Role of DNV Hospital Accreditation in Quality and Patient Safety Improvement

Medical Staff Perspective

Presentation to NYSAMSS

4/25/13

Yehuda Dror, President, DNV Healthcare
Presentation Objective

- Why DNV
- Who is DNV
- CMS and Switching Accreditation
- The Accreditation Standard Concept
- The Accreditation Process
- Benefits – testimonials
- Q&A
DNV is

• Independent foundation established in 1864
• Self-owned with no shareholders
• Stakeholders are represented in our governing bodies and committees
• Vision “Global impact for a safe and sustainable future”
• We use financial results to develop our people and our research and innovation

Everywhere.

Dedicated to safeguarding life, property and the environment.

DNV Healthcare Inc. is a US corporation, wholly owned by DNV
DNV’s Core competence

Managing risk

- Maritime
- Healthcare
- Food & Beverage
- Transportation
- Energy
- IT & Telecom
- Public Sector
- Automotive
- Defense
Global position within healthcare

1300
1300 Hospitals and healthcare providers certified by DNV

China
- Partnership with China National Health Research & Development Centre addressing risk management in China Healthcare Reform
- Led the initiative to develop the first Biorisk management standard - CWA 15793

England
- Assess and rate all public healthcare trusts (550) in England on behalf of NHS Litigation Authority

US
- DNV broke 45 years of hospital accreditation monopoly in US – DNV NIAHO® accreditation (Recognised by CMS)

EU
- Multiple hospitals accredited to DNV International Standard - EU cross-border healthcare directive (2014)
Managing Risk: Example of Risk Assessment
Strategy - the 4 T

Describe work activities
Identify hazards
Determine Risk

Risk is Acceptable?

Tolerate: Proceed as planned and Monitor
Terminate work

Treat: Revise work
Prepare risk control action plan
Implement control measures
Review adequacy and Monitor

Transfer (Insurance)
Going to a US hospital is 7 times riskier than skydiving*

* USPA: Probability of death due to error = 0.10%
  HealthGrade: Probability of dying from an "error“ = 0.75%
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>Joint Commission established</td>
</tr>
</tbody>
</table>
| 1964 | Social Security Act – CMS (Centers for Medicare and Medicaid) established  
  • Accreditation required to receive CMS reimbursements  
  • TJC receives statutory privilege – no accountability to CMS |
| 12/2007 | DNV applies to CMS for deeming authority an approved AO for hospitals |
| 09/2008 | DNV Granted Deeming |
| 07/2008 | TJC loses statutory privilege, approved by CMS 11/09 |
| 08/2012 | DNV Notice of Continued Deeming by CMS  
  – 6 year extension (max. allowed by law) |
Additional Accreditation/Certification

• **Critical Access Hospitals** – Deeming authority received from CMS, December 2010

• **Stroke Center Certification**
  – PRIMARY:
  – COMPREHENSIVE:

• **Ambulatory Day Surgery and Psychiatric Hospitals** – Application to CMS in process

• **VAD Certification** – Application submitted to CMS

• Additional Disease Specific Certifications are also being developed for Cardiac Care, Diabetes, Orthopedic, and Others
Market Status & Recognition

• **Market**
  – 350 Hospitals currently under **contract**
  – 270 **deemed** (accredited)
  – References – Increasing number of C-Suite personnel agree to be included in the DNV reference list

• **Mutual Recognition Agreement (MRAs)**
  – Georgia and Florida – Bills signed by Governors (early 2012)
  – New York and Oregon – administrative ruling

• **Others**
  – Insurance
  – ACGME
Question
We want to switch to DNV right now. If we do, our current accreditation organization has told us they will immediately withdraw our accreditation. What do we do?

Answer
In this circumstance, accreditation withdrawal has no impact on your Medicare Provider Agreement or Medicare reimbursement.
If your current accreditation organization immediately revokes its accreditation, there is no interruption in your Medicare provider agreement, and thus, no break in Medicare reimbursement.

