



**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



MANAGING RISK **DNV**

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**Presentation Objective**



MANAGING RISK **DNV**

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

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**Why DNV**



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## DNV is

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- Independent foundation established in 1864
- Self-owned with no shareholders
- Stakeholders are represented in our governing bodies and committees
- Vision: **Global trust for safeguarding life, property and the environment.**
- We deliver financial results to develop our people and our research and innovation

**Everywhere**



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## DNV's Core competence

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## Global position within healthcare

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**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

**1st**  
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<sup>®</sup> accreditation (Recognised by CMS)

**EU**  
Multiple hospitals accredited to DNV International Standard - EU cross-border healthcare directive (2014)

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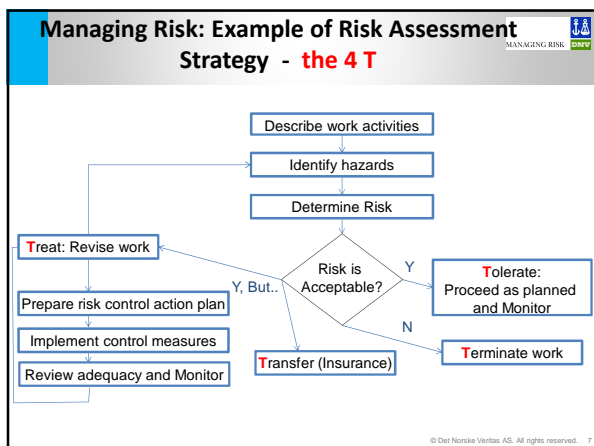
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### Managing Risk - Consider This

**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%

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### Changed Face for Hospital Accreditation in the US

<b>1951</b>	Joint Commission established
<b>1964</b>	Social Security Act – CMS (Centers for Medicare and Medicaid) established <ul style="list-style-type: none"> <li>• Accreditation required to receive CMS reimbursements</li> <li>• TJC receives statutory privilege – no accountability to CMS</li> </ul>
<b>12/2007</b>	DNV applies to CMS for deeming authority an approved AO for hospitals
<b>09/2008</b>	<b>DNV Granted Deeming</b>
<b>07/2008</b>	TJC loses statutory privilege, approved by CMS 11/09
<b>08/2012</b>	DNV Notice of <b>Continued Deeming</b> by CMS – 6 year extension (max. allowed by law)

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### 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

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### 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

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### Switching Accreditation Organization

**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](mailto:cmelanson@cms.hhs.gov)

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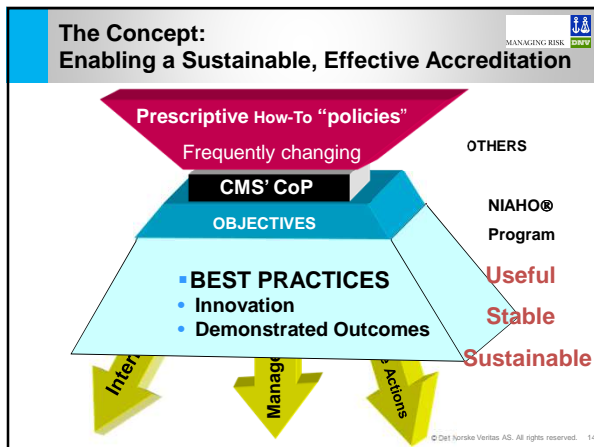
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Key Features	
Feature of NIAHO®	Benefit to Hospital
Stable standards, infrequent change	Sustainable system
Annual Surveys	Constant readiness
ISO 9001 Gradual Introduction @ no additional staff	More value, lower \$
Focus on sequence/interactions of all hospital processes	Clear, traceable pathway to improve
Demeanor of the survey team	Collaboration, sharing of ideas
No survey findings "tipping" point	Fear becomes confidence

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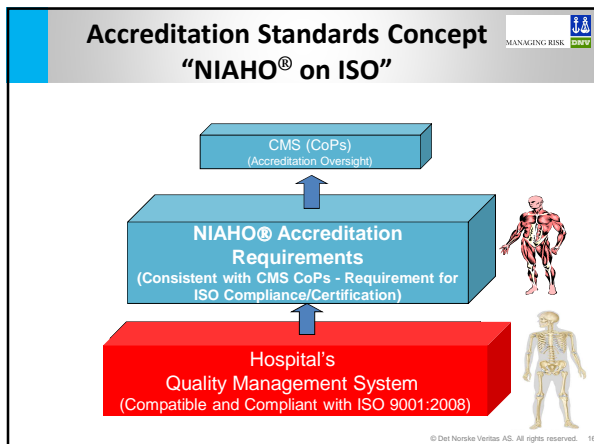
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### "NIAHO on ISO"

- 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

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- ### 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
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### 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

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### 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

