The Accreditation Process (ACC)

ACC Chapter Contents
This chapter introduces the Joint Commission’s accreditation process, beginning with general information about eligibility for accreditation and the application process, accreditation policies, and types of surveys. Details are then provided on what organizations can expect before, during, after, and between accreditation surveys. Finally, the chapter ends by listing the accreditation decision rules and outlining review and appeal procedures. This outline provides a way to easily navigate the chapter and find information quickly. This list contains a CMS icon next to sections that have content of special interest to hospitals that use Joint Commission accreditation for deeming purposes.

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Shading indicates a change effective January 1, 2017, unless otherwise noted in the What’s New.
Overview
The policies, procedures, and explanations of process described in this chapter apply to any health care organization interested in Joint Commission accreditation, whether it is applying for the first time or seeking continued accreditation. All organizations must follow the policies and procedures listed in this chapter to participate in the accreditation process. Failure to follow the policies and procedures described in this chapter can result in denial of accreditation. Because this information is reviewed and revised as necessary on a continuous basis, all accredited hospitals are responsible for keeping track of these policies and procedures.

Changes made to accreditation requirements between manual updates can be viewed at “The Joint Commission Requirements” page on The Joint Commission website at http://www.jointcommission.org/standards_information/tjc_requirements.aspx.

The “Accreditation Participation Requirements” (APR) chapter also includes specific requirements for accreditation participation. The APRs are existing policies and are currently effective for accreditation purposes. Cross-references to the APRs are noted in the applicable sections of this chapter.

General Eligibility Requirements
Any health care organization may apply for Joint Commission accreditation if all the following requirements are met:

- The organization is in the United States or its territories or, if outside the United States, is operated by the US government or under a charter of the US Congress.
- If required by law (for all programs), the organization has a facility license or registration to conduct its scope of services.
The organization can demonstrate that it continually assesses and improves the quality of its care, treatment, and/or services. This process includes a review by clinicians or other qualified individuals, including those knowledgeable in the type of care, treatment, and/or services provided at the organization.

The organization identifies the services it provides, indicating which care, treatment, and/or services it provides directly, under contract, or through some other arrangement.

The organization provides services that can be evaluated by The Joint Commission’s standards.

If the organization uses its Joint Commission accreditation for deemed status purposes, the organization meets the Centers for Medicare & Medicaid Services (CMS) definition of a hospital as set forth in “Appendix A: Medicare Requirements for Hospitals” (AXA); see “Appendix B: Special Conditions of Participation for Psychiatric Hospitals” (AXB) for information about psychiatric hospitals that use accreditation for deemed status purposes.

The organization meets parameters for the minimum number of inpatients/volume of services required for organizations seeking Joint Commission accreditation for the first time; that is, 10 inpatients served, with one active at the time of survey. A hospital that is seeking Medicare Certification and is new to The Joint Commission must have one active inpatient case at the time of survey.

- If the hospital’s average daily census (ADC) is 21 or more, or if the hospital is a specialty hospital (cardiac, orthopedic, or surgical), the hospital must be able to provide inpatient records for at least 10% of the ADC, but not less than 30 inpatient records at the time of survey.
- If the hospital’s ADC is less than 21 (1–20), the hospital must be able to provide 20 inpatient records.

The tests, treatments, or interventions provided at the organization are prescribed or ordered by a licensed practitioner in accordance with state and federal requirements.

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**Eligibility Requirements for Initial Surveys**

For hospitals new to the accreditation process or undergoing an initial survey for deemed status purposes, surveyors must be able to review records equal to 10% of the average daily census but not fewer than 30 inpatient records, or for small hospitals not fewer than 20 inpatient records. Surveyors will review a minimum of 30 records in a specialty

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*A small hospital is defined as having an average daily census of 20 patients or fewer.*
hospital (such as a cardiac, orthopedic, or surgical hospital) regardless of average daily census. For hospitals not using The Joint Commission for deemed status purposes, a minimum of 10 inpatients must be served, with one in active treatment at the time of survey.

