can stretch their return, etc. What didn't change was National Practitioner Data Bank reporting requirements and querying requirements. State licensing requirements were put on ice, and all these other things were on hold, logically, because of the pandemic. I hope that no one is thinking that also the National Practitioner Data Bank reporting requirements changed, because they didn't."

For instance, Snelson says, healthcare facilities granting disaster privileges still need to check the NPDB. Credentialing specialists and hospitals may have been unaware of this if they were utilizing disaster privileges for the first time during the pandemic.

"A lot of these credentialing specialists maybe did not realize, having never used disaster privileging before with credentialing, that they had to check the Data Bank on all those volunteers that they were giving disaster privileges," Snelson says. "This may have slipped, and that's a concern."

Brush up on changes

The NPDB provides updates frequently throughout the year to clarify reporting and querying matters. The latest as of May 5, 2021, can found *here*.

Snelson says providers should also check on some important updates the NPDB made to its NPDB Guidebook in October of 2018, which according to its website, is the latest such update. The NPDB refers to the Guidebook as a nonfederal resource that provides additional information to consumers. The content and views of the Guidebook have not been formally approved by HHS or the Health Resources and Services Administration.

"They changed their narrative in October of 2018," Snelson says, "and what I'm still finding is that people are not aware of those changes because they weren't official changes to the regulations. It was so under the radar that people still don't know about some of the changes. They changed their Guidebook, which is not the statute or the regulation. It's a publication. But it does really expand the regulations."

The significant changes in 2018 came in Chapter E: Reports, under the section "Reporting Adverse Clinical Privileges Actions." The NPDB added a new subsection, "Length of Restrictions."

In part, the addition discussed the following:

- Entities must report clinical privilege actions to the NPDB if they result from a professional review action and last longer than 30 days. "A professional review action that adversely affects the clinical privileges of a physician or dentist for longer than 30 days" shall be reported. The NPDB has consistently interpreted "adversely affects" to mean the impact of the restriction, not the manner in which the restriction is written.
- A healthcare entity may choose to structure a restriction based on when a healthcare practitioner demonstrates clinical competence, rather than attaching a specific time frame to the action. A significant percentage of clinical privileging actions are reported to the NPDB as "indefinite" in length, placing the

responsibility on the practitioner to demonstrate to the entity that the practitioner no longer needs the restriction. If such an adverse action is in effect for more than 30 days, it must be reported.

- With the exception of summary suspensions, which may be reported whenever a summary suspension is expected to last more than 30 days, a restriction begins at the time a physician cannot practice the full scope of their privileges and is reportable to the NPDB once that restriction has been in place for 31 days.

Updated Q&As

The *NPDB* also updated its Q&As, which can be really illustrative of some of the bigger chasms in the NPDB, according to Snelson. The October 2018 changes revealed different and more broad interpretations, and almost all of them were related to the requirement of making an NDPB report when a physician surrenders privileges while under investigation.

"That's always been there. That's in the statute," Snelson says. "But what they did in the Q&A was expand what a surrender is and expand what an investigation is. And one of the examples they use is about a quality improvement plan, which at that time was a fairly new development in how we take care of physicians: Where we see that there are problems, we institute a quality improvement plan."

Those quality improvement plans detail to the physician how the organization will work with them to improve. If you're developing a quality improvement plan, you're not investigating. You're improving, right? But it could end up being a report to the NPDB, Snelson cautions.

The requirement of reporting for physicians under investigation was not really new, says **Kathy Matzka, CPMSM, CPCS, FMSP**. It just set forth new guidelines for investigations.

"Some hospital bylaws included definitions of what was considered an 'investigation' that were crafted in such a way as to avoid reporting to the Data Bank," Matzka says. "The guidelines clarified what is meant in the regulation by the term 'investigation' and clarified that the definition of 'investigation' is not controlled by how that term is defined in the healthcare entity's bylaws or policies and procedures."

Details matter

For medical staffs, using the NPDB is a matter of two actions: reporting and querying. Most MSPs are very familiar with the query process, but reporting is by far more challenging, according to Matzka.

"What is put in that report will follow the practitioner for the rest of their career," Matzka says. "It is essential that the report is factual, and that [it] includes enough information so that those who query can know what the peer review action entailed."

It is a good idea to have legal counsel draft the report to the NPDB. MSPs should keep in mind that the reported practitioner will be reviewing the information submitted prior to the NPDB updating its records. The practitioner may dispute what is reported, Matzka notes, and may try to get the hospital to change the report.

MSPs should be ready for this dispute, and there should be a plan for referring the physician to the appropriate person for follow-up should the physician contact the medical staff services department, she says.

"Keeping legal counsel on board is a definite plus," Matzka says. "This will help allay the fears and concerns of the medical staff. It is a legal issue, and legal counsel is an important part of it. Many physicians on a peer review committee are afraid to take action against a practitioner because they are concerned about that practitioner taking legal action against them for taking a peer review action."

Although there are protections built in to the Health Care Quality Improvement Act of 1986 (HCQIA) for those conducting good faith peer review, there is always the chance that a practitioner who is the subject of a peer review action may try to take legal action against those who restricted the privileges, according to Matzka.

