



The **2012** CMS–Joint Commission **CROSSWALK**

A Side-by-Side Analysis of the
CMS Conditions of Participation and
the Joint Commission Standards

Cheryl A. Niespodziani, MBA

Beth A. Hepola, MBA, BSN, RN



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The 2012 CMS-Joint Commission Crosswalk: A Side-by-Side Analysis of the CMS Conditions of Participation and the Joint Commission Standards is published by HCPro, Inc.

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ISBN: 978-1-60146-915-1

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INTRODUCTION

Anyone involved in healthcare—from CEOs to frontline staff—dreads hearing, “We’re here to do an unannounced site visit of your facility.” On any day of the week, unexpected surveyors who say these words can cause anxiety, stress, and anguish in even the best-run organizations.

Such surveys will determine whether your healthcare facility meets regulatory requirements, of which there are several sets. These sets of requirements have evolved over the past 20 years, but the theme of change remains constant. Both the Centers for Medicare & Medicaid Services (CMS) and The Joint Commission (TJC) have continued to make changes to their requirements.

One thing that has not changed is that CMS and TJC both regulate the administration of care—that is, they both regulate the same aspect of healthcare. And most facilities can’t or don’t choose to follow one or the other. Healthcare organizations must meet federal requirements outlined by CMS called *Conditions of Participation (CoP)* if they want to receive Medicare or Medicaid reimbursement for services. In addition, most hospitals and healthcare systems participate in a voluntary survey process through the TJC. During such surveys, both the hospital and the regulatory/accrediting agency surveying the facility want to demonstrate that the organization meets the necessary requirements for compliance. They do this primarily through document review, interviews with leaders and staff, observations, and tracer methodology.

To keep up in this fast-changing environment, organizations must maintain a constant state of readiness and ongoing compliance. Doing so can seem overwhelming when you have two different surveys for which to be ready, but healthcare facilities do not necessarily need to prepare different documents or different processes to meet the CMS and TJC standards.

To help healthcare organizations maintain preparation for both surveys, this book outlines, or crosswalks, the CMS *CoP* and TJC standards and elements of performance (EP). Its goal is to provide a tool to help organizations understand the requirements, see the similarities as well as differences between the requirements, and identify the documents or processes that are already in place so that they can prepare for one or both surveys without duplicating efforts.

Beginning in January 2009, the TJC accreditation decisions are categorized based on criticality of findings. Accreditation decisions are defined as follows (most critical to least): Immediate Threat to Life, Situational Decision Rules, Direct Impact Requirements, and Indirect Impact Requirements. Immediacy of risk to patient care impacts the timeline allowed for resolution of noncompliant findings. Additionally, the accreditation decision methodology changed, eliminating “thresholds” as determinants of the accreditation decision. Thresholds are replaced by screens based on the number of less-than-fully-compliant direct impact standards, and the screens are adjusted based on size and complexity of the organization. Based on the results of a TJC survey, an organization will now fall under one of six accreditation decision categories:

1. Preliminary Accreditation (PA)
2. Accredited (A)
3. Accreditation with Follow-Up Survey (AFS)

Introduction

4. Contingent Accreditation (CONT)
5. Preliminary Denial of Accreditation (PDA)
6. Denial of Accreditation (DA)

The Joint Commission's Central Office will always review reports where PDA, CONT, or AFS decision rules triggered those decision categories. TJC's Standards Interpretation Group can also review decisions when unusual issues arise, such as a potential CMS Condition-level deficiency, a possible annual performance report (APR) noncompliance issue, or other unique circumstances that were not resolved during survey.

Another important understanding is the TJC survey cycles can occur from 18–36 months. Strategic Surveillance System (S3) scores are reportedly one determinant of how soon the accreditation survey recurs. It has been projected that those organizations with higher scores will be surveyed earlier; however, upper limits for earlier accreditation cycles are not known.

The crosswalk is arranged in a tabular format. The first column outlines the CMS *CoP*, which were taken from the *State Operations Manual, Appendix A – Survey Protocol, Regulations, and Interpretative Guidelines for Hospitals* (Rev. 47 issued 6-5-09, revised 2011).