**Scope of Accreditation Surveys**
The Joint Commission evaluates all health care services provided by the organization for which The Joint Commission has standards and makes an accreditation decision for each accreditation program surveyed. The survey results are documented by the surveyor(s) and left on site (with the exception of for-cause surveys) in the preliminary Summary of Survey Findings Report. During a survey, an organization must be prepared to provide evidence of its compliance with each applicable standard. To attain accreditation, an organization must demonstrate overall compliance with the standards and their elements of performance (EPs).

In addition to using standards and EPs, The Joint Commission also surveys organizations by using APRs, performance measurement data (when applicable), and the Joint Commission National Patient Safety Goals (see the APR, “Performance Measurement and the ORYX® Initiative” [PM], and “National Patient Safety Goals” [NPSG] chapters, respectively). Used in conjunction with the standards, these requirements help assess an organization’s performance.

**Accreditation Policies**
This section provides information on the policies that govern the accreditation process for hospitals and describes how The Joint Commission shares information about an individual organization.

**Tailored Survey Policy**
The public expects all of the programs or services delivered under the auspices of an accredited organization to have been evaluated. As such, The Joint Commission applies its Tailored Survey Policy to components (for which there are applicable Joint Commission standards) that are organizationally and functionally integrated with the health care organization applying for accreditation (see the “Organizational and Functional Integration” section).
The Joint Commission will include another service, program, or related entity (that is, component), whether providing programs or services directly or through a contractual arrangement, in the survey of the applicant organization under the following circumstances:

- There are Joint Commission standards applicable to the component.
- There is organizational and functional integration between the component and the applicant organization.

The Joint Commission survey, assuming satisfactory compliance, provides one accreditation award for each accreditation program surveyed (for example, ambulatory care, behavioral health care, home care, nursing care centers, and so forth).

Any service, program, or related entity that is a component of an accreditation-eligible organization may independently seek accreditation if it can meet Joint Commission survey eligibility requirements. The results of such a separate accreditation survey will not affect the overall organization’s decision. If the service, program, or related entity seeks separate accreditation, the Tailored Survey Policy does not require the larger complex organization to be separately accredited.†

**Complex Organization Survey Process**

The complex organization‡ survey process is applied to organizations that are governed by the Tailored Survey Policy. The Joint Commission conducts a complex organization survey based on the services or programs provided by the organization, as reported in its electronic application for accreditation (E-App). Because a complex organization survey process involves standards in more than one of the manuals listed in the “Identifying Applicable Standards” section of the “Introduction: How The Joint Commission Can Help You Move Toward High Reliability” (INTRO) chapter, The Joint Commission provides the organization with access to the electronic editions of the manuals to be used in the survey before it is conducted. The Joint Commission surveys and, assuming satisfactory compliance, provides one accreditation award for each program surveyed.

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†The laboratory must meet the requirements of decision rule FOC01 for the organization to be successfully accredited. See the “One-Month Survey” section in the “Accreditation Decision Rules” for the full requirement.

‡A complex organization refers to an organization that is surveyed under more than one accreditation manual.
Organizational and Functional Integration

Organizational and functional integration refers to the degree to which a component is overseen and managed by the applicant organization that is either seeking accreditation or currently accredited. A component is a service, program, or related entity that delivers care, treatment, or services and is eligible for survey under one of The Joint Commission’s accreditation programs listed in the INTRO chapter.

Organizational integration exists when an applicant organization’s governing body either directly or ultimately controls budgetary and resource allocation decisions for the component or, where individual corporate entities are involved, there is greater than 50% common governing board membership for the applicant organization and on the board of the component.

Functional integration exists when the entity meets at least three of the following eight criteria:

1. The applicant organization and the component do the following:
   - Use the same process for determining membership of licensed independent practitioners in practitioner panels or medical or professional staff and/or
   - Use the same process for credentialing and assigning of privileges or clinical responsibilities to licensed independent practitioners and/or
   - Share a common organized medical or professional staff between the applicant organization and the component

2. The applicant organization’s human resources function hires and assigns staff at the component and has the authority to do the following:
   - Terminate staff at the component
   - Transfer or rotate staff between the applicant organization and the component
   - Conduct performance appraisals of the staff who work in the component

3. The applicant organization’s policies and procedures are applicable to the component, with few or no exceptions.

4. The applicant organization manages significant operations of the component (that is, the component has little or no management authority or autonomy independent of the applicant organization).