"I once knew of a physician whose privileges were terminated for good cause, and he sued everyone on the medical executive committee, the hospital CEO, the medical director, the hospital governing board members, and the department chair," Matzka says. "It was many years—and many dollars—before these lawsuits were done."

It is also important for the MSP to remember that the law requires reports go to the state licensing agency as well as the NPDB. Since clinical privileging actions are reportable once they are made final, Matzka adds, there needs to be a clear delineation of when the action becomes final.

Policies vs. bylaws

Organizations may think it is a good idea to document their NPDB-related processes in their bylaws, so

physicians and medical staff alike have a clear understanding of what gets reported and what doesn't. However, Matzka does not believe the bylaws are the best place for this information. A policy and procedure is a better option, she says.

"The bylaws can include a general statement that the hospital will query and report as required by HCQIA," Matzka says. "I have seen bylaws include provisions for things that are not reportable. For example, if someone requests a leave of absence and does not subsequently request that medical staff appointment and privileges be reinstated, and therefore privileges and medical staff appointments are automatically terminated, the bylaws may reflect that this is not reportable."

Checking for all practitioners

Querying the NPDB is ultimately an important step in credentialing practitioners beyond just new physicians and dentists. Since healthcare entities have the ability to report not only physicians but also other practitioners who have been granted clinical privileges, it is important to check the NPDB for other licensed independent practitioners as well, Matzka adds.

Although not required, hospitals and other healthcare entities should consider enrolling their practitioners in the NPDB's Continuous Query option. This allows the facility to receive email notifications within 24 hours of a report received by the NPDB. Hospitals need to also have a policy in place to evaluate NPDB reports when they become available, according to Matzka.

"If the hospital was notified of the report, there needs to be a mechanism for reviewing that report and making a determination as to whether or not the report reflects a potential issue with patient care or safety," she says. "For example, if it is a medical malpractice case that finalizes and is reported to the Data Bank, [there] should be a mechanism for reviewing the outcome of a case. If it is a hospital privileging action from another facility or licensure disciplinary action, then the medical staff needs to determine how that is going to affect the privileges of that practitioner at that hospital."

Remember, the NPDB is by no means a black-and-white matter when it comes to bringing physicians on board, according to Snelson. What gets reported varies greatly, she adds, from hospital to hospital. ■

Dom Nicastro is a freelance writer for the Credentialing Resource Center Journal, a Simplify Compliance publishing partner which originally published this article.

ICYMI

COVID-19 vaccines: CDC asks hospitals to offer shots at discharge

In case you missed it, here's a roundup of breaking news items posted on the Accreditation & Quality Compliance Center since Inside Accreditation & Quality *was last published.*

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

Include COVID-19 vaccination status as part of your emergency room triage and medical history, and educate clinicians on how to address vaccine hesitancy.

The CDC is encouraging hospitals and urgent care centers to step up outreach to vulnerable patient populations by offering COVID-19 vaccinations to patients at discharge from emergency departments (ED).

The agency is also asking jurisdictions to allocate portions of their vaccine supplies to hospitals and urgent care centers to carry out the effort. However, jurisdictions will not be provided extra vaccine doses, according to a CDC *fact sheet*.

In its weekly summary, the CDC noted that "EDs serve as the primary healthcare access point for up to a fifth of the U.S. population and UCs account for up to 29% of all primary care visits. These settings are therefore important access points for people who have not yet been vaccinated."

The call comes on the heels of *news that COVID-19 cases are no longer declining* across the United States as severe variants of the novel coronavirus begin to take hold.

The CDC told providers "*we are asking you to promote this effort* as an important way to protect the communities you serve and to encourage them to participate in vaccinating patients upon discharge if they are not already doing so. Please also help to spread the word that facilities interested in becoming a COVID-19 vaccine provider should reach out to the health department or visit *How to Enroll as a COVID-19 Vaccination Provider | CDC* for more information."

After establishing efforts to increase vaccinations upon discharge from EDs, the CDC is encouraging hospitals to "expand COVID-19 vaccination efforts at discharge to all hospital departments," according to the fact sheet, which the American Hospital Association (AHA) says it helped to develop.

The AHA noted in a *news update* that the CDC's latest effort is "is meant to reach unvaccinated individuals at their primary point of healthcare. CDC stressed that there is no special allocation channel for this program; jurisdictions would use already-received inventory."

"Providers are *encouraged to enroll* to become COVID-19 vaccinators, which will enable them to legally store, handle, and administer the vaccines to patients," noted the AHA.

The fact sheet includes a list of best practices for facilities, including assessing vaccination status at triage and as part of the medical history, and addressing vaccine hesitancy.

The fact sheet notes that EDs and urgent care centers can bill a patient's insurance for administration of the COVID-19 vaccine but as a separate service from the reason for the patient's visit. "Patients cannot be charged directly for the vaccine administration fee if they do not have health insurance and *cannot be denied vaccination because of a lack of insurance*," according to the fact sheet. ■

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