

Inside the Joint Commission

Independent news and guidance to ensure rigorous compliance and accreditation excellence

October 15, 2018 | Volume 23, Issue 20

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CMS

Increased oversight means even more pressure on AOs to ID problems

Expect CMS to continue to put pressure on The Joint Commission (TJC) and other accrediting organizations (AO) to find more of the serious fire safety and infection control issues the federal agency says they are still missing during surveys.

Also, you may find CMS surveyors showing up soon with your AO team. But they won't be there to watch you. They're going to be watching the watchers, as a part of a pilot program that could potentially end the 60-day validation survey process.

(see *AOs*, p. 5)

CMS

Alert public relations teams: CMS making deficiency reports more accessible

Hospitals may find themselves directly in the line of fire as CMS ramps up its oversight of The Joint Commission (TJC) and other accrediting organizations (AO).

CMS wants to put a stronger spotlight on times when TJC and other AOs fail to find patient safety problems later discovered by CMS survey teams conducting performance checks referred to as validation surveys.

To do so, CMS has created a website that provides a graphic about the disparity rate of deficiencies found on validation surveys and then posts deficiency reports from hospitals it

(see *Online reports*, p. 6)

Survey Success: A Hospital Guide to Mock Surveys



Gets your entire team ready for survey with this workbook, which breaks down the latest CMS standards into a mock survey checklist format and guides you through practice tracers throughout your organization. It includes tools to train chapter leaders and checklists for departments. Information:

<http://hcmarketplace.com/survey-success>

*Infection control***Guest column: Take new look at all patient care with eye to stop HAIs**

Healthcare organizations are feeling the repercussions of noncompliance when it comes to infection prevention. For several years now, the most cited clinical standard in hospitals, critical access hospitals, and ambulatory healthcare by The Joint Commission has been:

IC.02.02.01: *The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.*

According to The Joint Commission, the most common reasons for noncompliance include:

- Not following current, nationally accepted, evidence-based guidelines and manufacturers' instructions for use
- Orientation, training, and assessments of staff competency not conducted by an individual qualified to do so
 - Lack of quality assurance process
 - Lack of collaboration with infection prevention professionals
 - No pre-cleaning at point of use
 - Recordkeeping: Incomprehensible or non-standardized logs, incomplete documentation, and lack of bidirectional tracing of scopes and/or surgical instruments

- Inconsistent processes in performing high-level disinfection and sterilization such as handling, transporting, and cleaning reusable instruments

As infection prevention challenges evolve—such as emerging infectious organisms and resistance—healthcare organizations must focus on preventing hospital-acquired infections and ensuring better patient outcomes. To achieve these goals, infection prevention professionals must be involved in all decisions affecting the delivery of patient care. Healthcare is ever-changing, and innovative approaches are critical as we look to the future of infection prevention.

On the surface

As innovative technology is developed and new processes are implemented to prevent hospital-acquired infections (HAI), infection prevention professionals need support from leadership, as well as a strong collaboration with all service lines.

When conducting infection prevention and control risk assessments, hospitals may consider the following innovative techniques for preventing HAIs:

- Implement “no touch” systems that use UVA light or hydrogen peroxide mist to disinfect patient care areas
- Use disinfecting wipes that change color indicating when contact time is met and surfaces are completely covered to effectively kill microorganisms

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Editor:

A.J. Plunkett, x6001
aplunkett@decisionhealth.com

Content Manager

Jay Kumar, 978-624-4560
jkumar@blf.com

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- Implement continuous visible light technology in patient care areas
 - When possible, use disposable non-critical, semi-critical, and critical devices instead of reprocessing these types of devices
 - Implement a central surveillance program for infection control programs
 - Implement quality checks at established intervals (adenosine triphosphate bioluminescence, chemical reagent tests)

In addition to the above innovative techniques, robust collaboration among infection prevention, nursing, environment of care, and leadership is imperative to effectively monitor quality assurance and minimize the potential risks of infection transmission.

Emerging pathogen: *Candida auris*

There is a new *Candida* species, and it is a multi-drug-resistant organism: *Candida auris*.

C. auris presents new challenges, as it is often misidentified, is resistant to antifungal drugs, can cause rapid outbreaks in healthcare settings, and is emerging globally.

Numerous challenges exist in implementing measures to reduce the transmission of *C. auris*, including hand hygiene noncompliance, standard precautions and transmission-based precautions noncompliance, inconsistent cleaning of surfaces and medical equipment, and ineffective interfacility communication (handoffs).