5. The component’s medical records are integrated into the applicant organization’s medical record system.

6. The applicant organization applies its performance improvement program to the component and has authority to implement actions intended to improve performance at the component.
7. The applicant organization bills for services provided by the component under the name of the applicant organization.

8. The applicant organization and/or the component portrays to the public that the component is part of the organization through the use of common names or logos; references on letterheads, brochures, telephone book listings, or websites; or representations in other published materials.

A checklist to help determine whether organizational and functional integration exists is provided in Figure 1.
# Checklist to Determine Organizational and Functional Integration

<table>
<thead>
<tr>
<th>Organizational Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Budgetary decisions</strong>—Does the governing body of the applicant organization control budget and resource allocation for component?</td>
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<td><strong>2. Shared governance</strong>—If separate corporate entities, do the applicant organization and the component share over 50% of governing body membership?</td>
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</table>

<table>
<thead>
<tr>
<th>Functional Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Common medical staff</strong>—Is there a unified process for credentialing staff and/or licensed independent practitioner membership?</td>
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<tr>
<td><strong>2. Human resources</strong>—Does the applicant organization have hiring/firing/performance appraisal authority over the component’s staff?</td>
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<tr>
<td><strong>3. Policies and procedures</strong>—Are there common policies and procedures?</td>
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<td><strong>4. Management</strong>—Does the applicant organization manage operations of the component?</td>
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<tr>
<td><strong>5. Patient records</strong>—Is there an integrated patient record system?</td>
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<tr>
<td><strong>6. Performance improvement</strong>—Is there an integrated performance improvement program? Does the applicant organization have authority to implement performance improvement actions at component?</td>
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<tr>
<td><strong>7. Billing</strong>—Are the component’s services billed by the applicant organization?</td>
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<td></td>
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<tr>
<td><strong>8. Public portrayal</strong>—Is there public portrayal of component as part of a parent organization through names, logos, or such?</td>
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</tr>
</tbody>
</table>

**Note:** Applicant organization needs minimum of one “Yes” response for organizational integration and three “Yes” responses for functional integration to include components as “sites” on the electronic application for accreditation (E-App).

**Figure 1.** Checklist to determine organizational and functional integration.
Inclusion of Physician Practices in Survey
Physician practices are included in an accreditation survey only if the physician practice is included in the hospital’s Medicare cost report as a provider-based (that is, not freestanding) practice.

Multiorganization Option
The Joint Commission offers a multiorganization system that owns or leases at least two organizations the option of using a modified survey process. This option has the following three components:
1. A corporate orientation held at the beginning of the year
2. Surveys of participating organizations with the same survey team leader
3. A corporate summation after the last organization in the system is surveyed

A system may choose either a corporate orientation, a corporate summation, or both. The orientation session provides an opportunity for corporate staff to orient the surveyor or survey team to the structure and practices of the system. The surveyor or survey team also surveys centralized corporate services, documentation, and policies and procedures applicable to Joint Commission standards. The corporate summation provides an overall analysis of the system’s strengths and weaknesses. It also provides consultation and education related to accreditation survey findings across the system. There is a separate fee for both the corporate orientation and corporate summation.

Continuity in the composition of a survey team is maintained by the survey team leader(s). The remaining members of the survey team rotate in and out of the system’s unannounced schedule. The survey team leader compiles the information necessary to support the corporate summation.

Through the multiorganization option, The Joint Commission accredits the individual health care organizations that are part of a multiorganization system, not the system itself. Therefore, each organization within a system receives its own accreditation decision and Accreditation Survey Findings Report. The findings and decision for one organization within a system have no bearing on those of another organization within the system.
Concurrent Survey Option
The Joint Commission offers a concurrent survey option for health care systems with more than one accredited entity included in a single system even if the organizations maintain distinct CMS Certification Numbers (CCNs), if applicable. This option provides a structure across the entire system and has the following components:

- Unannounced surveys of participating organizations occur at the same time.
- Each participating organization must demonstrate compliance with all Joint Commission requirements independent of any other organization within the system.
- Each organization with a distinct CCN will receive a separate survey report and accreditation decision.