The second column details the corresponding 2012 version of the TJC hospital standards and EPs. Many CMS-inspired changes have been incorporated, including standards and EPs that are specific to deemed accreditation. One important note is that, due to copy-right protection, we have modified the TJC standards statements; however, the standard numbers and EPs remain the same.

The last column provides a brief summary or analysis of the similarities and differences between CMS and TJC requirements. This section also includes other tips and recommendations for helpful documents to have available where applicable.

The 2012 crosswalk incorporates some additional features including:

- A CD-ROM with the updated *CoP* interpretative guidelines and survey procedures. Major changes are under the Patient Rights (482.13), Medical Staff (482.22), and Anesthesia Services (482.52) sections.
- Appendix A: TJC-CMS crosswalk.
 - Ties CMS *CoP* to each of TJC standards as applicable
- Appendix B: Tabular summary of what changed for 2011 and what's new for 2012, including recommended actions. Highlights of those changes include:
 - Patient visitation rights
 - Telemedicine services
 - Anesthesia guidelines
- Appendix C: Types of surveys by both CMS and the TJC
 - Brief explanations of the various kinds of surveys

- Appendix D: Plans of correction (POC)/action plans
 - Questions to be addressed in a POC
 - Examples of a complete POC/action plan

These tools, together with a searchable PDF file of the CMS-TJC crosswalk, can be placed on computer desktops for easy electronic access.

Despite the continuing changes, the fact remains that all healthcare organizations will undergo some type of survey at some point in time. The key is to understand and educate staff about the changes and at the same time remain flexible to manage the changes and processes. Many similarities still exist between CMS and the TJC. Hopefully, by understanding these similarities, ongoing survey preparation can be efficient and can help your organization achieve excellent results. After all, the goal of all participants—the hospital, the regulatory agency, and the patient—is high-quality care and service that meets and exceeds standards and expectations.

CMS CoP (v2011)**The Joint Commission
Hospital Standards (v2012)****§ 482.11 CoP:
Compliance with Federal, State,
and Local Laws (A-0020)****Emergency Management (EM), Leadership (LD),
Management of Human Resources (HR),
Medical Staff (MS)**

- a. The hospital must be in compliance with applicable Federal laws related to the health and safety of patients. (A-0021)
- b. The hospital must be (1) Licensed; or (2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals. (A-0022)
- c. The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. (A-0023)

EM.02.02.11, EP1–9: In order to provide patient care during a disaster, procedures to grant disaster privileges to volunteer LIPs and then assign and oversee care of those volunteer LIPs will be developed

EM.02.02.15, EP1–9: In order to provide patient care during a disaster, procedures for assigning and overseeing non-LIP volunteer practitioners who are required by law and regulation to have a license, certification, or registration will be developed

HR.01.02.05, EP1–7, 10–15, 16, 18: Verification of licensure/certification/registration, credentials, education, criminal background check, and health screen is done

LD.04.01.01, EP1–3, 16–18: Compliance with applicable laws/regulations is required

MS.06.01.03, EP1–6, 7, 9: When processing applications and verifying credentials, the organized medical staff's defined process to verify practitioner identity, collect current licensure status, training, experience, competence, and ability to perform the requested privilege is followed within the specified time frames and as defined by the medical staff bylaws

MS.06.01.05, EP1–12: Objective, evidence-based criteria and decisions are used to grant or deny a privilege(s) and/or renew existing privilege(s)

§482.11 (a–c) CoP Analysis/Guidelines

CMS and TJC requirements are similar when it comes to compliance with federal, state and local laws. Both are looking to see that the hospital has a current license and meets the licensure standards for the State in which the hospital resides. Both are looking to see that hospital personnel required to be licensed have a current license to practice; these licensure laws vary state to state. Positions needing a license could include MDs, DOs, RNs, PAs, PTs, OTs, and RTs. This includes nonemployees providing direct care. Both CMS and TJC also require primary source verification of licensure. Verification of qualifications, training/education, and permits should be checked. TJC standards covering these areas are found in the Emergency Management, Leadership, Management of Human Resources, and Medical Staff chapters.

