CMS and Joint Commission

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Disclaimer

The views and opinions expressed in this lecture are those of this speaker and do not reflect the official policy or position of any agency of the U.S. government.
Objectives

1. Discuss the CMS Hospital Conditions of Participation (CoPs)
2. Discuss the CMS revised infection control worksheet and survey process
3. CMS TJC Crosswalk
4. Other initiatives related to HAI reduction
Organization of Quality, Safety and Oversight Group (QSOG), formerly Survey and Certification Group (SCG)

Federal
CMS Headquarters ------- AOs

10 Regional Offices

State Agencies

https://www.cms.gov/About-CMS/Agency-Information/RegionalOffices/RegionalMap.html
Organization of Quality, Safety and Oversight Group (QSOG)

- Division of Acute Care Services (DACS)
  - Acute Care Hospitals, LTACs, CAHs, ASCs, Rehab, Psychiatric

- Division of Nursing Homes (DNH)
  - Nursing Homes

- Division of Continuing Care Providers (DCCP)
  - Home Health and Hospice, ESRD, Psychiatric Residential Treatment Facilities

Clinical Laboratory Improvement Amendments (CLIA)
Where to Submit a Question or Inquiry?

Division of Acute Care Services (DACS)
PFP.SCG@cms.hhs.gov

Division of Nursing Homes (DNHs)
DNH_TriageTeam@cms.hhs.gov

ESRD Survey & Certification Group
ESRDSurvey@cms.hhs.gov
Find resources for compliance with the ESRD Conditions for Coverage here: www.cms.gov/GuidanceforLawsAndRegulations/05_Dialysis.asp

SCG General Information
http://www.cms.gov/SurveyCertificationGenInfo/
CMS Conditions of Participation (CoPs) & Conditions for Coverage (CfCs)

CMS develops CoPs - (hospitals, CAHs, ASCs)

CfCs - (ESRD, LTC/NH, ASCs)

Minimum health and safety standards that providers and suppliers must meet in order to be Medicare and Medicaid certified and receive reimbursement.

The Interpretive Guidelines (IGs) provide instructions to the surveyors on how to survey the CoP. Note: key are “should” versus “must” statements

cms.gov
CMS Hospital Infection Control
Conditions of Participation (CoPs)

- Provide a sanitary environment and have an active program for prevention, control, investigation of infections/communicable diseases (A-0747)

- Have a designated person(s) as infection control officer(s) to develop and implement policies (A-0748)

- Infection control officer(s) must develop a system for identifying, reporting, investigating and controlling infections/communicable disease of patients/personnel (A-0749)

- CEO, medical staff, and Director of Nursing must (A-0756)
  - Ensure hospital-wide QAPI and training programs address problems identified by IPs
  - Be responsible for implementation of successful corrective action plans
CMS Hospital Interpretive Guidance

Program must:
- Be incorporated into hospital-wide QAPI program
- Include nationally recognized practices, guidelines, and regulations
- Conduct surveillance facility-wide (all locations, departments, services, campuses), follow NHSN
CMS Hospital Interpretive Guidance

Program must:

• Appropriately monitor housekeeping, maintenance, and other activities to ensure sanitary environment

• Have active surveillance component covering patients and personnel

• Develop and implement IC interventions to address issues identified through detection, and monitor effectiveness of interventions
CMS Hospital Interpretive Guidance – Organizational Policies

• Designate in writing infection control officer(s)
  ➢ Must be qualified
  ➢ No specification on number of IPs or hours

• Develop and implement policies governing control of infections/communicable disease
CMS Hospital Interpretive Guidance

IP(s) must

Develop and implement infection control measures for HCPs
Mitigate risk (POA and HAI)
Active surveillance
Monitor compliance with policy and procedures
Program evaluation and revision
Report communicable diseases
Maintain sanitary physical environment
Notice of Proposed Rule Making (NPRM) Hospital and CAH Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, 2016

Hospital-wide IPC and antibiotic stewardship programs (ASP);

Designate leaders of the IPCP and the ASP respectively, who are qualified through education, training, experience, or certification.