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### ISO 9001:2008

Section	Description
1. Scope	General information
2. Normative reference	
3. Terms and definitions	
4. Quality management system	Mandatory requirements
5. Management responsibility	
6. Resource management	Certain requirements may be excluded
7. Product/Service realization	
8. Measurement, analysis and improvement	Mandatory requirements

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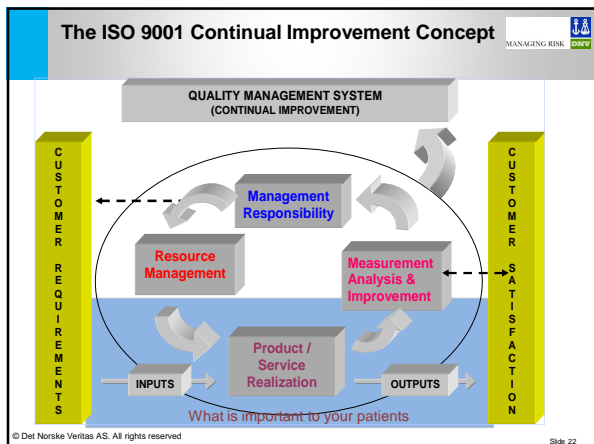
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### Example of ISO 9001:2008 Clauses

#### 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.

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### Example of ISO 9001:2008 Clauses

#### 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.

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## 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
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- 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.

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## 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.
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## 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.

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

Sec. 482.11 Condition of participation: Compliance with Federal, State and local laws.	GOVERNING BODY (GB) GB.1 LEGAL RESPONSIBILITY	5.1 5.5.1 5.5.2	Management responsibility
Sec. 482.12 Condition of participation: Governing body.	GOVERNING BODY (GB) GB.1 LEGAL RESPONSIBILITY	5.1, 5.5.1, 5.5.2	Measurement, analysis and improvement
	MEDICAL STAFF (MS) MS.2 ELIGIBILITY MS.7 MEDICAL STAFF BYLAWS MS.3 ACCOUNTABILITY MS.8 APPOINTMENT MS.11 GOVERNING BODY ROLE	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	
	CHIEF EXECUTIVE OFFICER (CE) CE.1 QUALIFICATIONS	5.1, 5.5.1, 5.5.2	Resource management
	MEDICAL STAFF (MS) MS.15 ADMISSION REQUIREMENTS	6.2.1, 6.2.2	
	GOVERNING BODY (GB) GB.2 INSTITUTIONAL PLAN AND BUDGET GB.3 CONTRACTED SERVICES	5.4, 6.1 7.4.1, 7.4.2, 7.4.3	Purchasing process
	EMERGENCY DEPARTMENT (ED) ED.3 EMERGENCY SERVICES NOT PROVIDED ED.4 OFF-CAMPUS DEPARTMENTS	7.5.1, 7.5.2, 8.2.3 5.5.1, 6.2.1, 6.2.2, 6.3	

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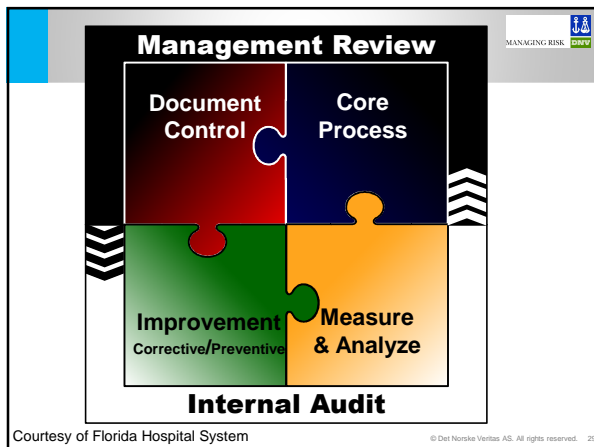
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Courtesy of Florida Hospital System

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### ISO 9001 and LEAN are congruent

LEAN is a specific methodology of continual improvement espoused by ISO

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

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### ISO Principles vs. Baldrige Values

ISO 9001	BALDRIGE
<ul style="list-style-type: none"><li>• Leadership</li><li>• Customer focus</li><li>• Continual Improvement</li><li>• Involvement of People</li><li>• Mutually Beneficial Supplier Relationships</li><li>• Process Approach</li><li>• Factual Approach to Decision Making</li><li>• Systems Approach</li></ul>	<ul style="list-style-type: none"><li>• Visionary Leadership</li><li>• Customer- Driven</li><li>• Organizational &amp; Personal Learning</li><li>• Valuing Employees and Partners</li><li>• Agility</li><li>• Focus on Future</li><li>• Managing for Innovation</li><li>• Management by Fact</li><li>• Public Responsibility &amp; Citizenship</li><li>• Focus on Results</li><li>• Systems Perspective</li></ul>