Survey Tips:

- Post the hospital license in a central place within the organization
- Have managers keep updated records of current licensure and training/education for staff (including employees, non-employee individuals, and LIPs)
- Ensure nonemployee direct care providers have contractual language requiring primary source verification
- Review medical staff files to verify that credentials information is current

Suggested Documents:

- Hospital license, DEA license, CLIA license, and radio therapeutic and nuclear medicine licensure/certifications
- Personnel files/credentials information with proof of primary source verification
- Bylaws regarding credentialing and privileging
- Policies and procedures regarding volunteer LIP and non-LIP practitioners during disaster

CMS CoP (v2011)

**The Joint Commission
Hospital Standards (v2012)**

**§482.12 CoP:
Governing Body**

**Leadership (LD),
Medical Staff (MS)**

The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. (A-0043)

(a) Standard: Medical Staff

The governing body must: (A-0044)

- (1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff; (A-0045)
- (2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff; (A-0046)
- (3) Assure that the medical staff has bylaws; (A-0047)
- (4) Approve medical staff bylaws and other medical staff rules and regulations; (A-0048)
- (5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients; (A-0049)
- (6) Ensure the criteria for selection are individual character, competence, training, experience, and judgment; and (A-0050)
- (7) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society. (A-0051)
- (8) Ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site hospital's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical

LD.01.01.01, EP1–3: An organizational structure exists.

LD.01.03.01, EP1–2: Quality and patient safety activities within the organization are overseen by the governing body.

LD.01.05.01, EP1–6, 7: A single medical staff, with accountability to the governing body, is organized to oversee the quality of patient care and services provided by those medical staff with appropriate credentials and privileges.

LD.04.03.09, EP1–9: Clinical services provided via contractual agreements is defined in writing and approved and monitored by hospital leadership. Performance expectations are included in the contract. Clinical leaders and medical staff have opportunity to provide advice about contracted clinical services. *Change to EP4 effective 7/15/10 for deemed accredited. Change to EP 9 for hospitals not seeking deemed status effective 7/15/09.*

MS.01.01.01, EP1–19, 20, 21, 22–36: Self-governance and accountability to the governing body are addressed in the medical staff bylaws and followed as adopted and amended by the medical staff.

MS.02.01.01, EP1–12: A medical staff executive committee exists and carries out its work in conformance with medical staff bylaws.

MS.03.01.01, EP1–11, 13–14, 16, 17: The quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process and activities related to patient safety and satisfaction are overseen by those LIPs designated by the medical staff.

MS.06.01.03, EP1–6, 7, 9: When processing applications and verifying credentials, the organized medical staff's defined process to verify practitioner identity and collect current licensure status, training, experience, competence, and ability to perform the requested privilege is followed within the specified time frames and as defined by the medical staff bylaws.

MS.06.01.05, EP1–12: Objective, evidence-based criteria and decisions are used to grant or deny a privilege(s) and/or renew existing privilege(s).

MS.06.01.07, EP1–8: Each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform a requested privilege is reviewed and analyzed and any privileging criteria are consistently applied by the organized medical staff as defined and in a timely manner with the governing body or

CMS CoP (v2011)**The Joint Commission
Hospital Standards (v2012)****§482.12 CoP:
Governing Body (cont.)****Leadership (LD),
Medical Staff (MS) (cont.)**

staff recommendations that rely on information provided by the distant-site hospital.

- (9) Ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity's physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital's medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity. (A-0052)

delegated governing body committee having final authority for denying privileges or granting/renewing privileges for a period not to exceed two years.

MS.07.01.01, EP1–4: Oversight for quality of care, treatment, and services is performed using developed criteria for medical staff membership when recommending members for appointment to the medical staff.

MS.13.01.01, EP1: Licensed Independent Practitioners who are responsible for the care, treatment and services via telemedicine link are credentialed and privileged to do so from the originating site.

§482.12 CoP (a) Analysis/Guidelines

Both CMS and TJC emphasize the interrelationship between a hospital's governing board and its medical staff. The governing body has overall responsibility for the conduct and care provided by the organization. The medical staff has responsibility for its members and provides recommendations on quality of care and services, credentials and clinical privileges, and medical staff bylaws/policies and procedures to the governing body. One group cannot work without the other to establish consistent policies, processes, and care guidelines for the institution. CMS and TJC require the medical staff to have bylaws, policies, procedures, credentialing and clinical privileging processes, and quality of care oversight, with accountability to the governing board of the hospital. CMS and TJC are now in alignment regarding telemedicine privileges; deemed status organizations can now use distant-site privileging information for telemedicine providers if there is a contract with the distant-site hospital detailing their requirements for compliant privileging processes and that information regarding periodic appraisals is shared. To be compliant with TJC OPPE and FPPE requirements, the periodic appraisal information should be sufficiently detailed to address the hospital P&P regarding OPPE and FPPE.