Quality Assessment and Performance Improvement (QAPI) program incorporate quality indicator data related to hospital readmissions and hospital-acquired conditions;

Competencies documented for IPC training

Assess for IPC during Transitions of Care
NC Rules for Licensing Hospitals – Section .5100 – Infection Control

Infection Control Committee required to meet at least quarterly

All policies and procedures must be reviewed at least every three years
  Except Exposure Control Plan and Infection Control Plan (Annual)
Infection Control Worksheet
CMS ICW Structure

5 Modules
1 – Infection Control/Prevention Program
2 – General Infection Control Elements
3 – Equipment Reprocessing
4 – Patient Tracers
5 – Special Care Environments

CMS ICW Structure

5 Modules

20 Sections

4 tracers

- Urinary Catheter Tracer
- Central Venous Catheter Tracer,
- Ventilator/Respiratory Therapy Tracer
- Surgical Procedure

49 pages

Using Worksheet for Self-Assessment

CoPs set minimum standard
  Worksheet also includes best practice
  Recommendations that are not scored

This version of worksheet is “ideal” self assessment tool

Final version will change to accommodate surveyor needs
CMS – Joint Commission Crosswalk
TJC Scoring

Elements of Performance (EPs) are scored on a 3-point scale:

0 = insufficient compliance
1 = partial compliance
2 = satisfactory compliance

EPs are divided into two scoring categories

A – Structural, NPSGs, CoPs (scored as 0 or 2)
C – Scored based on number of found deficiencies

2 = one or no occurrences of noncompliance
1 = two occurrences
0 = ≥ three occurrences

All 0s and 1s have to be addressed by Evidence of Standards Compliance (ESC) submissions
TJC Chapter Outline

PLANNING (IC.01)
- Responsibility (IC.01.01.01)
- Resources (IC.01.02.01)
- Risk (IC.01.03.01)
- Goals (IC.01.04.01)
- Activities (IC.01.05.01)
- Influx (IC.01.06.01)

IMPLEMENTATION (IC.02)
- Plan Implementation (IC.02.01.01)
- Medical Equipment, Devices, Supplies (IC.02.02.01)
- Transmission of Infections (IC.02.03.01)
- Influenza Vaccinations (IC.02.04.01)
- Evaluation and Improvement (IC.03.01.01)
TJC Crosswalk for Tag A-0747

CMS

A-0747

Hospital **must provide a sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

EC.02.05.01 – Hospital manages risk associated with its utility systems.

   EP 1 – Designs and installs utility systems that meet patient care and operational needs.

   EP 5 – Minimizes pathogenic biological agents in cooling towers, domestic water systems, and other aerosolizing water systems

   EP 6 – In areas designed to control airborne contaminants, the ventilation system provides appropriate pressure relationships, air-exchange rates, and filtration
TJC Crosswalk for CMS Tag A-0747

**CMS**

A-0747

Hospital *must provide a sanitary environment* to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

**TJC STANDARDS**

EC.02.05.05 –

Hospital inspects, test, and maintains utility systems

EP 4 – Hospital inspects, test and maintains the following: infection control utility system components on the inventory. Activities are documented
CMS

Hospital **must provide a sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

EC.02.06.01 – Hospital establishes and maintains a safe, functional environment

- EP 13 – Hospital maintains ventilation, temperature, and humidity levels suitable for the care, treatment and services provided
- EP 20 – Areas used by patients are clean and free of offensive odors
TJC Crosswalk for CMS Tag A-0747

CMS

A-0747
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

EC.02.06.05 – Hospital manages its environment during demolition, renovation, and new construction to reduce the risk to those in the organization

EP 2 – When planning for demolition, construction, or renovation, hospital conducts a preconstruction risk assessment for air quality, infection control, utility systems, noise, vibration, and other hazards that affect care.

EP 3 – Hospital takes actions based on its assessment to minimize risk during demolition, construction and renovation.
CMS

A-0747

Hospital must provide a **sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.01.02.01 – Hospital leaders allocate needed resources for IC program

EP 1 – Provides access to information
EP 2 – Provides laboratory resources
EP 3 – Provides equipment and supplies
CMS

A-0747
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.01.03.01 – Hospital identifies risk for acquiring and transmitting infections

EP 1 – identifies risk for acquiring and transmitting infections based on: its geographic location, community, and population served
EP 2 – IDs risk based on: The care treatment and services it provides
EP 3 – IDs risk based on: analysis of surveillance activities and other IC activities
EP 4 – Reviews and identifies its risk at least annually and whenever significant changes occur with input from IPs, medical staff, nursing, leadership
Infection Control Risk Assessment: References

• Infection Control Risk Assessment
  APIC 2011-Baltimore (Web search)

• http://oregonpatientsafety.org/healthcare-professionals/infection-prevention-toolkit/section-1-infection-prevention-programdevelopment/473/oregonpatientsafety.org/healthcare.../infection...toolkit/...infection.../473/
TJC Crosswalk for CMS Tag A-0747

CMS

A-0747

Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.01.05.01 – Hospital has an infection control plan (ICP)