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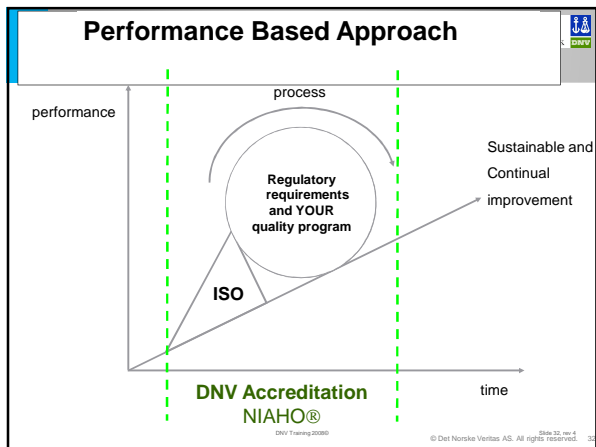
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## The Survey

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**“DNV Surveyors Make the Difference”**

**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

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**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

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**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)

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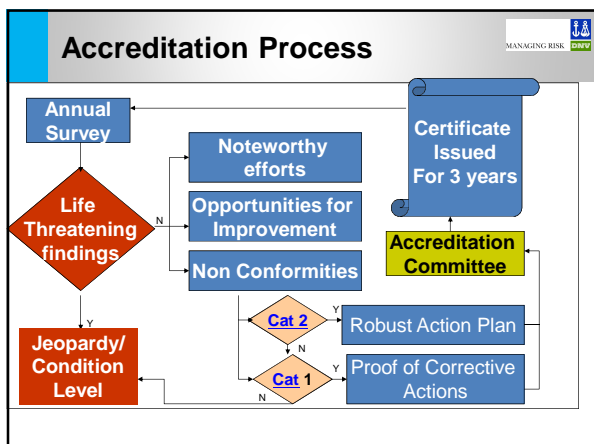
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## Findings are Good!

**I did not fail.**

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

*Thomas Edison*

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- ### 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.
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## Compliance, Corrective Action

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- **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

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### DNV HEALTHCARE INC. CERTIFICATE OF ACCREDITATION

Certificate No. 37842-2009-AHC-USA-NDAD0  
This is an **accreditation**

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

Complies with the requirements of the:  
**NIAHO<sup>SM</sup> 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

*[Signature]*  
Executive Vice President, Accreditation

CENTERS FOR MEDICARE & MEDICAID SERVICES

Det Norske Veritas Healthcare, Inc.  
Houston, Texas

*[Signature]*  
Vice President

Link of original text/letter of the conditions set out in the Certification/Accreditation Agreement may be found in this Certificate Issued.  
Det Norske Veritas Healthcare, Inc., 1400 Wall Street, Suite 1400, Dallas, TX 75201, Tel: 214-366-0800 - www.dnv.com/veritas

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## From NIAHO<sup>®</sup> to ISO

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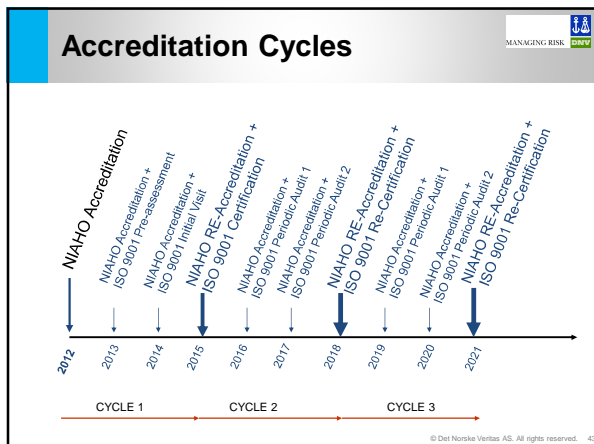
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- ### Innovative Approach
- Annual on-site surveys
  - Collaborative
  - Less prescriptive
  - Allows organization innovation
    - More than one way to accomplish a goal
    - Encourages best practices
    - ISO Tenets
      - Document what you do
      - Do what you document
      - Prove it
      - Improve it
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- ### 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
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## Why NIAHO® - Hospital's Testimonial

MANAGING RISK

- 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

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The screenshot shows a news article titled "Upstate University Hospital earns national certification" dated March 31, 2011. The article text states: "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." A large "DNV ACCREDITED Hospital" logo is featured prominently in the article. The website header includes navigation links like "Home", "About", "Library", and "Giving".

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## WHY DNV Accreditation

MANAGING RISK

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**DNV Guiding Principle** MANAGING RISK DNV

WE ARE JUDGED BY THE LEVEL ATTAINED  
BY THOSE WHOM WE SERVE, AND WE  
STRIVE TO RAISE THAT LEVEL AS HIGH AS  
POSSIBLE

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