Licensing and Certification
Survey Basics Web Seminar

August 21, 2012
CHA Web Seminar

Welcome and Program Overview

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California Hospital Association
Continuing Education Offered for this Program

- **Health Care Executives** — CHA is authorized to award 2 hours of pre-approved ACHE Qualified Education Credit (non-ACHE) for this program toward the advancement, or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.

- **Nursing** — Provider approved by the California Board of Registered Nursing, CEP #11924, for 2.4 Contact Hours

Continuing Education Requirements

Full attendance, completion of online survey, and attestation of attendance is required to receive continuing education credit for this seminar. **Note:** only registrant may receive complimentary CEs. If additional participants under the same registration would like to be awarded CEs, a fee of $20 per person, will apply. Post-event survey will be sent to registrant and provide information on how to apply online for additional CEs.
Jana Du Bois is vice president and legal counsel for the California Hospital Association. Jana has a broad foundation of health law experience, including serving as in-house counsel for a large integrated hospital health system and regulatory counsel for state public health and managed care departments. Prior to becoming an attorney, Jana was a registered nurse for over 10 years.
The ABCs of Licensing and Certification

- An Overview of Licensing and Certification: Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), Accreditation Organization (AO)
- The Types of Surveys: Licensing, Certification, Accreditation, and Overlap
- The Survey and Post-Survey: Outcomes and Responses

Licensing, Certification, and Accreditation: What’s the Difference?

- Licensing: state process/law
  - CDPH
- Certification: federal process/law
  - CMS
- Accreditation: private — not government-based
An Accreditation Survey — How Does This Fit In?

- Voluntary — initiated by application
- Surveyors: employees or contractors of the AO
- Criteria: the AO’s standards and requirements
- Option: AOs with “deeming” authority survey the entire hospital for federal requirements to participate in Medicare

Comparison: State and Federal Surveys

- Purpose
- Regulator and oversight
- Requirements
Comparison:
First Up — State Surveys

- Regulator — CDPH: Center for Healthcare Quality — Licensing and Certification
- Criteria — Requirements of Licensure
  - Health and Safety Code
  - Title 22, Division 5
  - www.leginfo.ca.gov
  - www.calregs.com

CDPH: Licensing and Certification

- Headquarters
  - Center for Healthcare Quality
  - Licensing and Certification
- District offices
  - 16
  - Operations
- Surveyors
  - 700+
  - Health Facilities Evaluator Nurses (HFENs)
  - Consultants
Overview of the Types of State Surveys

- Licensure Survey or Consolidated Accreditation and Licensure Survey (CALS)
- Complaint-based survey
- Survey after a self-report
- Patient Safety Licensing Survey (PSLS)
- Medication Error Reduction Plan (MERP) survey

Licensure Surveys/CALS

Two Options:
1. CALS: a single, consolidated survey by CDPH, the Institute of Medicine (IOM), and The Joint Commission (TJC) (certification)
2. Licensing Survey: CDPH inspection for requirements of licensure

Note: To participate in Medicare, a separate certification survey will also be required
Complaint-Based Survey

- Triggered by a complaint
- Response: investigation with onsite-inspection if indicates ongoing threat of imminent danger of death or serious bodily harm to a patient
- Timing: within 48 hours or two business days, whichever is greater. Must be completed within 45 days
- Follow-up notice required

Hospital Self-Reporting

- Triggers:
  - Reported unusual occurrence; (70737)
  - Reported privacy breach (H&S 1279.2)
  - Reported adverse event (AE) (H&S 1279.1)
- Response: discretionary response, unless AE
- See California Hospital Survey Manual for details about these reporting requirements
Hospital Self-Reporting (cont.)

Adverse Events

- Trigger: hospital reported AE
- Response: Requires on-site inspection if may be an ongoing threat of imminent danger of death or serious bodily harm
- Timing: within 48 hours or two days, and completed within 45 days

Patient Safety Licensing Survey

Specific focus on patient safety laws:
- Patient safety and infection control laws
- Elimination/relocation of services
- End-of-life care option information and brain death policy
- Discharge planning
- Dietary personnel
- Immunizations
- Fair pricing/charity care policies

www.cdph.ca.gov/programs/LnC/Pages/PSLS.aspx
Medication Error Reduction Plan Survey