EP 1 – When developing plan, hospital uses evidence-based national guidelines, or expert consensus

EP 2 – ICP includes written description of the activities, including surveillance, to minimize, reduce, or eliminate risk of infection

EP 3 – ICP includes description of the process to evaluate ICP
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.01.05.01 – Hospital has an infection control plan (ICP)

- EP 5 – describes the process for investigating outbreaks
- EP 6 – All hospital components and functions are integrated into IC activities
- EP 7 – Hospital has method for communicating responsibilities about preventing and controlling infections to LIPs, staff, visitors, patients, and families.
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

IC.01.06.01 – Hospital prepares to respond to influx of potentially infectious patients

EP 4 – Hospital describes in writing how it will respond to influx of potentially infectious patients

EP 6 – When necessary, hospital activates its response to influx of potentially infectious patients
CMS

A-0747
Hospital **must provide a sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.02.01.01 – Hospital implements its ICP

   EP 1 – Hospital implements its IC activities, including surveillance, to reduce risk of infection

   EP 2 – Hospital uses Standard Precautions to reduce the risk of infection

   EP 3 – Hospital implements Transmission-based Precautions
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.02.01.01 – Hospital implements its ICP

  EP 6 – Minimizes risk of infection with storing and disposing of infectious waste

  EP 7 – Implements methods to communicate responsibilities for IC to LIPs, staff, visitors, patients, and families

  EP 8 – Reports infection surveillance, prevention, and control information to the appropriate staff within hospital
TJC Crosswalk for CMS Tag A-0747

CMS

A-0747
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.02.02.01 – Hospital reduces the risk of infection associated with medical equipment, devices and supplies
   EP 1 – Implements IC activities during: Cleaning and low-level disinfection
   EP 2 - Implements IC activities during: intermediate and high-level disinfection and sterilization
   EP 3 – Disposing of medical equipment, devices, supplies
   EP 4 – Storing medical equipment devices and supplies
Flexible endoscopy inspection and testing

Pre-cleaning processes
Use of enzymatic cleaners
Cleaning brush maintenance
Chemicals used in high level disinfection
Automated equipment processing
Appropriate processing length of time and temperature recorded
Rinsing process following disinfection
Drying of equipment following disinfection
Maintenance records for disinfection equipment
Equipment storage following disinfection
Logs regarding equipment use
Reprocessing of Critical Equipment

- Pre-cleaning process
- Use of enzymatic cleaners
- Cleaning brush maintenance
- Wrapping/packaging process- Labeling of sterile packs—sterilizer, load number and date
- Use of chemical indicators in all packs in every load
- Use of biological indicators at least weekly and with all implants
- Bowie-Dick testing in pre-vacuum steam sterilization
- gravity displacement vs. pre-vacuum steam sterilizers
- Sterilizer logs are kept for all loads
- Maintenance of sterilizers is per manufacturers recommendations
- Storage of sterilized items prevents contamination
TJC Crosswalk for CMS Tag A-0747

**CMS**

A-0747

Hospital **must provide a sanitary environment** to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

**TJC STANDARDS**

IC.02.03.01 – Hospital works to prevent transmission of infectious disease among patients, LIPs, and staff

EP 1 – Makes screening for exposure/immunity to Infectious diseases available to LIPs and staff

EP 2 – Refers/provides LIPs and staff with an infectious disease for assessment, testing, prophylaxis/treatment, and counseling

EP 3 – Refers/ provides occupationally exposed LIPs and staff for assessment, testing...

EP 4 – Patients exposed to infectious diseases, hospital provides/refers for assessment, testing...
TJC Crosswalk for CMS Tag A-0747T

CMS

A-0747
Hospital must provide a sanitary environment to avoid sources and transmission of infections/CD. There must be an active program for the prevention, control and investigation of infections/CD.

TJC STANDARDS

IC.03.01.01 – Hospital evaluates the effectiveness of the IC plan
   EP 1 – Hospital evaluates IC Plan annually and whenever risk change
   EP 4 – Evaluation includes: implementation of IC plan activities
   EP 6 – Findings from evaluation communicated annually to individuals/group that manages patient safety program
   EP 7 – Uses findings from evaluation if IC plan when revising IC plan
Organization and Policies: A person(s) must be designated as infection control officer(s) to develop and implement policies governing control of infections/CD. The infection control officer(s) must develop a system for identifying, reporting, investigating, and controlling infections/CD of patients and personnel.