Confirmation
For confirmation of above statement, you may call Cindy Melanson, Centers for Medicare & Medicaid Services, Survey & Certification Group, Baltimore, MD, phone: 410-786-0310, email: cmelanson@cms.hhs.gov.
The DNV Accreditation Concept
The Concept: Enabling a Sustainable, Effective Accreditation

BEST PRACTICES
- Innovation
- Demonstrated Outcomes

CMS’ CoP

Prescriptive How-To “policies”
Frequently changing

OTHERS
NIAHO® Program
Useful
Stable
Sustainable

© Det Norske Veritas AS. All rights reserved.
# Key Features

## Feature of NIAHO®

<table>
<thead>
<tr>
<th>Feature</th>
<th>Benefit to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stable standards, infrequent change</td>
<td>Sustainable system</td>
</tr>
<tr>
<td>Annual Surveys</td>
<td>Constant readiness</td>
</tr>
<tr>
<td>ISO 9001 Gradual Introduction</td>
<td>More value, lower $</td>
</tr>
<tr>
<td>@ no additional staff</td>
<td></td>
</tr>
<tr>
<td>Focus on sequence/interactions of</td>
<td>Clear, traceable pathway to improve</td>
</tr>
<tr>
<td>all hospital processes</td>
<td></td>
</tr>
<tr>
<td>Demeanor of the survey team</td>
<td>Collaboration, sharing of ideas</td>
</tr>
<tr>
<td>No survey findings “tipping” point</td>
<td>Fear becomes confidence</td>
</tr>
</tbody>
</table>
Accreditation Standards Concept
“NIAHO® on ISO”

CMS (CoPs)
(Accreditation Oversight)

NIAHO® Accreditation Requirements
(Consistent with CMS CoPs - Requirement for ISO Compliance/Certification)

Hospital’s Quality Management System
(Compatible and Compliant with ISO 9001:2008)
• Integrates ISO 9001 and Medicare CoP compliance

  –ISO 9001 provides the framework for a sustainable CoP implementation
  –ISO 9001 allows hospitals to use its combined knowledge, wisdom, and innovation to improve quality and safety
  –ISO 9001 is the framework within which methodologies such as LEAN and Six Sigma are better understood and utilized

• Combined result drives quality transformation into the organization’s core processes
NIAHO® Chapters

- Quality Management System
- Governing Body
- Chief Executive Officer
- Medical Staff
- Nursing Services
- Staffing Management
- Rehabilitation Services
- Obstetric Services
- Emergency Department
- Outpatient Services
- Dietary Services
- Patient Rights
- Infection Control

- Medical Records Service
- Medication Management
- Surgical Services
- Anesthesia Services
- Laboratory Services
- Respiratory Care Services
- Medical Imaging
- Nuclear Medicine Services
- Discharge Planning
- Utilization Review
- Physical Environment
- Organ, Eye and Tissue Procurement
Medical Staff Chapters in NIAHO®

- MS.1 Organized Medical Staff
- MS.2 Eligibility
- MS.3 Accountability
- MS.4 Responsibility
- MS.5 Executive Committee
- MS.6 Medical Staff Participation
- MS.7 Medical Staff Bylaws
- MS.8 Appointment
- MS.9 Performance Data
- MS.10 Continuing Education
- MS.11 Governing Body Role
- MS.12 Clinical Privileges
- MS.13 Temporary Clinical Privileges
- MS.14 Corrective or Rehabilitation Actions
- MS.15 Admission requirements
- MS.16 Medical records Maintenance
- MS.17 History and Physical
- MS.18 Consultation
- MS.19 Autopsy
- MS.20 Telemedicine
Quality Management Principles

1. Customer-focused organization
2. Leadership
3. Involvement of people
4. Process approach
5. System approach to management
6. Continual improvement
7. Factual approach to decision making
8. Mutually beneficial supplier relationships
## Section 1. Scope

- **Description**: General information

## Section 2. Normative reference

- **Description**: General information

## Section 3. Terms and definitions

- **Description**: Mandatory requirements

## Section 4. Quality management system

- **Description**: Mandatory requirements

## Section 5. Management responsibility

- **Description**: Mandatory requirements

## Section 6. Resource management

## Section 7. Product/Service realization

- **Description**: Certain requirements may be excluded

## Section 8. Measurement, analysis and improvement

- **Description**: Mandatory requirements
The ISO 9001 Continual Improvement Concept

What is important to your patients

QUALITY MANAGEMENT SYSTEM
(CONTINUAL IMPROVEMENT)

Management Responsibility

Resource Management

Measurement Analysis & Improvement

INPUTS

Product / Service Realization

OUTPUTS

INPUTS

OUTPUTS

© Det Norske Veritas AS. All rights reserved
4.2.3 Control of documents

Documents required by the quality management system shall be controlled. Records are a special type of document and shall be controlled according to the requirements given in 4.2.4.