- Scope: general acute care hospitals (GACHs), surgical clinics, and special hospitals
- Targeted survey
- Timing: at least every three years
- Requirement: a formal plan to eliminate or substantially reduce medication-related errors
- Guidance in preparing for MERP surveys may be found in All Facility Letters (AFLs) 08-39 and 09-31 at: www.cdph.ca.gov/certlic/facilities/Pages/LnCAFL.aspx

Additional Sources for State Survey and Compliance

- Hospital policies and procedures
- Message: write policies and procedures carefully!
CDPH Compliance Guidance: All Facility Letters

- AFLs: guidance on new or revised laws, programs and processes, and other information
- AFLs are typically focused by facility type
- Posted by year issued on CDPH website at: www.cdph.ca.gov/certlic/facilities/Pages/LnCAFL.aspx
- Posted by topic on CHA website at: www.calhospital.org/ALF-index

A Comparison: Next Up — CMS Survey and Certification

- Purpose: to participate in Medicare
- Regulator: CMS
- Criteria: surveyed to federal requirements in the Conditions of Participation (CoPs)
- Surveyors: by CMS or the “State Agency” (or “deemed status” option by a CMS-approved private AO)
CMS: Licensing and Certification

- Headquarters
  - Baltimore
- Regional offices
  - Ten
  - California: Region IX
- Surveyors
  - CMS
  - “State Agents”
  - Deeming AO

So … What is “Deemed Status”?

- Deemed Status: the hospital is deemed to be Medicare compliant by a CMS approved AO
- Approved AOs:
  - TJC
  - American Osteopathic Association’s (AOA) Healthcare Facilities Accreditation Program (HFAP)
  - Det Norske Veritas Healthcare, Inc. (DNV)
Types of CMS Surveys

- Certification or recertification surveys
- Complaint-based surveys
- Validation surveys: partial or full

Certification/Recertification Surveys

- Inspected for compliance with all of the CoPs
- Re-inspected periodically to confirm compliance with CoPs
- Not applicable to hospitals with “deemed status” (subject to validation surveys)
Validation Surveys

- Hospitals with “deemed status”
- Conducted on a random sample basis to validate the accreditation process
- May be comprehensive, or focused on a specific CoP
- If significant deficiencies, CMS will then authorize a full validation survey

Complaint/Allegation Surveys

- Trigger: a complaint
- Standard: a “substantial allegation of noncompliance” of a condition-level deficiency
- Complainant: can be anyone — patient, employee, visitor, labor union, media, etc.
- Scope of survey: limited to the CoPs related to the complaint — can expand if warranted
Which Laws are Federal Surveyors Assessing Compliance With?

- CoPs
  - Acute Care Hospitals: Part 482, 23 CoPs
  - Psychiatric Hospitals: two additional CoPs
  - Critical Access Hospitals: Part 485 CoPs
- CoPs apply to all patients, not just Medicare (or Medicaid) patients
- www.gpo.gov/fdsys

CMS Surveyor Tools and Guidelines

State Operations Manual (SOM)
- Surveyor instructions and required process for all federal surveys
- Chapters organized by topic:
- Appendices
  - Appendix A: Interpretive Guidelines
  - Appendix Q: Calling an Immediate Jeopardy (IJ)

Surveyor Tools and Guidelines (cont.)

Survey and Certification (S&C) Memos:

- CMS memos to surveyors: for updates, clarification, changes, survey tools
- Found at:
  - Bookmark this page and check it periodically — CMS does not send this information to hospitals

The Survey: A Surveyor’s Perspective

- IOM Report “To Err Is Human”
- TJC sentinel events
- National Quality Forum’s 27 Never Events
- AE reporting
- Sanctions for reporting delays
- Administrative penalties for state IJs
- Anecdotal legends
Survey Alert: A Surveyor Switches Hats

- CMS contracts with CDPH as the state surveyor to inspect hospitals
- CDPH surveyors may begin with a state survey inspection, and if findings indicate a federal CoP problem, the same surveyors may broaden to a full federal validation survey

The Survey: Prepare and Respond

So your hospital is being surveyed …

and problems are identified …

now what …?
Responses to the Survey

For now, suffice it to say surveys are all of the following:

- Unannounced, but certain!
- Time and resource consuming
- Strict substantive and procedural requirements

Hospital readiness is key

Potential Outcomes

<table>
<thead>
<tr>
<th>State</th>
<th>Federal</th>
</tr>
</thead>
<tbody>
<tr>
<td>No deficiencies</td>
<td>No deficiencies</td>
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<tr>
<td>Deficiencies</td>
<td>Deficiencies</td>
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<tr>
<td>IJ</td>
<td>IJ</td>
</tr>
<tr>
<td>Revoke license</td>
<td>Termination</td>
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</tbody>
</table>
The Survey is Wrapping Up, Now What?