The concurrent survey process works best when conducted in systems where 12 or fewer entities wish to be surveyed at the same time.

Contracted Services
The Joint Commission evaluates an organization’s management and oversight of the quality of care, treatment, and services (for which there are Joint Commission standards) provided under contractual arrangements. The Joint Commission reserves the right to evaluate, as part of its survey, the care, treatment, and services provided by another organization or provider on behalf of the applicant organization. It may survey performance issues between the contracted organization and the applicant organization, regardless of the accreditation decision of the contracted organization. The Joint Commission also surveys care, treatment, and services provided on site under contract to the applicant organization.

Integrated Care Certification Option
Integrated Care Certification evaluates how well an organization integrates key processes and coordinates care as a patient moves across the continuum of care. The certification program is an optional process open to entities that are integrating patient care across the continuum:

- A hospital or health system that is integrating with a physician practice (freestanding or hospital based) or an ambulatory organization
- A physician practice (freestanding or hospital based) or an ambulatory organization integrating with a hospital
- Home care providers and/or nursing care centers that are integrating with any of the above entities or with other home care and/or nursing care centers
At least one of these entities must be accredited by The Joint Commission at the time that an integrated program applies for certification. The organization(s) must be working toward improving outcomes through integration and coordination of care.

The certification review will evaluate compliance with the Integrated Care Certification standards, which are designed to be flexible to accommodate different models and sizes of organizations. The requirements will help organizations develop a foundation for using data to identify their risk points and then determine ways to manage those risks. The review will also utilize the tracer methodology, which will follow the experiences of a select number of patients as they move between the integrated care organization’s care providers.

When ready to apply for Integrated Care Certification, an organization can use the application to describe the integrated programs and also the specific sites to be reviewed.

The results of Integrated Care Certification, which is valid for three years, will have no effect on an organization’s accreditation status.

For further information, please e-mail integratedcare@jointcommission.org or visit The Joint Commission website at https://www.jointcommission.org/certification/integrated_care_certification.aspx.

**Primary Care Medical Home Certification Option**

The Joint Commission’s Primary Care Medical Home (PCMH) certification option helps hospitals provide patient-centered, comprehensive, accessible, and coordinated care delivered by a primary care clinician working with an interdisciplinary care team. PCMH certification is achieved by demonstrating compliance with all hospital standards, plus an additional set of PCMH-only requirements that support the five operational characteristics of the PCMH model (see the “Primary Care Medical Home Certification Option” [PCMH] chapter). PCMH certification is an optional selection available as part of the application for accreditation; hospital accreditation is required for an organization to be eligible for PCMH certification. Also, hospitals will be able to select those eligible clinics/practices for which they want PCMH certification. Therefore, a hospital may elect to have the PCMH certification for all or only some of their eligible clinics/practices. As with an initial hospital accreditation survey, all PCMH initial surveys are unannounced, with the evaluation of PCMH requirements being integrated as part of the on-site survey process. PCMH certification can also be added to an already existing hospital
accreditation through an extension survey. In an extension survey, the surveyor will conduct an unannounced on-site survey prior to the hospital’s next resurvey. Additional information about the PCMH certification option for hospitals is available on The Joint Commission website at http://www.jointcommission.org/accreditation/primary_care_medical_home_certification_option_for_hospitals.aspx. The Joint Commission also offers similar certification for ambulatory care organizations, behavioral health care organizations, and critical access hospitals.

Organizations that are requesting or that have achieved PCMH certification may access the Provider Information Tool via their E-App or Joint Commission Connect™ extranet site. This optional tool enables organizations to identify clinical providers who serve as staff at eligible PCMH sites. Depending on the location of the organization, this information may be used by payers for reimbursement or funding purposes.

**Patient Blood Management Certification Option**

The Patient Blood Management certification program is a collaborative effort between AABB and The Joint Commission. The AABB–Joint Commission Patient Blood Management Certification is designed to promote patient safety and quality and to help hospitals realize the maximum benefits of establishing a comprehensive patient blood management program. This voluntary hospital certification, which is based on the AABB Standards for a Patient Blood Management Program, is new; hospitals already accredited by AABB are not automatically certified. In addition, hospitals that wish to become certified need to be currently accredited by The Joint Commission.