A documented procedure shall be established to define the controls needed

- a) to approve documents for adequacy prior to issue,
- b) to review and update as necessary and re-approve documents,
- c) to ensure that changes and the current revision status of documents are identified,
- d) to ensure that relevant versions of applicable documents are available at points of use,
- e) to ensure that documents remain legible and readily identifiable,
- f) to ensure that documents of external origin determined by the organization to be necessary for the planning and operation of the quality management system are identified and their distribution controlled, and
- g) to prevent the unintended use of obsolete documents, and to apply suitable identification to them if they are retained for any purpose.
5.6 Management review
5.6.1 General
Top management shall review the organization's quality management system, at planned intervals, to ensure its continuing suitability, adequacy and effectiveness. This review shall include assessing opportunities for improvement and the need for changes to the quality management system, including the quality policy and quality objectives.

Records from management reviews shall be maintained (see 4.2.4).

5.6.2 Review input
The input to management review shall include information on
a) results of audits,
b) customer feedback,
c) process performance and product conformity,
d) status of preventive and corrective actions,
e) follow-up actions from previous management reviews,
f) changes that could affect the quality management system, and
g) recommendations for improvement.

5.6.3 Review output
The output from the management review shall include any decisions and actions related to
a) improvement of the effectiveness of the quality management system and its processes,
b) improvement of product related to customer requirements, and
c) resource needs.
Bylaws

- **MS.12 CLINICAL PRIVILEGES**

- **SR.4** Medical staff bylaws shall include provisions for mechanisms for corrective action, including indications and procedures for automatic and summary suspension of medical staff membership or clinical privileges. Ref. CoP:

| 482.12(a)(3) | (3) Assure that the medical staff has bylaws; | MS 7 SR 1 | The medical staff shall be appointed by the governing body and operate under bylaws, rules and regulations adopted and enforced by the medical staff and approved by the governing body |

- **SR.6** The medical staff bylaws shall provide a mechanism for consideration of automatic suspension of clinical privileges in any of the following instances:
  - SR.6a. revocation/restriction of professional license;
  - SR.6b. revocation/suspension/probation of Federal Narcotics Registration Certificate (DEA);
  - SR.6c. failure to maintain the specified amount of professional liability insurance; or,
  - SR.6d. non-compliance with written medical record delinquency or deficiency requirements.
Accountability and Responsibility

• Med staff is accountable to the governing body for the quality of medical care provided to patients. (Hence, Board must receive information regarding physician conduct, MR deficiencies, event review including those that result in peer review of a practitioner...)

• NIAHO

• MS.3 ACCOUNTABILITY
• The medical staff shall be organized in a manner approved by and accountable to the governing body and shall be responsible for the quality of the medical care provided to patients.

• Interpretive Guidelines:
  – The medical staff shall be organized in a manner approved by and accountable to the governing body and shall be responsible for the quality of the medical care provided to patients.
  – All patients must be under the care of a member of the medical staff or under the care of a practitioner who is directly under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner who meets the medical staff criteria and procedures for the privileges granted, who has been granted privileges in accordance with those criteria by the governing body, and who is working within the scope of those granted privileges.

• MS.4 Responsibility

| 482.22(b)(3) | (3) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by State law of the State in which the hospital is located, a doctor of dental surgery or dental medicine. |
| MS 4 | The responsibility for organization and conduct of the medical staff must be assigned to an individual doctor of medicine or osteopathy or, when permitted by State law, a doctor of dental surgery or dental medicine. |
Medical Staff Participation