Statement of Deficiencies and Plan of Correction

- State and federal Form 2567
- Left two columns: deficiencies are described, and contain the corresponding state or federal requirement with citation
- Same form used for Plan of Correction (PoC)

Example 2567s:
www.cdph.ca.gov/certlic/facilites/Pages/Counties.aspx
State Immediate Jeopardy

Legal standard: the hospital’s noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to a patient

Health and Safety Code Section 1280.1

Federal Immediate Jeopardy

Legal standard: “a situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident”

42 CFR 489.3

SOM Appendix Q
So, How Are They Different?

State
- Requirement of licensure
- Issued after the survey
- Statement of deficiencies
- PoC
- Consequences

Federal
- A CoP
- Called during the survey
- Statement of deficiencies
- PoC
- Consequences

Consequences of a State Immediate Jeopardy
- PoC
- Administrative Penalties
  - $50,000 for the first IJ
  - $75,000 for the second IJ
  - $100,000 for the third and subsequent IJ
- After three years from prior IJ, subsequent IJ considered a first IJ penalty if in substantial compliance with laws
- May trigger a federal IJ
- Revoke license
Consequences of a Federal Immediate Jeopardy

- 2567 and PoC, but no Termination Track:
  - IJ and ALL associated noncompliance are corrected while surveyors are onsite
  - IJ and Condition corrected, but standard level noncompliance remains
- 2567 and Termination Track:
  - 90-day track: IJ resolved but condition-level deficiency remains
  - 23-day track: IJ unresolved during survey

But Wait! There's More: State Administrative Penalties

State Administrative Penalties apply to other instances of noncompliance with requirements of licensure. For additional information:

- CDPH penalties assessed by hospital and county:
  www.cdph.ca.gov/certlic/facilities/pages/counties.aspx
- CHA Catalog of Administrative Penalties: tracks each IJ fine, details about the event, investigation timeline, etc.: www.calhospital.org/ij-catalog/reports
Appeals: IJ and/or State Administrative Penalty

- Timing: ten days from receipt of notice
- Form and content: no required content, but address comprehensively:
  - The law cited on the 2567
  - The legal standard
  - The circumstances
  - The judgments and conclusions of the surveyor
- Engage experienced legal counsel

Appeals: State IJ, Deficiencies and Administrative Penalty

Lessons learned:
- Challenge accuracy of the findings
- Appealing is a lengthy process
- Benefits could exceed the burdens:
  - IJ deficiency withdrawn
  - Penalty withdrawn (but IJ remained on their record)
  - Negotiate a reduced penalty
Federal Appeals: Termination

- May challenge the deficiency cited
- Timing: within 60 days from receipt of notice from CMS of an initial or revised determination
- Content: identify specific issues, findings of fact, conclusions of law with which the hospital disagrees, and details showing compliance
- Hearing before an Administrative Law Judge
- Seek experienced legal counsel!

Thank you

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We Are Here!

- Surveyors generally present to the front desk
- Surveyors have IDs and expect to be asked that they be presented
- Surveyors will inform you of the reason for the survey
- There is a team leader, provided there is more than one person

Surveyor General Needs

- Facilities
  - Private room for all the surveyors which can be locked
  - Power outlets/strips for computers
  - Internet access
  - Telephone
  - Meals — ask; refreshments — appreciated gesture
  - Private time for team discussion
  - Issue temporary IDs if this is your policy
Materials

- The hard copy materials needs will vary based on the type of survey and which agency is conducting the survey
- In general one should have available soon after arrival the following:
  - Binder with medical staff bylaws, rules and regulations, medical staff members with categories, allied staff members, medical staff officers, committees and chairs
  - Performance Improvement Policy (QA/PI)/Plan and data including restraints, organ procurement
  - Infection Control Policy and data
  - Life Safety Code information

Materials (cont.)

- Environment of Care Management Plans (fire drills, power supply, biomed documents, design plans, etc.)
- Utilization and Review Policy
- Medication Management Policy and Pharmacy and Therapeutic (P&T) data — don’t forget your MERP
- List of all sites performing sedation/general anesthesia and hours of operation
- Hospital map and location of services
- Hospital census by units and schedule for the operating room, cath lab, GI, special procedures
Materials (cont.)