Survey Tips:

- Review medical staff bylaws/policies/procedures and have changes or revisions approved by the governing body
- Review credentials files to verify information is up to date and complete
- Review governing body meeting minutes for documentation on approval/denial of medical staff recommendations and actions
- Review contract for telemedicine privileges if using distant-site information
- Review medical staff bylaws if using distant-site information for telemedicine providers
- Review contracted clinical service agreements for medical staff input

Suggested Documents:

- Hospital bylaws
- Medical staff bylaws/policies/procedures and organizational chart
- Medical staff executive committee minutes
- Credentials files/medical staff privileges
- List of governing body members
- Governing body meeting minutes
- Contractual clinical service agreements
- Responsibility matrix outlining hospital board responsibilities

CMS CoP (v2011)**The Joint Commission
Hospital Standards (v2012)****§482.12 CoP:
Governing Body (cont.)****Leadership (LD),
Medical Staff (MS) (cont.)****(b) Standard: Chief Executive Officer**

The governing body must appoint a chief executive officer who is responsible for managing the hospital. (A-0057)

LD.01.02.01, EP1–2, 4: The governing body appoints leaders responsible for hospital operations.

LD.01.03.01, EP1–2: Quality and patient safety activities within the organization are overseen by the governing body.

LD.01.04.01, EP1–3, 5, 11: Hospital operation oversight is managed by the CEO, in partnership with other organizational leaders.

§482.12 CoP (b) Analysis/Guidelines

The governing body must have a formal process for appointing one CEO for the hospital who is responsible for managing the entire organization. CMS and TJC verify that the documented process is followed and the CEO has ultimate responsibility.

Survey Tips:

- Review hospital bylaws outlining process for CEO appointment
- Have updated CEO job description
- Review chain of command structure if CEO is absent

Suggested Documents:

- Hospital bylaws
- Governing body meeting minutes
- Job description for CEO
- Responsibility matrix outlining hospital board responsibilities

CMS CoP (v2011)

**The Joint Commission
Hospital Standards (v2012)**

**§482.12 CoP:
Governing Body (cont.)**

**Leadership (LD),
Medical Staff (MS) (cont.)**

(c) Standard: Care of Patients

In accordance with hospital policy, the governing body must ensure that the following requirements are met: (A-0063)

- (1) Every Medicare patient is under the care of:
 - (i) A doctor of medicine or osteopathy. (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified healthcare personnel to the extent recognized under State law or a State's regulatory mechanism.)
 - (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license
 - (iii) A doctor of podiatric medicine, but only with respect to functions which he/she is legally authorized by the State to perform
 - (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he/she practices
 - (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist
 - (vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law (A-0064)
- (2) Patients are admitted to the hospital only on the recommendation of a licensed practitioner permitted by the State to admit patients to a hospital. (A-0065) If a Medicare patient is admitted by a practitioner not specified in paragraph (c)(1) of this section, that patient is under the care of a doctor of medicine or osteopathy. (A-0066)
- (3) A doctor of medicine or osteopathy is on duty or on call at all times. (A-0067)

MS.03.01.01, EP1–11, 13–14, 16, 17: The quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process and activities related to patient safety and satisfaction are overseen by those LIPs designated by the medical staff.

MS.03.01.03, EP1–6, 12: Practitioners with appropriate privileges coordinate and manage patient care, treatment, and services.

CMS CoP (v2011)**The Joint Commission
Hospital Standards (v2012)****§482.12 CoP:
Governing Body (cont.)****Leadership (LD),
Medical Staff (MS) (cont.)**

- (4) A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that:
- (i) Is present on admission or develops during hospitalization; and
 - (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine or optometry; a chiropractor; or clinical psychologist, as that scope is (A) defined by the medical staff; (B) Permitted by State law; and (C) limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. (A-0068)

§482.12 CoP (c) Analysis/Guidelines

CMS is more specific in their requirements than TJC and focus primarily on Medicare/Medicaid patients. CMS hospital regulations permit licensed practitioners (e.g., doctors of dental surgery, podiatric medicine, optometry, chiropractors, nurse practitioners, midwives, etc.) to admit patients to the hospital (if allowed by the State), and CMS does not require these practitioners to be employed by a MD/DO. CMS regulations do require that Medicare/Medicaid patients admitted by these practitioners be under the care of a MD/DO, and this must be documented in the patient's record. CMS also requires a MD/DO to be on call 24/7; TJC has no corresponding standard for this.