- Required med staff participation in specified organizational activities

- MS.6
  - The medical staff shall participate in at least the following organization activities:
    - SR.1 Medication management oversight;
    - SR.2 Infection prevention and control oversight;
    - SR.3 Tissue review;
    - SR.4 Utilization review;
    - SR.5 Medical record review; and,
    - SR.6 Quality Management System.
  - SR.7 Reports and recommendations from these activities shall be prepared and shared with the medical executive committee and the governing body.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>GOVERNING BODY (GB)</th>
<th>MEDICAL STAFF (MS)</th>
<th>CHIEF EXECUTIVE OFFICER (CE)</th>
<th>GOVERNING BODY (GB)</th>
<th>EMERGENCY DEPARTMENT (ED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sec. 482.11</td>
<td>Condition of participation: Compliance with Federal, State and local laws.</td>
<td>GB.1 LEGAL RESPONSIBILITY</td>
<td>MS.2 ELIGIBILITY</td>
<td>CE.1 QUALIFICATIONS</td>
<td>GB.2 INSTITUTIONAL PLAN AND BUDGET</td>
<td>ED.3 EMERGENCY SERVICES NOT PROVIDED</td>
</tr>
<tr>
<td>Sec. 482.12</td>
<td>Condition of participation: Governing body.</td>
<td>5.1, 5.5.1, 5.5.2</td>
<td>MS.7 MEDICAL STAFF BYLAWS</td>
<td>MS.11 GOVERNING BODY ROLE</td>
<td>GB.3 CONTRACTED SERVICES</td>
<td>ED.4 OFF-CAMPUS DEPARTMENTS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.5.1</td>
<td>MS.3 ACCOUNTABILITY</td>
<td></td>
<td>5.4, 6.1</td>
<td>7.5.1, 7.5.2, 8.2.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.5.2</td>
<td>MS.8 APPOINTMENT</td>
<td></td>
<td>7.4.1, 7.4.2, 7.4.3</td>
<td>5.5.1, 6.2.1, 6.2.2, 6.3</td>
</tr>
</tbody>
</table>

**Notes:**
- 5.1, 5.5.1, 5.5.2
- 5.1, 5.5.1, 5.5.2
- 5.1, 5.5.1, 5.5.2
- 5.5.1, 7.2.1, 7.2.2
- 5.5.1, 6.3, 8.5.2
- 5.5.1
- 6.2.2, 8.1, 8.2.2, 8.2.3, 8.2.4, 8.4, 8.5.1, 8.5.2, 8.5.3
- 5.5.1, 6.3
- 5.1, 5.5.1, 5.5.2
- 6.2.1, 6.2.2
- 7.5.1, 7.5.2, 8.2.3
- 5.5.1, 6.2.1, 6.2.2, 6.3

**Crosswalk CoP – NIAHO® - ISO 9001 - Example**

- Management responsibility
- Measurement, analysis and improvement
- Resource management
- Purchasing process
Management Review

Document Control

Core Process

Improvement
Corrective/Preventive

Measure & Analyze

Internal Audit

Courtesy of Florida Hospital System
ISO 9001 and LEAN are congruent

LEAN is a specific methodology of continual improvement espoused by ISO

<table>
<thead>
<tr>
<th>ISO Clause</th>
<th>ISO 9001:2008</th>
<th>Relationship to Lean</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2</td>
<td>Customer Focus</td>
<td>Lean and ISO require a Customer focus</td>
</tr>
<tr>
<td>5.4.1</td>
<td>Quality Objectives</td>
<td>Lean metrics provide a means to measure Customer Satisfaction as part of the ISO Management System</td>
</tr>
<tr>
<td>8.1</td>
<td>Measurement, analysis and improvement</td>
<td>This reduces waste in the form of rejects from incapable processes or processes that are unstable</td>
</tr>
<tr>
<td>8.4</td>
<td>Data Analysis</td>
<td>Lean eliminates waste from processes as procedures are developed or reviewed.</td>
</tr>
<tr>
<td>7.5.2</td>
<td>Validation of processes for production and service provision</td>
<td>Lean Principles can be the focal point of the Continual Improvement process</td>
</tr>
<tr>
<td>8.2.3</td>
<td>Monitoring and measurement of processes</td>
<td>Standard work, a Lean Concept, can provide the framework for developing standard work instructions.</td>
</tr>
<tr>
<td>8.5.1</td>
<td>Continual Improvement</td>
<td></td>
</tr>
<tr>
<td>7.5.1</td>
<td>Control of production and service provision</td>
<td></td>
</tr>
</tbody>
</table>
ISO Principles vs. Baldrige Values

**ISO 9001**
- Leadership
- Customer focus
- Continual Improvement
- Involvement of People
- Mutually Beneficial Supplier Relationships
- Process Approach
- Factual Approach to Decision Making
- Systems Approach

**BALDRIGE**
- Visionary Leadership
- Customer-Driven
- Organizational & Personal Learning
- Valuing Employees and Partners
- Agility
- Focus on Future
- Managing for Innovation
- Management by Fact
- Public Responsibility & Citizenship
- Focus on Results
- Systems Perspective
Performance Based Approach