TJC STANDARDS

IC.01.01.01 – Hospital identifies individual(s) responsible for the IC program
   EP 1 – Identifies individual(s) with clinical authority over the IC program
   EP 2 – When individual with authority over IC program does not have expertise in IC, he or she consults with someone who has such expertise to make decisions.
## TJC Crosswalk for CMS Tag A-0748

### CMS

**A-0748**  
**Organization and Policies:**  
A person(s) must be designated as infection control officer(s) to develop and implement policies governing control of infections/CD.

### TJC STANDARDS

**IC.01.01.01** – Hospital identifies individual(s) responsible for the IC program.

- **EP 3** – Hospital assigns responsibility for daily management of IC activities

- **EP 4** – Deemed status purposes: Individual with clinical authority is responsible for:
  - Developing polices
  - Implementing policies
  - Developing system for identifying reporting, investigating and control infections/CD
Infection control officer(s) must develop as system for identifying, reporting, investigating, and controlling infections/CD of patients and personnel.

HR.01.04.01 – Hospital provides orientation to staff

EP 4 – The hospital orients staff on the following:

Specific job duties, including those related to infection control and assessing and managing pain

Orientation completion is documented
TJC Crosswalk for CMS Tag A-0749

CMS

A-0749
Infection control officer(s) must develop as system for identifying, reporting, investigating, and controlling infections/CD of patients and personnel.

No Log required for HAIs

TJC STANDARDS

IC.01.05.01 – The Hospital has an IC Plan

EP 8 – Hospital identifies method for reporting infection surveillance and control information to external organizations
Infection control officer(s) must develop as **system for identifying, reporting, investigating, and controlling infections/CD of patients and personnel**

**TJC STANDARDS**

IC.02.01.01 – Hospital implements IC plan

EP 9 – Hospital reports infection surveillance, prevention, and control information to local, state, and federal public health authorities.
TJC Crosswalk for CMS Tag A-0756

CMS

A-0756

Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)

2) Be responsible for implementation and corrective actions

TJC STANDARDS

HR.01.05.03 – Staff participate in ongoing education and training

   EP 1 – Staff participate in ongoing education and training to maintain/increase competency. Staff participation is documented
Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)

2) Be responsible for implementation and corrective actions

IC.01.01.01 – Hospital identifies individual(s) responsible for the IC program

EP 3 – The hospital assigns responsibility for the daily management of infection prevention and control activities
TJC Crosswalk for CMS Tag A-0756

CMS

A-0756

Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)

2) Be responsible for implementation and corrective actions

TJC STANDARDS

IC.01.05.01 – The hospital has an infection prevention and control plan

   EP 6 – All hospital components and functions are integrated into the infection prevention and control activities
Responsibilities of CEO, Medical Staff and Director of Nursing must:

1) Ensure that the hospital-wide QAPI program and training programs address problems identified by the infection control officer(s)

2) Be responsible for implementation and corrective actions

LD.01.02.01 – The hospital identifies the responsibilities of its leaders

EP 4 – Deem purposes: CEO, Medical Staff, and nurse executive make certain that the hospital-wide QAPI and training programs address problems identified by the individual(s) responsible for infection prevention and control and that corrective action plans are successfully implemented
## 2018 National Patient Safety Goals

<table>
<thead>
<tr>
<th>Goal Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.07.01.01</td>
<td>Use the hand cleaning guidelines from the CDC and Prevention or the WHO. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.</td>
</tr>
<tr>
<td>NPSG.07.03.01</td>
<td>Use proven guidelines to prevent infections due to MDROs.</td>
</tr>
<tr>
<td>NPSG.07.04.01</td>
<td>Use proven guidelines to prevent infection of the blood from central lines.</td>
</tr>
<tr>
<td>NPSG.07.05.01</td>
<td>Use proven guidelines to prevent infection after surgery.</td>
</tr>
<tr>
<td>NPSG.07.06.01</td>
<td>Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.</td>
</tr>
</tbody>
</table>
2018 National Patient Safety Goals

NPSG.07.01.01 - Use the hand cleaning guidelines from the CDC and Prevention or the WHO. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

EP 1 – Implement program that follows categories 1A, 1B and 1C recommendations

IC.02.01.01, EP 2: "The [organization] uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection." The new rule is applicable to all accreditation programs.