A Patient Blood Management certification review is scheduled to last one day. If the hospital is accredited by AABB for blood banking and/or transfusion services, a Joint Commission surveyor will conduct the review. If the hospital is not AABB accredited, the review will be conducted by both a Joint Commission surveyor and an AABB assessor. Certification is valid for two years.

For further information, or to access a complimentary trial edition of the standards for Patient Blood Management Certification, please contact qualityhospitals@jointcommission.org or visit The Joint Commission website at https://www.jointcommission.org/certification/patient_blood_management_certification.aspx.
Accrediting in Accordance with CMS Certification Numbers

In accordance with The Joint Commission’s continuing deeming authority, The Joint Commission accredits a hospital in accordance with its CCN. Each hospital must meet all requirements as specified in the CMS definition of a hospital (as set forth in “Appendix A: Medicare Requirements for Hospitals” [AXA] of this manual; see also “Appendix B: Special Conditions of Participation for Psychiatric Hospitals” [AXB] of this manual) and demonstrate compliance with all applicable Joint Commission standards independent of any relationship or affiliation with any other hospital or health care organization.

Initial Surveys

An organization that is seeking Joint Commission accreditation for the first time or that has not been denied accreditation by The Joint Commission during the previous four months is eligible for an initial unannounced survey if it serves the required minimum number (defined below) of patients regardless of how long the organization has been in operation. The full scope of applicable standards is reviewed during the survey. The Joint Commission’s policy for assessing and monitoring organizations new to the accreditation process is as follows:

- If an organization new to the accreditation process demonstrates compliance with applicable Joint Commission accreditation requirements, the organization will receive accreditation.

- All organizations new to the accreditation process that become accredited after their initial survey will be included in a 2% “pool” of organizations undergoing a random unannounced on-site validation survey of their Evidence of Standards Compliance (ESC) (see the “Random Validation of Evidence of Standards Compliance” section for more information).

- The organization has a sufficient number of inpatient records to review to adequately determine compliance equal to 10% of the average daily census but not fewer than 30 inpatient records, or for small general hospitals (with an average daily census of 20 patients or less) not fewer than 20 inpatient records. Specialty hospitals (such as cardiac, orthopedic, or surgical hospitals) have a minimum of 30 inpatient records regardless of average daily census. (See the “Eligibility Requirements for Initial Surveys” section for more information.)
The organization meets parameters for the minimum number of patients/volume of services required for organizations seeking Joint Commission accreditation for the first time, that is, 10 inpatients served, with one active at the time of survey, if the hospital is not using Joint Commission accreditation to meet deemed status requirements.

The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has a Requirement for Improvement (RFI). If there are no RFIs, the effective date is the day after the last day of the survey.

**Survey Postponement Policy**
In rare circumstances, it may be appropriate to request a survey postponement. An organization should direct a request for a postponement to its account executive. A request to postpone a survey may be granted if a major unforeseen event has occurred that has totally or substantially disrupted operations, such as the following:
1. A natural disaster or major disruption of service due to a facility failure
2. The organization’s involvement in an employment strike
3. The organization’s cessation of admitting or treating patients
4. The organization’s inability to treat and care for patients and its transferrence of patients to other facilities or organizations

The Joint Commission may, at its discretion, approve a request to postpone a survey for an organization not meeting any of the criteria described above. The organization may be charged a fee to defray costs.

**Information Accuracy and Truthfulness Policy**
The accuracy and veracity of relevant information, whether actually used in the accreditation or certification processes, are essential to the integrity of the Joint Commission’s accreditation and certification processes. *Falsification*, as the term is used in the Joint Commission’s Information Accuracy and Truthfulness Policy, applies to both commissions and omissions in sharing information with The Joint Commission. Information provided at any time by the organization must be accurate and truthful (see APR.01.02.01 in the APR chapter). Such information may be furnished in any of the following manners:
- Provided verbally or in writing
Obtained through direct observation or interview by Joint Commission surveyor(s) or reviewer(s).