Performance Based Approach

- Regulatory requirements and YOUR quality program
- DNV Accreditation NIAHO®
- Sustainable and Continual improvement
- ISO

quality program
The Survey
Clinical, Generalist and Physical Environment Surveyors

- Complete the DNVHC NIAHO® Surveyor Training
- Complete the DNV ISO 9001 for Healthcare Lead Auditor
- Physical Environment / Life Safety Specialists must successfully complete a NFPA Life Safety Code for Hospitals training
- Fluency in Accreditation Process
- Mentored surveys
- All must attend annual surveyor training & complete 45 hours CEUs every 3 years
Survey Team – Typical Activities

• **Clinical Surveyor**
  Patient Care Unit Visits (Clinical Settings)
  Med-Surg, ICU, CCU, Obstetrics, Emergency Department
  High acuity units

• **Generalist Surveyor**
  Quality Management Review
  Medication Management
  Medical Staff and Human Resources Review
  Utilization Review Interview
  Patient Grievance Interview
  Med-Surg & Ancillary / Support Services Review (Lab, Medical Imaging, Rehab, etc.)

• **Physical Environment / Life Safety Specialist**
  All Physical Environment aspects and Management Plans
  – Physical Environment / Comprehensive Building Tour
  – Biomedical Engineering & Calibration of Equipment
Survey Activities

Survey activities are carried out as follows:

• A comprehensive review includes observation of care/services provided to the patient in all patient care areas, both in and out, patient and/or family interview(s), staff interview(s), and medical record review.

• Using Tracer methodology as it was intended, department/patient unit visits to include staff interviews and open medical record review as appropriate (both clinical and support departments)
  • identify performance issues
  • handoff between steps
  • Tracer methodology

• Visits to non-clinical support areas

• Comprehensive Building Tour (days, not hours)
Accreditation Process

Annual Survey

Life Threatening findings

Noteworthy efforts

Opportunities for Improvement

Non Conformities

Certificate Issued For 3 years

Accreditation Committee

Jeopardy/Condition Level

Cat 1

Cat 2

Robust Action Plan

Proof of Corrective Actions

Accreditation Process
Findings are Good!

I did not fail.

I only found 10,000 ways that won’t work.

Thomas Edison
Top/Common Findings Identified During Survey...

• Life Safety Management – Various issues not meeting LSC and NFPA requirements
• Medical Record Content – Dating and timing of medical record entries/orders
• Anesthesia Services – Incomplete/missing pre/post anesthesia evaluations
• Care Plan – Incomplete or not updated Plan of Care for the patient
• Verbal Orders – Missing/delayed authentication of verbal/telephone orders
• Medication Security – Medications storage and labeling issues
• Infection Control – activities related to surveillance issues and monitoring
• Informed Consent – Missing elements of the Informed Consent
• Medical Staff – Missing/Limited quality/performance data for practitioners (Quality Profile)
• Restraint and Seclusion – timeframes of orders and incomplete documentation
• Advance Directives – Missing documentation regarding patient’s Advance Directive – not present in the record or not following process when requested by a patient
• Staffing Management – (Orientation)- not including contracted staff or students in the process.
• Quality Management (Measure, monitoring and Analysis) – not implementing a documented process of evaluation of all organized services.
• **Medical Staff (Performance Data)** – not implementing a documented process that generates a quality profile for each medical staff member to be used for evaluation as part of appointment and reappointment.
• Governing Body – (Contracted services) – not having a current list or not including scope/nature of service.
• **Category 1 Nonconformities**
  – Submit Corrective Action Plan within 10 days from receipt of Final Report
  – The organization shall submit performance measure(s) data, findings, results of internal audits, or other supporting documentation, including timelines, to verify implementation of the corrective action measure(s).

• **Category 2 Nonconformities**
  – Submit Corrective Action Plan within 10 days from receipt of Final Report
  – Validation of effective implementation of the agreed Corrective Action Plan will take place at the next annual survey.

• **Category One Condition Level Finding** – requires re-survey to clear egregious findings
DNV HEALTHCARE INC.