Current CDC recommendations to prevent the spread of *C. auris* focus on proper prevention practices and the importance of communication, specifically:

- Ensuring contact precautions with a private patient room
- Reinforcing hand hygiene
- Daily and terminal cleaning of the room and equipment using EPA-registered, bleach-based disinfectants that are also active against *C. difficile*
- Ensuring notification of *C. auris* status upon handoff and facility transfer

Healthcare professionals need to collaborate with infection prevention and proactively educate staff and implement processes to reduce the spread of infection. The healthcare professionals closest to the patient can make the biggest impact in reducing HAIs by providing education to patients, families, and visitors. Routine

infection prevention education and training are necessary for success.

Innovative approaches in surveillance

Centralized infection surveillance programs change infection control surveillance radically by removing the sole burden of surveillance responsibility from the infection prevention professional. Many organizations struggle with accuracy of infection prevention data due to lack of standardization in HAI surveillance, no leadership oversight of HAI event determination or mandatory reporting, and inadequate National Healthcare Safety Network (NHSN) training among auditors.

The CDC and CMS require that the following infections be reported to NHSN:

- Infections meeting specified NHSN criteria
- Requirements by CMS for incentive payments or public reporting purposes

Infection definitions and criteria are needed to ensure accuracy, completeness, and comparability of infection information. Centralized surveillance staff would be responsible for staying current on NHSN updates and criteria changes and regularly updating infection prevention professionals on these changes.

Standardized surveillance, identification, and reporting of central line–associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections improves accuracy and decreases errors, which results in improved patient outcomes and reduced financial risks for organizations.

Steps to successfully implement a centralized surveillance program should include the following:

- Develop current and future state process mapping
- Review and update NHSN mapped locations
- Develop a standardized process for HAI event review
- Develop standardized HAI collection forms
- Develop standardized scripts for HAI event communication
- Develop schedules and responsibilities of required data entry
- Develop definitions for accurate ADT data (inpatient vs. outpatient, date of admission)

Infection prevention professionals commonly wear many hats; having a centralized infection surveillance program

with well-trained individuals to perform surveillance improves efficiency and provides more accurate and reliable data. Furthermore, such a program allows infection prevention professionals to do what they do best: prevention.

Midline catheter HAI surveillance

As we focus on the future, we can't forget midline catheter HAI surveillance. Midlines — for example, peripherally inserted central catheters—have been reported to decrease CLABSI rates, but few organizations have assessed the incidence of midline catheter — associated bloodstream infections. New York Presbyterian Hospital System conducted a study on the incidence of midline catheter — associated bloodstream infections in five acute care hospitals and determined that the incidence of these infections is not significantly lower than CLABSI incidence.

Future work is needed to evaluate the association between midline catheter use and central line utilization and CLABSI rates. Hospitals using midline catheters should consider including midline catheter-associated bloodstream infection surveillance as part of an overall vascular access safety program.

(Guest column by Lena Browning, MHA, BSN, RN, a consultant with Compass Clinical Consulting, in Covington, Kentucky. This column originally appeared in IJC's partner publication, Briefings on Accreditation and Quality.)

Resources

- ▶ CDC recommendations on controlling *Candida auris*: <https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html>
- ▶ American Journal of Infection Control, "Incidence of Midline Catheter-Associated Bloodstream Infections in Five Acute Care Hospitals:" [https://www.ajicjournal.org/article/S0196-6553\(18\)30252-9/fulltext](https://www.ajicjournal.org/article/S0196-6553(18)30252-9/fulltext)

Workplace violence

Review policies, environment as assaults against ER staff rise

Violence against ER physicians is pervasive and increasing, research released this month shows.

In a survey conducted for the American College of Emergency Physicians (ACEP), a majority of the 3,539 doctors polled said they had been the victims of workplace violence recently. About 62% of ER physicians reported being assaulted in the past year, with 24% saying they had been assaulted two to five times.

"The main point is this is a problem that is real, it is increasing, and unfortunately the results of this poll will not surprise any practicing physician," **Vidor Friedman, MD, ACEP** president-elect and an ER physician in Florida, said during a press conference October 2.

The press conference focused on research findings, solutions for violence in ERs, and the impact on patients who witness acts of violence.

In addition to the survey, "ACEP Emergency Department Violence Poll Research Results," unpublished research unveiled showed a significant increase in ER violence in Michigan.