Survey Tips:

- Review credentials files to verify information is up to date and complete
- Verify that patients are admitted to the hospital only by licensed practitioners (physicians, nurse practitioners, PAs, midwives, etc.) who have admitting privileges as approved by the governing board
- Review which categories of practitioners have admitting privileges (as allowed by bylaws and State law)
- Audit medical records to verify each patient is under the care of a MD/DO
- Interview nursing staff about how they identify the on-call physician and if a MD/DO is available at all times

Suggested Documents:

- On call schedules
- Credentials files
- Medical staff bylaws/policies/procedures
- Policies and procedures related to privileging and credentialing, Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation
- Hospital Body bylaws
- Have minutes of governing body available demonstrating approval of medical staff bylaws, including amendments to bylaws
- Responsibility matrix outlining hospital board responsibilities

CMS CoP (v2011)**The Joint Commission
Hospital Standards (v2012)****§482.12 CoP:
Governing Body (cont.)****Leadership (LD),
Medical Staff (MS) (cont.)****(d) Standard: Institutional Plan and Budget**

The institution must have an overall institutional plan that meets the following conditions:

- (1) The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.
- (2) The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.
- (3) The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable.
- (4) The plan must include and identify in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of \$600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following:
 - i. Acquisition of land
 - ii. Improvement of land, buildings, and equipment
 - iii. The replacement, modernization, and expansion of building and equipment (A-0073)
- (5) The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act, or if an agency is not designated, to the appropriate health planning agency in the State. (A-0074) A capital expenditure is not subject to section 1122 review if 75% of the healthcare facility's patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a HMO or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Act, and if the Department determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because:
 - i. The facilities do not provide common services at the same site

LD.01.01.01, EP1–3: An organizational structure exists.

LD.01.03.01, EP1–2: Quality and patient safety activities within the organization are overseen by the governing body.

LD.04.01.03, EP1, 3–6, 14–17: Hospital leaders coordinate, implement, and monitor operating and capital expenditure budgets that are audited annually and approved by the governing body.

LD.04.01.11, EP2–5: The governing body and hospital leaders provide the resources necessary to carry out hospital operations and patient care, inclusive of space, supplies, and equipment.

MS.06.01.01, EP1–2: Processes determining whether sufficient space, equipment, staffing, and financial resources are available are followed within a specified time frame prior to granting a requesting privilege.

CMS CoP (v2011)**The Joint Commission
Hospital Standards (v2012)****§482.12 CoP:
Governing Body (cont.)****Leadership (LD),
Medical Staff (MS) (cont.)**

- ii. The facilities are not available under a contract of reasonable duration
- iii. Full and equal medical staff privileges in the facilities are not available
- iv. Arrangements with these facilities are not administratively feasible
- v. The purchase of these services is more costly than if the HMO or CMP provided the services directly. (A-0075)
- (6) The plan must be reviewed and updated annually. (A-0076)
- (7) The plan must be prepared:
 - i. Under the direction of the governing body; and
 - ii. By a committee consisting of representatives of the governing body, the administrative staff, and the medical staff of the institution. (A-0077)

§482.12 CoP (d) Analysis/Guidelines

Whereas CMS outlines seven requirements vs. TJC's two standards, both require the organization to have an operating and capital budget plan that is reviewed, updated, and approved by the governing board on an annual basis. Both require staff input in the budget process. TJC identifies the requirement of an annual financial audit; CMS does not specify this in the COP. CMS outlines the requirement for the capital expenditures plan to be submitted to the planning agency designated to review capital expenditures. In some cases, facilities used by HMO or competitive medical plan (CMP) patients are exempt from this review.