- List of all contracts — they will review some or all clinical-related contracts
- Anesthesia Policy (CMS) — including sedation policy
- Fall policy and data
- Emergency Management Plan and Policies
- Minutes to the following meetings: Governing Board, Medical Executive Committee, Credentials, Infection Control, Utilization Management (UM), P&T, Environment of Care, Emergency Management, Quality, Safety, Peer Review

Materials (cont.)

- Description of all services, locations and units by floor
- Location where instruments are cleaned, disinfected, sterilized
- A thorough understanding of your present documentation system (paper, hybrid, electronic)
- Complaint Policy and related documentation
- Advance Directive Policy
Materials (cont.)

- Investigational Review Board (IRB) information if applicable
- Make sure to secure information each night
- Plan for HR file review
- Organizational chart
- Hospital license

Surveyor Activity

- Depending on the agency and type of survey, surveyors may visit units, ask questions and will always review documents and medical records
- During unit visits, the “survey team” accompanying the surveyor should always have a strong clinician as escort that knows your documentation, a runner and a scribe
Survey Activity (cont.)

- Staff should answer questions with limited assistance from the survey team
- Do not get into arguments — especially while around patients or on the units

Survey Activity (cont.)

- If a surveyor is asking for a policy, determine if they need it immediately or if it can be presented later in the day
- Questions: ask surveyors when you could discuss an issue, provide more clarification, etc. — know the cut-off time
- Being organized, confident, professional is key to success
Conclusion of Survey

- Collect IDs
- Validate with surveyors that HIPAA compliance is being met
- Depending on the agency, a report may be available
- Parking validation?

Top 10 List of Things Surveyors Appreciate

1. Quick set up response with internet access, extension cords, etc.
2. Provide requested materials quickly — avoid leaving surveyors empty handed for long-periods
3. Respect surveyor cut-off times — last minute information drops are hard on everyone
4. Keep only necessary people with the surveyors — especially when in patient’s rooms
5. Receptive, courteous hospital staff especially during watching activities
6. Honest answers — if you don’t know, that’s ok
7. Privacy for brief meetings, and more…
8. Be attentive, without “guarding”
9. Guidance on the hospital’s culture — surveyors want to be respectful, fit in
10. Realistic descriptions about the hospital’s achievements or goals

Thank you

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Preparing for the Survey

- Structure for ongoing survey readiness
- Documentation and tools
- Training employees — from information desk staff to patient care staff to medical staff
- Mock surveys

Survey Readiness Team

- Develop a Licensing/Certification/Accreditation (LCA) Team of leaders by regulation/standard; e.g., Patient Rights, Medication Management, who meet regularly to review new updates, perform gap analysis, participate in mock surveys, respond to PoC
Survey Readiness Team (cont.)

- Examples of LCA Team may be medication safety officers, accreditation managers, human resource directors, educators, facility managers, dieticians
- LCA Team should also include members of the executive staff, department heads, medical directors, compliance, and risk manager and quality assessment performance improvement (QAPI) coordination. Legal counsel may participate as needed

Survey Playbook

- CMS policy and memos to states and regions
- CDPH AFLs
- Accreditation updates; e.g., TJC, AOA, etc.
- Standards and regulations (Title 22, accreditation standards, CoPs) for specific surveys: MERP, PSLS, CALS
Training Hospital and Medical Staff

- Include all inpatient and outpatient staff who may encounter surveyors; e.g., dietary, information, lab, dietary, pharmacy
- Develop survey handbook for ancillary and hospital staff that includes basic information about survey organization and role of surveyor
- Dos and Don’ts; e.g., understand the question, answer truthfully, don’t report areas of concern

Training Hospital and Medical Staff (cont.)

- Instruct staff that they can ask for assistance, use tools, and whom to turn to if nervous, or have concerns about patient privacy
- Meet separately with medical staff to provide education and opportunity to rehearse interview sessions; e.g., QAPI Committee, Quality Council, Medication Safety Committee
Preparing for Survey

- Identify list of Key Leaders (and backups) from each department and service who respond when surveyors arrive to prepare their unit for surveys and are called when the surveyors come to inspect their units.
- Develop a Survey Kit that contains: contact information of key employees, staff members, management. Include the location and number of “Command Center” that will be utilized by the hospital during the survey.