Derived from documents supplied by the organization to The Joint Commission, including, but not limited to, an organization’s comprehensive systematic analysis (for example, a root cause analysis) in response to a sentinel event or an organization’s request for accreditation/certification.

Electronically transmitted data or documents including, but not limited to, data or documents provided as part of the E-App process.

An attestation that the organization does not currently and knowingly use Joint Commission full-time, part-time, or intermittent surveyors or reviewers to provide any accreditation/certification-related consulting services including, but not limited to, the following:

- Helping an organization meet Joint Commission accreditation/certification requirements
- Helping an organization with any intracycle monitoring process
- Conducting mock surveys for an organization
- Helping an organization in the ESC process

**Policy Requirements**

The Joint Commission’s Information Accuracy and Truthfulness Policy includes the following:

1. An organization must never provide The Joint Commission with falsified (as defined below) information relevant to the accreditation/certification process. The Joint Commission construes any effort to do so as a violation of the organization’s obligation to engage in the accreditation/certification process in good faith.

2. *Falsification* is defined for this policy as the fabrication, in whole or in part, and through commission or omission, of any information provided by an applicant or accredited organization/certified program to The Joint Commission. This includes, but is not limited to, any redrafting, reformatting, or content deletion of documents.

3. The organization may submit additional material that summarizes or otherwise explains original information submitted to The Joint Commission. These materials must be properly identified, dated, and accompanied by the original documents.

4. The Joint Commission conducts an evaluation when it has cause to believe that an accredited organization/certified program may have provided falsified information to The Joint Commission relevant to the accreditation/certification process. Except as otherwise authorized by the president of The Joint Commission, the evaluation may include an unannounced on-site survey. This survey uses special protocols designed
to address the information determined by The Joint Commission to constitute possible falsification. It assesses the degree of actual organization compliance with the standards and EPs that are the subject of the allegation, if appropriate.

5. The Joint Commission takes action to deny accreditation/certification to an organization/program whenever The Joint Commission is reasonably persuaded that the organization/program has provided falsified information.

6. The Joint Commission may notify responsible federal and state government agencies of any organization/program subject to such action.

7. If an organization/program is denied accreditation/certification because it provided falsified information, The Joint Commission prohibits it from participating in the accreditation or certification process for a period of one year. The president of The Joint Commission, for good cause only as determined in his/her sole discretion, may waive all or a portion of this waiting period. If an organization requests to participate in the accreditation/certification process prior to the completion of the one-year prohibition period and the president of The Joint Commission does honor the request, executive leadership will be so notified.

**Good Faith Participation in Accreditation/Certification**

The Joint Commission requires each organization seeking (re)accreditation or (re)certification to engage in the process in good faith. The Joint Commission may deny accreditation or certification to any organization that fails to participate in the process in good faith. The following are examples of actions interfering with good faith participation:

- **Deceiving The Joint Commission.** Compliance with the Information Accuracy and Truthfulness Policy requires a commitment on the part of the accredited organization/certified program not to deceive The Joint Commission in any aspect of the accreditation/certification process, such as during the completion of an application for accreditation/certification, during the Intracycle Monitoring (ICM) process, or during a survey/review.

- **Deceiving the public.** An accredited organization/certified program is not acting in good faith if it misleads the public about the meaning and limitations of accreditation/certification. Also, an accredited organization/certified program must not inaccurately suggest to the public that its accreditation/certification award applies to any unaccredited affiliated or otherwise related activities.
Retaliation. The Joint Commission invites open communication from any accredited organization’s/certified program’s staff and recipients of care, treatment, and services about any standards compliance or other issues related to the accreditation/certification process. An organization’s/program’s good faith participation in the accreditation/certification process is questioned if the organization/program does any of the following:

- Attempts to discourage such communication—for example, by taking disciplinary steps against an employee solely because that employee provides information to The Joint Commission
- Threatens those who communicate with The Joint Commission with a defamation lawsuit based solely on what was said to The Joint Commission
- Allows the treatment or access to services of any individual or staff member to be adversely affected by his or her or a family member’s communication with The Joint Commission

Standards compliance. If an organization’s/program’s conduct reflects a lack of commitment to standards compliance, issues of good faith may be raised. For example, an intentional refusal to attempt to comply with a standard could suggest a cavalier view of the accreditation/certification process.