The Michigan research compares survey data from 2005 and 2018. In 2005, about 28% of ER physicians surveyed said some form of violence had been perpetrated against them in the past year. In 2018, the figure had risen to 38% of ER physicians.

Physicians are not the only emergency department personnel enduring violent encounters, the lead author of the Michigan research said during the ACEP press conference.

"Every job title had violence perpetrated against them. What we found is that the time you spend with the patient increases the chance that violence will be perpetrated against you," said **Terry Kowalenko, MD**, chair of emergency medicine at Beaumont Hospitals in Dearborn, Michigan.

Key findings

The ACEP survey features several key findings:

- 71% of ER physicians reported witnessing an assault at work
 - 97% of assailants were patients
 - The most common administrative and security responses to physical assaults were to place a behavioral flag in the patient's medical chart (28%) or to have the patient arrested (21%)
 - 27% of ER physicians reported sustaining an injury from a workplace assault
 - The top five kinds of physical assaults were hit or slap (44%), spit (30%), punch (28%), kick (27%), and scratch (17%)
 - About 80% of ER physicians reported that workplace violence reduces staff productivity, increases emotional trauma, and extends wait times

- The Number One suggestion (49%) to address ER violence was increasing security
- 69% of ER physicians reported that workplace violence has increased over the past five years

Solving the problem

Kowalenko said there are four approaches to addressing violence in emergency departments: hospital policies, environment changes, staff education, and legal.

- Policies related to violence in the ER should be clear and consistently enforced. This approach applies to policies that may seem indirectly related to violence such as rules governing how many visitors can see a patient at one time.
- Environmental factors include security, cameras, and “badging” in and out of an ER’s treatment area.
- Education of staff should not be limited to reacting to violent situations. Training should include identifying potentially violent patients and strategies to defuse potentially violent situations.
- More than two dozen states have adopted laws that make assaulting a healthcare worker a felony. These laws make assaulting a healthcare worker equivalent to assaulting a police officer.

Friedman said ER physicians and other staff members should consider pressing charges after a patient assaults them.

“Healthcare workers underreport violence because we want to take care of people. We don’t want to create more of a problem when one already exists, but we are enabling the problem to a certain extent,” he said.

Impact on patients

In the ACEP survey, 77% of ER physicians reported that emergency department violence undermines patient care.

Patient care suffers when there is violence in an emergency department, Friedman said.

“Emergency room patients can be traumatized to the point where they leave without being seen or treated because they were exposed to acts of violence. It also increases wait times and distracts physicians and nurses from the other patients in the emergency department who need their care,” he said. — *Christopher Cheney* (ijc_editors@decisionhealth.com)

(Christopher Cheney is the senior clinical care editor at HealthLeaders, a partner publication with Inside the Joint Commission.)

Resource

- ▶ ACEP study, “Violence in Emergency Departments Is Increasing, Harming Patients, New Research Finds.” <http://newsroom.acep.org/2018-10-02-Violence-in-Emergency-Departments-Is-Increasing-Harming-Patients-New-Research-Finds>

AOs

(continued from p. 1)

In a new report to Congress, CMS says the disparity rate between serious problems identified by the AOs at hospitals and those found by CMS surveyors within 60 days of survey was 46% in fiscal year 2016, up from 38% and 39%, respectively, in the two preceding fiscal years.

Most of those disparities were in infection control and physical environment, which includes fire safety violations.

Fiscal year 2016 began on October 1, 2015, and ended September 30, 2016, about a month before CMS began enforcing compliance with the 2012 editions of the NFPA 101 *Life Safety Code*® (LSC) and NFPA 99 Health Care Facilities Code on November 1, 2016.

Both fire codes were adopted by CMS in June 2016 after more than a decade of requiring hospitals to adhere to the 2000 version of the LSC. Although long warned that the change was coming, many hospitals scrambled to play catch-up to the new requirements, as did AOs that had to update standards.

Report required by Congress

CMS is required by regulation to evaluate how its approved AOs do their jobs and must report to Congress every year. After last year’s report was highly critical of AO performance, TJC and other AOs stepped up their efforts to find problems and are likely to do so again, say consultants (*IJC 8/7/17*).

In addition, the Senate Energy and Commerce committee earlier this year announced it was seeking answers from each of the hospital AOs about patient safety (*IJC 3/26/18*).

CMS evaluates AOs based on their ability to meet certain quality measures, including providing information back to CMS on problems found at hospitals in a timely fashion, and by conducting what it calls validation surveys in which CMS inspectors conduct a second survey within 60 days of an AO survey.