Effective January 1, 2018, for all accreditation programs, any observation by surveyors of individual failure to perform hand hygiene in the process of direct patient care will be cited as a deficiency resulting in a Requirement for Improvement (RFI) under Infection Prevention and Control (IC) Standard.
Environmental Services

Environmental service worker PPE use *(also 07.03.08)*

Patient care area cleaning processes—high touch areas are cleaned daily

Terminal Cleaning and removal of linen

Use of cleaners and disinfectants reflect manufacturers guidelines for use

Clean cloths for each patient room/corridor *(07.03.06)*

Mop head and cloth cleaning daily *(also 07.03.06)*

Blood and body fluid cleaning process—spills
Environmental Services

Equipment cleaning schedules (HVAC, eyewash stations, ice machines, refrigerators, scrub sinks and aerators on faucets)

Handling of clean and dirty laundry with no potential for cross contamination

Bagging and storage of dirty linen

Segregation of clean from dirty in laundry processing area

(Also 07.04.01 for all three)
2018 National Patient Safety Goals

NPSG.07.03.01 – Implement evidence based practices to prevent HAIs due to MDROs (9 EPs)

1. Periodic risk assessment for MDRO acquisition and transmission
2. Education LIPs/Staff about HAIs, MDROs, and prevention strategies annually
3. Educate patients and families about MDROs
4. Surveillance for MDROs based on risk assessment
5. Measure and monitor MDRO prevention processes and outcomes
6. Proved MDRO outcomes and process data to key stakeholders (LIPs, leadership, staff)
7. Implement polices and procedures based evidence-based MDRO guidelines
8. Implement laboratory alert system that identifies new pts. with MDROs
9. Implement alert system that identifies readmitted or transferred patients positive for MDROs
2018 National Patient Safety Goals

NPSG.07.04.01 – Implement evidence-based practices to prevent CLABSIs (13 EPs)

1. Educate staff and LIPs involved in central lines annually (include involvement into job descriptions)
2. Education patients/families about CLABSIs
3. Implement polices and procedures based on evidence-based guidelines
4. Periodic risk assessments for CLABSI, compliance with practices, and evaluate prevention efforts
5. Provide data (rates and outcome measures) to stakeholders
6. Use standardized insertion checklist
7. Perform hand hygiene
8. Do not use femoral vein (adults only), unless other sites unavailable
9. Use standardized supply cart/kit
10. Use standardized protocol for sterile barrier precautions
11. Use aseptic skin preparation
12. Use standardized protocol to disinfect catheter hubs/ports before accessing
13. Evaluate all CVCs routinely and remove non-essential catheters
2018 National Patient Safety Goals

NPSG.07.05.01 – Implement evidence-based practices to prevent SSIs (8 EPs)

1. Educate all LIPs/Staff involved in surgical procedures
2. Educate patients and families about SSI prevention
3. Implement polices and procedures based on evidence-based guidelines
4. Conduct periodic risk assessments, select SSI measures based on evidence-based guidelines, monitor compliance with best practices, and evaluate effectiveness of prevention efforts
5. Measure SSI rates for first 30 days following procedure (1 year for implantables)
6. Provide process and outcome measure results to stakeholders
7. Administer antimicrobial prophylaxis according to method cited in scientific literature or endorsed by professional organizations.
8. When hair removal necessary, use method cited in scientific literature or endorsed by professional organizations.
2018 National Patient Safety Goals

NPSG.07.06.01 – Implement evidence-based practices to prevent CAUTI (3 EPs)

1. Insert indwelling urinary catheters according to established evidence-based guidelines

   Limit use and duration to situations necessary for care

   Using aseptic techniques

2. Manage indwelling urinary catheters according to evidence-based guidelines

   Securing catheters

   Maintaining sterility of collection system

   Replacing collection system when required

   Collecting urine samples

3. Measure and monitor CAUTI prevention processes and outcomes
Federal Initiatives to reduce HAIs
Federal Initiatives to Reduce HAIs

HHS HAI Action Plan
Partnership for Patients (PfP)
NHSN
QIOs
HENs
CMS required reporting, VBP
Partnerships for Patients

Hospital Engagement Networks

26 National, Regional, State and Hospital System level HENs

  CAUTI
  CLABSI
  SSI
  VAP/VAE

Hospital Improvement and Innovation Networks (HIINs)

The period of performance for the HIINs begins in September 2016 - 2019, consists of 24-month base period and a 12-month option year to implement and spread well-tested, evidence-based best practices.

-12% reduction in 30 day readmission

-20% decrease in overall harm
QIO Activity in 11\(^{th}\) SOW: HAIs

QIOs will work to reduce the following HAIs in hospitals (ICU and non-ICU wards) the 11\(^{th}\) SOW:

- Central line bloodstream infections (CLABSI)
- Catheter-associated urinary tract infections (CAUTI)
- Clostridium difficile infections (CDI)
- Surgical site infections (SSI)
Thank You!