The good faith participation requirement applies continuously throughout the accreditation/certification process.

Public Information Policy

Introduction

The Joint Commission is committed to making relevant and accurate information about health care organizations available to interested parties. Information regarding a health care organization’s quality and safety can help organizations improve their services. This information may also help educate consumers and health care purchasers in making informed choices about health care. At the same time, it is important that confidentiality of certain information be maintained to encourage candor in the accreditation and certification processes. The Joint Commission’s primary vehicle for providing public information are Quality Check® and Quality Reports.

This policy meets the requirements of the Health Insurance Portability and Accountability Act of 1996.
Quality Check. Quality Check is The Joint Commission’s website for making available descriptive and performance information about accredited organizations and certified programs.

Quality Reports. The Quality Reports are publicly available and include relevant and useful information about the quality and safety of care provided in individual Joint Commission–accredited organizations and—certified programs. Quality Reports are created at the organization level and contain information reflecting an organization’s accreditation and/or certification status, its compliance with National Patient Safety Goals, and performance measurement results, as appropriate. Quality Reports are available on The Joint Commission’s Quality Check website.

Publicly Available Accreditation and Certification Information
Joint Commission Quality Reports for each accredited organization and/or certified program include the following information:

- The date of an organization’s/program’s most recent full on-site survey/review, and if the organization/program has had any subsequent surveys/reviews since its last full survey/review
- The accreditation/certification decision based on the most recent full on-site survey/review, as well as any subsequent updates to the decision
  - Organizations that are successful in obtaining accreditation following an initial survey will be posted on the Quality Check website.
  - Programs that achieve certification will be posted on the Quality Check website.
- For organizations in the accreditation renewal process, with an accreditation decision of Contingent Accreditation, Preliminary Denial of Accreditation, or Denial of Accreditation, the standards with Requirements for Improvement leading to the decision
- Services included within the scope of the organization’s accreditation and/or certification decision
- A list of an organization’s previous accreditation and/or program’s certification decisions and the effective date of those decisions for the past seven (7) years
  - If the organization had a previous decision of Contingent Accreditation or Preliminary Denial of Accreditation, the standards with Requirements for Improvement

Denial of Accreditation decisions, for organizations that were in the accreditation renewal process, will be posted on the Quality Check website for a duration of one year from the rendering of the accreditation decision.
The receipt of national quality recognition awards, as recognized by the Board of Commissioners
Attainment of Top Performer® on Key Quality Measures designation from The Joint Commission
Compliance with National Patient Safety Goal requirements
Performance against National Quality Improvement Goals (core measures)

Each accredited organization/certified program is afforded the opportunity to prepare a commentary of up to two pages regarding its Quality Report. The commentary will accompany any organization/program Quality Reports distributed by The Joint Commission, whether via hard copy or The Joint Commission’s website.

When performance measurement data is included in Quality Reports, such data will be accompanied by information regarding its source or derivation; accuracy, reliability, and validity; and appropriate uses of the data.

An organization’s Quality Report may be obtained via the Customer Service Department or through Quality Check. See “The Joint Commission Quality Report” (QR) chapter for more details.

Release of Aggregate Data
The Joint Commission reserves the right to publish or release aggregate data. Protected health information will not be made publicly available. Performance data displayed on Quality Check are available to any interested party at no cost and may be downloaded electronically in a series of predefined report formats through a linked webpage called “Quality Data.”

Information That Is Publicly Disclosed on Request
Release of Accreditation and Certification Information. In addition to information provided in Quality Reports, the following information may be obtained by writing or calling The Joint Commission:

- For organizations that were previously Denied Accreditation, are no longer certified, or withdrew from the accreditation/certification process
  - The organization’s accreditation and/or certification history (for the past 7 years)

*This information is not available for ambulatory health care organizations and office-based surgery practices.
Standards for which The Joint Commission had no or insufficient evidence of resolution when an organization withdrew from accreditation and was subsequently Denied Accreditation

**Sentinel Event Information.** As applicable, confirmation of the occurrence of a sentinel event at an accredited organization for the three-year period prior to the date of the request and The Joint Commission’s intent to apply its Sentinel Event Policy or other applicable procedures to this occurrence.