In those validation surveys, CMS state survey agency inspectors look for any problems in which a hospital fails to meet federal *Conditions of Participation*, which allows the facilities to bill Medicare. CMS assumes those condition-level problems were present during the AOs survey, and that is marked against the AO as a missed deficiency.

Consultants and others have noted that the practice of doing validation surveys as long as 60 days after an AO visit is unfair because the condition-level problem identified later might not have existed when AO teams were on site.

Double survey may be eliminated

On October 4, CMS announced several changes it says will make hospital patient safety and accountability more transparent for the public, including posting deficiency reports online for hospitals where it identifies condition-level problems (*see p. 1*).

In addition, CMS is launching a test project to directly observe AO surveyors on site as they work instead of conducting a follow-up validation survey within 60 days.

“Direct observation will enable CMS not only to evaluate AO performance more effectively, but also to suggest improvements and address concerns with AOs immediately. This approach will relieve providers from having to undergo the burden of a state’s follow-up assessment,” said CMS, in announcing the pilot project.

“CMS will also analyze and incorporate State complaint investigations of accredited facilities as part of the agency’s strengthened validation program. This work will focus on identifying and monitoring accredited facilities that are out of compliance with Medicare health and safety requirements. CMS will use this information as an additional indicator of AO performance,” said the CMS announcement.

In the meantime, the validation surveys and disparities found continue to dominate the report to Congress.

CMS says it conducted 98 validation surveys in fiscal 2016, behind AO surveys at 3,448 hospitals. The top three condition-level deficiencies identified by CMS

in fiscal 2016, were Physical Environment, Infection Control, and Governing Body.

LSC problems are typically cited under Physical Environment, with the top LSC problems identified with fire and smoke barriers, hazardous areas, sprinklers, and doors, according to the report to Congress. — *A.J. Plunkett* (aplunkett@h3.group)

Resource

- ▶ CMS memo QSO: 19-01-AO/CLIA, FY 2017 Report to Congress: Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program: <https://tinyurl.com/CMS-AO-rpt2Congress-2017>

Online reports

(continued from p. 1)

says have “recent substantial deficient practices.” The reports can be searched according to AO or by state.

The database also notes if the patient safety problems government surveyors found posed an immediate jeopardy to patients. A ruling of immediate jeopardy threatens the hospital’s ability to bill Medicare and, in many cases, to stay in operation.

Website posts deficiency information

This new CMS website provides the summarized “Statement of Deficiencies and Plan of Correction” for each hospital, with this notation: “This website lists all hospitals who were found to be substantially out of compliance during a State Survey Agency survey in the last six months and provides the survey report for public review.”

The website states at the top of the page for each AO the number of hospitals the AO accredits, and the percentage of those where CMS found a “substantial deficiency in the last six months.”

For instance, the top of the webpage for TJC says: “The Joint Commission deems 3993 Hospitals. CMS cited 1.7% of them for a Substantial Deficiency in the last six months.”

The implication is that the reports show the critical patient safety problems that AOs missed but CMS later found on the validation surveys done within 60 days of the AO visits.

However, the reports posted are not from the validation surveys, but from complaint surveys, according to

a CMS Quality, Safety and Oversight Group memo to its state survey agencies. The memo, **QSO: 19-01-AO/CLIA**, also includes CMS latest report to Congress on AO performance (*for more on the report, see 1.*)

CMS inspections done following a complaint can happen at any time. And each of the AOs also can revisit hospitals in response to complaints.

CMS seeks more transparency

The report to Congress focuses on several AO performance measures, including the disparities found on validation surveys.

Accreditation consultants and other compliance experts note that because CMS validation surveys can be done several weeks after an AO survey, the deficiencies CMS finds may or may not have existed at the time of the initial survey.

CMS officials have also complained that deficiencies they found were critical enough for surveyors to rule immediate jeopardy, yet the AO’s online list of accredited facilities still showed the hospital fully accredited.

Earlier this summer, TJC updated its Accreditation Participation Requirements to specifically state that hospitals that use TJC for accreditation must notify the commission “immediately upon receiving notice from the Centers for Medicare & Medicaid Services (CMS) that its deemed status has been removed due to Medicare condition-level noncompliance identified during a recent CMS complaint or validation survey.”