Develop Documentation

- Prepare informational binders of pertinent information in advance that contains patient safety plan, supporting policies and procedures, MERP documents.
- Educate appropriate leaders and staff on contents of binders and role play survey process.
- Develop Quick Review Checklists; e.g., clutter in hallways, expired medications, outdated patient food, restraint documentation, Code Cart, staff wearing badges, presence of consents, H & Ps, Universal Protocol/Time out.
Training Survey Staff

- Train appropriate personnel
  - Identify and train escorts, scribes and runners
  - Escort — accompanies the surveyor and announces the surveyor’s presence in a cordial manner as they round
  - Scribe — documents surveyor questions, medical record numbers, names of hospital and medical staff. Contacts Command Center to alert next department that surveyor will be visiting
  - Runner — obtain documents and backup as needed

Establish a Communication Structure

- Command Center is set up immediately upon entrance of surveyors by a pre-determined leader
  - Central hub for communication
  - Coordination of all survey activities
  - Facilitates production, review, and copying of documents
  - Scheduling of daily briefings
- LCA Team is contacted to assist department leaders with preparation, assist with staff communication
Establish a Communication Structure (cont.)

- Surveyors are greeted by Survey Team representatives and escorted to location that includes a telephone, computer and printer
- Simultaneously, an overhead announcement by the operator stating: “Scripps welcomes the surveyors”— this is repeated three times 15 minutes apart

Role of Executive Team

- Chief executive, chief nurse, members of the executive team, chief of staff and medical director for Quality/PI assemble to review type of survey, cancel meetings as needed, notify other leaders who may be called upon to assist as needed — system CEO, board members, and legal counsel
Perform Mock Surveys

- Develop plan for mock surveys that includes team, frequency, survey tools, hospital response, report generation and role/responsibility for follow-up action plan
- Mock surveyors may be from another hospital in the health system who are content experts or from the hospital’s LCA Team

Perform Mock Surveys (cont.)

- Methodology/Timing:
  - Unannounced — mock survey team is treated as actual survey team
  - Conducted annually, and again 3 – 4 months prior to potential survey
  - Team focuses on data to prioritize their survey activity; e.g., root cause analysis (RCAs), occurrence report data, QAPI, past deficiencies and PoCs
  - Reports are generated and presented during Exit Conference
  - Hospital LCA Team has responsibility for follow up action plans, auditing, tracking/trending outcomes
Assess and Improve Mock Survey

Internal mock survey feedback questions:
1. The survey approach was consultative and educational
2. Talking to the surveyors was good practice for me
3. The survey was helpful in identifying areas that we should work on prior to our actual survey
4. The surveyors were knowledgeable
5. I learned something new during the course of this survey
6. I would like to learn more about the survey process and be a part of it
7. What can we do to improve the survey process?

During the Survey

- First impressions count!
- Notify key personnel immediately
- Escorts and scribes
- Debrief staff who interact with surveyors
- Daily team meetings during survey
During the Survey (cont.)

- Respectful, cordial, partners in patient safety
- Determine who will meet the survey team; e.g., chief executive/designee
- Ensure identification of surveyor — obtain business card, check picture identification, copy to Command Center
- Implement communication plan and set up Command Center
- Implement predetermined list of escorts, scribes, and runners
- Debrief daily with above staff to identify trends, issues, etc.

During the Survey (cont.)

- If finding is discovered, ask surveyor to cite the standard, applicable tag number, CoP, Title 22 section
- Provide documentation to surveyors in response to requests to support compliance
- Hospital Leadership Team should be available during survey for strategy regarding potential deficiencies, clarification, meeting with surveyors to discuss issues, daily meetings to debrief at end of day, communication with staff, and preparation for next survey day
The Exit Conference

- Participants
  - Senior leadership, Chief of Staff, Medical Directors, health system leadership, Board of Directors representative
- Consider recording the exit conference or assign a scribe
- It is alright to ask questions:
  - To identify the deficiencies/CoPs, tag numbers and whom they interviewed
  - Address or clarify issues

After the Survey

- Communicating survey results to governing body, employees, medical staff, news media
- Process to review issues when surveyors leave
- Who is your response team?
- Developing preliminary action plan
- Receipt of Form 2567 — develop official PoC
- Documentation and continuous improvement after PoC submitted
Communicating After the Survey