Survey Tips:

- Review budget process to include governing body, administrative staff, and medical staff participation

Suggested Documents:

- Hospital's annual financial plan
- Hospital's annual operating and capital budgets
- Governing body meeting minutes
- Medical staff meeting minutes
- Financial audit report
- Organizational chart for medical staff services, including medical staff leadership positions
- Responsibility matrix outlining hospital board responsibilities

CMS CoP (v2011)	The Joint Commission Hospital Standards (v2012)
§482.12 CoP: Governing Body (cont.)	Leadership (LD), Medical Staff (MS) (cont.)
<p>(e) Standard: Contracted Services</p> <p>The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. (A-0083)</p> <ol style="list-style-type: none"> (1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. (A-0084) (2) The hospital must maintain a list of all contracted services, including the scope and nature of the services provided. (A-0085) 	<p>LD.01.03.01, EP1–2: Quality and patient safety activities within the organization are overseen by the governing body.</p> <p>LD.03.03.01, EP1–7: The organization takes a proactive planning approach related to patient safety and quality patient care.</p> <p>LD.04.03.09, EP1–9: Clinical services provided via contractual agreements is defined in writing and approved and monitored by hospital leadership. Performance expectations are included in the contract. Clinical leaders and medical staff have opportunity to provide advice about contracted clinical services. <i>Change to EP4 effective 7/15/10 for deemed accredited. Change to EP 9 for hospitals not seeking deemed status effective 7/15/09.</i></p> <p>LD.04.04.01, EP1–4: The hospital’s priorities for performance improvement are established by the organization’s leadership.</p>

§482.12 CoP (e) Analysis/Guidelines

The governing body is responsible for the services provided at the hospital, whether those services are provided directly by hospital staff or indirectly through a contractual arrangement (e.g., formal contract, joint venture, informal agreements, shared services, or lease arrangements). It is important to understand the definition of contract services and the scope of compliance. Both CMS and TJC require processes to ensure contracted services are provided in a safe and effective manner. These services should be monitored and evaluated to the same hospital-wide quality and performance improvement expectations as other services provided directly by the organization. CMS language on contract services includes all contracts, both clinical and non-clinical. TJC standards were more focused on clinical contracts; however, their standards have been rewritten to put emphasis on all contract services. There must be a complete list of contract services and those services must be evaluated to align with CMS expectations. CMS and TJC have an expectation that clinical contract services require the same onboarding procedures (i.e. criminal background checks and primary source verification) as required for employees. CMS has this expectation for anyone entering patient care areas whereas TJC remains more focused on clinical services. There also should be evidence that these non-employees have been oriented to their job description, hospital and department. CMS expects there to be a facility file for nonemployees providing clinical contract services and that on-site files are maintained for outsourced and clinical contractors. TJC came out with a FAQ to further clarify expectations.

Survey Tips:


- Review contracting process and update policy as needed.
- Verify that contractor services provided in the organization are in compliance with *CoP*.
- Review contract template and sample of clinical contract services to ensure contracted services include language regarding performance expectations.
- Ensure language in each contract addresses need to comply with *CoP*; state, federal and local laws and other regulations.
- For contracted staff or staff having direct contact with patients or entering patient care areas, the contract should also reflect need for criminal background checks, employee health screening, and primary source verification of licensure. Contractor policies should also entail facility check-in and check-out procedures and HR file requirements, including evaluation of contract workers.
- Ensure governing body minutes reflect periodic review of all contract services and include review of performance expectations.
- Ensure there is a process of check-in for all nonemployees entering patient care areas that are unescorted or that critical components of orientation have been given to nonemployees (including nonclinical).

Suggested Documents:

- Hospital bylaws
- Hospital policy regarding contract process, review, and approval by hospital board
- Documents that show regulatory oversight of contracts
- List of contracted services provided to the hospital including scope and nature of services
- Medical staff and leadership minutes demonstrating their opportunity to provide advice about those contracted services
- Have Contract Services P&P available (if applicable)
- Provide contract services evaluation method/tool
- Ensure clinical contract services QAPI is integrated into the hospital's quality program
- Matrix outlining hospital board responsibilities for contract workers

The 2012 CMS–Joint Commission CROSSWALK

A Side-by-Side Analysis of the
CMS Conditions of Participation and
the Joint Commission Standards



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CMSJC8

ISBN: 978-1-60146-915-1