The website currently offers only information on hospitals and the four organizations approved to accredit hospitals: TJC, the Healthcare Facilities Accreditation Program (HFAP), DNV GL Healthcare (DNV), and the Center for Improvement in Healthcare Quality (CIHQ). (HFAP is listed on the site as the American Osteopathic Association, which was the original AO for osteopathic hospitals when Medicare was created in the 1960s. HFAP has since expanded to accredit all hospitals.)

CMS says the creation of the website and other moves are part of an effort to intensify oversight of the AOs, to making hospitals safer and the accreditation process more transparent.

While the details of CMS deficiency reports on hospitals have been publicly available for a number of years, they were difficult to find on CMS’ website and were in a hard-to-read spreadsheet. The Association for Health Care Journalists worked with CMS to get the information in a searchable format that it now posts online at HospitalInspections.org.

However, those reports were only of CMS surveys at hospitals where government surveyors from CMS State Survey Agencies (SSA) were investigating a complaint. It does not have reports on routine surveys or validation surveys, and did not offer the hospital’s response to findings. Those responses, called plans of correction, were available through public information requests from the SSAs, if not posted online by the states themselves.

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PAS 2018

Alert public relations team

With the new website, the CMS deficiency reports are much easier to find and to read, note accreditation experts. Which means that hospitals should be prepared for the public relations ramifications.

“Hospitals should be concerned because this data is easier to read than other formats CMS already had publicly posted,” says **Kurt Patton**, who served as TJC’s director of accreditation services before starting his own compliance consulting company, Patton Healthcare Consulting.

“This is fast and easy to find the hospitals in any individual state,” he says. “Consumers might read it, and attorneys who have litigation planned or pending might read it. Hospitals should be prepared with a communications strategy for each state survey report at the same time as they are working on their Plan of Correction. It appears that as soon as the POC is accepted this may be posted.” Patton notes that some September data is already available on the site.

Hospitals already face funding challenges to meet fire code requirements after CMS finally adopted the 2012 NFPA *Life Safety Code*®, and it will get even worse as survey scrutiny increases, predicts **Ernest E. Allen**, a former TJC surveyor and current consultant and patient safety executive with The Doctor’s Company in Columbus, Ohio.

Having the survey findings on the Internet “could result in public relations issues for the facility,” says Allen. But compliance officers might be able to use that to their advantage. “That is the argument I would use when asking for more funding” to meet requirements, he added.

“Additional staff and funds to replace any deficiencies as quickly as possible will be needed,” says Allen.

While the reports will be more accessible to the public, it is important to remember that the information was always available, notes **Frank Ruelas**, a facility compliance professional at St. Joseph’s Hospital and Medical Center Dignity Health in Phoenix.

Arizona, for instance, posts the same information for its hospitals, as do many states through their health or licensing agencies, he says.

Making the information more accessible and AOs more accountable could ultimately be positive for hospitals, because it means that all the AOs are coming

more in line with CMS expectations, says Ruelas. That means that any requirements that exceeded CMS regulations could be eased.

Validation surveys to also change

In announcing the website, CMS also said it is changing how it will conduct validation surveys.

Instead of waiting until after an AO finishes its survey to do a follow-up survey, CMS inspectors will now show up at the same time and watch as the AO surveyors work.

CMS says the new process will be more effective.

“Historically, CMS has measured the effectiveness of AOs by choosing a sample of facilities, performing state-conducted assessment surveys within 60 days following AO surveys, and comparing results of the state surveys with the AO surveys,” according to the CMS announcement.

“In a pilot test, CMS will eliminate the second state-conducted validation survey and instead use direct observation during the original AO-run survey to evaluate AOs’ ability to assess compliance with CMS’s *Conditions of Participation*,” said CMS.

“Today, the public relies on accreditation status as a way to gauge providers’ and suppliers’ quality of care. By posting more detail — accredited hospitals’ complaint surveys, out-of-compliance information, and performance data for AOs themselves — CMS will offer the public more nuanced information than accreditation status alone provides. The agency is currently prohibited by law from disclosing the actual surveys done by AOs, except for surveys of home health agencies and surveys related to an enforcement action.”

CMS discussed in more detail its efforts to intensify scrutiny of AOs in its latest report to Congress on AO performance, released on October 4. — *A.J. Plunkett* (aplunkett@h3.group)

Resources

- ▶ Quality, Certification and Oversight Reports (hospitals only): https://qcor.cms.gov/hosp_cop/HospitalCOPs.html
- ▶ QSO: 19-01-AO/CLIA, FY 2017 Report to Congress: Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program: <https://tinyurl.com/CMS-AO-rpt2Congress-2017>

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