- Schedule meetings for hospital and medical staff, health system leadership regarding the survey results
- Prepare report for Governing Body, Medical Executive Committee, Quality Council
- Collaborate with marketing/communication on press release and development of talking points and prepping of spokesperson as appropriate

Response to Survey Results

- Immediately assemble a Response Team to review the deficiencies, and develop action plans with responsibilities, timelines, auditing, and outcomes
- Engage hospital and medical staff in the corrective action plan
- Periodically report updates to hospital and system meetings; e.g., QAPI Committee, Governing Body, Quality Council, MEC
- Consider other resources as needed to resolve the deficiency; e.g., legal counsel
Receipt of Form 2567

- Reconvene the Response Team to review and analyze:
  - Are there new findings to be addressed?
  - Is finding consistent with Exit Conference and is the action plan fully implemented?
  - Does preliminary corrective action plan need to be modified?

Questions Regarding the Report

- Leadership Team should gather questions and determine if a call to CMS, accrediting agency, or CDPH or other hospitals may be necessary to obtain clarification
- Carefully consider the chain of command within CDPH and CMS
Elements of an Acceptable PoC

- Addresses correcting each deficiency
- Addresses improving the processes that led to the deficiency
- Must include the procedure for implementing the PoC for each deficiency
- Must include a completion date for each deficiency
- Must take a QAPI approach
- Must include monitoring
- Must include the title of the person responsible

Drafting the Response — an Example

- Finding: The light fixture in linen closet X was burned out
- Response: The burned out light fixture in closet X was immediately replaced on 6/13/12. The hospital’s policy and procedure regarding how often lights bulbs should be checked was amended on 6/14/12 to require weekly checking and weekly documentation of checking. A sign was placed in all linen closets informing staff to call Environmental Services at extension xxxx upon finding a burned-out bulb
Describe New or Revised Policies

- Provide details of new or revised policies and procedures, not that “a new policy and procedure was developed or policy revised"
- Not acceptable to attach policy without referencing the detail in the PoC

Staff Education

- Include all types of education; group, individual, written, oral, and dates
- Maintain sign-in logs and educational materials — consider attaching to PoC
- Identify staff: RNs working in Neonatal ICU, not all RNs
Describe Monitoring

- Describe all monitoring — what review, quality assurance measures, monitoring to ensure deficiency does not recur
- Who is responsible, how often they monitor, what they monitor for, who the results are reported to, what happens to results (positive/negative) and alerts in place if problem arises so it can be corrected
- Stratify frequency of monitoring depending on severity; e.g., weekly, then bi-weekly, monthly
- Integrate all of the above into the hospital’s ongoing QAPI process

Attaching Documents

- Consider that attachments may lead to other deficiencies and may be made publicly available
- PoC must stand on its own
- If attaching, catalog the attachments to clearly reference back to the PoC
- Attachments may avert another survey
### Acceptable PoC

- State agency/or CMS must determine if PoC is acceptable
- Submission does not mean acceptance
- To be acceptable the PoC must demonstrate that the hospital has fixed the problem with a QAPI process, has established a mechanism to monitor and track the “fix” and that process ensure the “fix” is sustained

### Ongoing Compliance

- Ensure QAPI process is implemented
- Monitor the measures and report to Quality Council with actions plans when targets not met
- Assign timelines for corrective action plans that are achievable
California Hospital Survey Manual

A guide to the licensing and certification survey process that explains how to:

- Prepare for surveys
- Interact with the surveyors
- Write plans of correction
- Appeal adverse actions

2012 Publications

- California Hospital Compliance Manual
- Consent Law
- Principles of Consent and Advance Directives
- Minors and Health Care Law
- Mental Health Law (Available August 2012)
- California Health Information Privacy Manual (Available Late 2012)

Learn more at www.calhospital.org/publications
Upcoming Programs

- Disaster Planning for California Hospitals  
  October 15 – 17, 2012, Sacramento
- Behavioral Health Care Symposium  
  December 3 – 4, 2012, Huntington Beach
- Post-Acute Care Conference  
  January 31 – February 1, 2013, Huntington Beach
- Rural Health Care Symposium  
  March 13 – 15, 2013, Sacramento

Thank You and Evaluation

Thank you for participating in today’s program. An online evaluation will be sent to you shortly.

Reminder: evaluation completion is required to receive continuing education credits.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.