CERTIFICATE OF ACCREDITATION

Certificate No. 57442-2009-AHC-USA-NIAHO

This is to certify that

St. Luke’s Episcopal Hospital
6720 Bertner Avenue, Houston, Texas 77030

Complies with the requirements of the:

NIAHO SM Hospital Accreditation Program

Pursuant to the authority granted to Det Norske Veritas Healthcare, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482). This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

Effective Date of Accreditation:
June 11, 2009

for the Accreditation Body:

DET NORSKE VERITAS HEALTHCARE, INC.
HOUSTON, TEXAS

Lack of continual fulfillment of the conditions set out in the Certification/Accreditation Agreement may render this Certificate invalid.

DNV NORSE VERITAS HEALTHCARE, INC., 1400 BAVELLO DRIVE, KATY, TX 77449, TEL.: 281-396-1000 – WWW.DNVACCREDITATION.COM
From NIAHO® to ISO

Year 1: Sign contract with DNV

Year 2: NIAHO Accreditation + ISO 9001 Pre-assessment

Year 3: NIAHO Accreditation + ISO 9001 Initial Visit (Stage I)

Year 4: NIAHO re-Accreditation + ISO 9001 Certification (Stage II)

Phase 1 - Planning
Phase 2 – System Development
Phase 3 – Implementation
Phase 4 – Conformance
Phase 5 - Certification

Do nothing different
Accreditation Cycles

2012 - NIAHO Accreditation
2013 - NIAHO Accreditation +
2014 - ISO 9001 Pre-assessment +
2015 - NIAHO Accreditation +
2016 - ISO 9001 Initial Visit +
2017 - NIAHO Accreditation +
2018 - ISO 9001 Periodic Audit +
2019 - NIAHO Accreditation +
2020 - ISO 9001 Periodic Audit +
2021 - NIAHO Accreditation +

CYCLE 1

CYCLE 2

CYCLE 3
Innovative Approach

- Annual on-site surveys
- Collaborative
- Less prescriptive
- Allows organization innovation
  - More than one way to accomplish a goal
  - Encourages best practices
  - ISO Tenets
    - Document what you do
    - Do what you document
    - Prove it
    - Improve it
Why DNV?
According to TMH and SLEH Presentation in ACHE

• The Survey Experience
  – Collaborative relations with surveyors
  – Tremendous engagement with Leadership
  – Surveyors were transparent – no surprises
  – Success based on unique organizational needs
  – Opportunities for improvement
  – Noteworthy efforts

• Post Survey Experience
  – Energy and excitement from staff and management team
  – Involvement of broader cross-section of hospital departments in action plans
  – Continued contact with actual survey team leaders
  – Process mapping is now the normal approach to problem solving
  – Emphasis on Continual Improvement
  – Annual Survey = Continual Readiness
• Currently **300 hospitals already Switched** to DNV Accreditation

• What do they say?
  – Enhances our continuous improvement
  – Embraces our ability to utilize our competence to innovate
  – Drives us to adopt best practices
  – Demands we discard ineffective practices
  – Improved communication between hospital and medical staff
  – Reduces the costly need for implementation and preparation for the program
  – Improves understanding of all hospital processes
  – Performed in a collaborative manner
News from Upstate
March 31, 2011
Doretra Royer 315 464-4833

Upstate University Hospital earns national certification

SYRACUSE, N.Y. — Upstate University Hospital is the first hospital in New York state to achieve certification as a DNV Primary Stroke Center (PSC) Hospital. In addition, the hospital has received accreditation by DNV’s National Integrated Accreditation for Healthcare Organization (NIAHO) program.

“We are proud to have successfully met the high level of standards that DNV expects hospitals to achieve for its accreditation and certification,” said Paul Seale, chief operating officer for Upstate University Hospital. “These distinctions demonstrate to our patients and their family members the importance that Upstate University Hospital places in offering safe, high quality patient care services.”
WHY DNV Accreditation
WE ARE JUDGED BY THE LEVEL ATTAINED BY THOSE WHOM WE SERVE, AND WE STRIVE TO RAISE THAT LEVEL AS HIGH AS POSSIBLE
Contacts

Yehuda Dror, President
yehuda.dror@dnv.com

Patrick (Pat) Horine, EVP
patrick.horine@dnv.com
513-388-4888

Darrel Scott, SVP
darrel.scott@dnv.com
513-388-4862

Web

US Hospital Accreditation
www.dnvaccreditation.com

DNV Global Healthcare
www.dnvhealthcare.com

DNV Corporate
www.dnv.com