**Release of Aggregate Complaint-Related Information.** The Joint Commission addresses all incidents that pertain to alleged patient safety or quality of care issues within the scope of Joint Commission standards. Information about complaints may be forwarded by the Centers for Medicare & Medicaid Services (CMS) or other federal or state agencies having oversight responsibilities for health care organizations, federal or state legislators or legislative committees on behalf of constituents, or may be received directly from patients, families, payers, or health care professionals. As used here, the term complaint includes potentially relevant reports that are received from federal or state agencies, identified in the media, or otherwise obtained by The Joint Commission. It is the policy of The Joint Commission that it will only disclose patient-identifiable information if authorized by the patient, as consistent with its business associate obligations, or otherwise authorized by law. For any other party than the complainant, The Joint Commission will not disclose patient name or identifiable information, per the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Upon request from any party, The Joint Commission releases the following aggregate information relating to complaints about an accredited organization or a certified program for the three-year period prior to receipt of the request: When an unannounced or unscheduled survey/review is based on information derived from a complaint or public sources, a summary of the standards areas for which Requirements for Improvement were issued as a result of The Joint Commission’s evaluation activities.

**Release of Specific Complaint-Related Information**

The Joint Commission also provides the following information as appropriate to complainants regarding their complaints (and those authorized by the complainant), or other individuals who have knowledge regarding a specific complaint:

**The term complaint refers to an alleged adverse event, unsafe condition, or concern.**

**The term standard area refers to the focus area of the complaint review as it relates to The Joint Commission’s standards. Depending on the review status or outcome of the complaint review, the level of information provided may vary.**
■ Confirmation of the receipt of the complaint and that it will be reviewed to
determine what, if any, Joint Commission action is warranted.
■ Any determination that the complaint is not related to Joint Commission
requirements.
■ If The Joint Commission has decided not to take action regarding an organization’s
accreditation/a program’s certification decision, the complainant is to be so advised.
■ If the complaint is related to Joint Commission requirements, upon completion of
review, the course of action that was taken regarding the complaint, including the
standards areas that were evaluated.
■ If The Joint Commission has decided not to take action regarding an organization’s
accreditation/a program’s certification decision as a result of the complaint review,
the complainant is to be so advised.
■ If The Joint Commission has taken action regarding an organization’s accreditation/
a program’s certification decision as a result of an on-site complaint review, the
noncompliant standards leading to that decision will be made publicly available on
Quality Check.

Data Release to Government Agencies and
Organizations with Which The Joint Commission
Performs Coordinated Survey Activities

The Joint Commission makes available to federal, state, local, or other governmental
certification or licensing agencies or public health agencies, or any other appropriate
enforcement agency, specific accreditation-related information under the following
circumstances:
■ When The Joint Commission identifies a serious situation in an organization that
may jeopardize the health or safety of patients or the public and immediately takes
action to deny accreditation.

‡‡Section 92, PL 96-499, the Omnibus Budget Reconciliation Act of 1980, requires that Medicare
providers include, in all their contracts for services costing $10,000 or more in any 12-month period, a
clause allowing the Secretary of the US Department of Health and Human Services (DHHS), the US
Comptroller General, or their representatives to examine the contract and the contractor’s books and
records. The Joint Commission herein stipulates that if its charges to any such organization amount to
$10,000 or more in any 12-month period, the contract or any agreement on which such charges are
based and any of the Joint Commission’s books, documents, and records that may be necessary to verify
the extent and nature of Joint Commission costs will be available to the Secretary of DHHS, the
Comptroller General, or any of their duly authorized representatives for four years after the survey. The
same conditions will apply to any subcontracts The Joint Commission has with related organizations if
the payments under such contracts amount to $10,000 or more in any 12-month period.
When The Joint Commission identifies a serious situation, or a significant pattern of risk in an organization that may have jeopardized the health or safety of previous patients or the public, or that represents risk that extends beyond the organization, such as an incident involving the reuse of contaminated instruments.

If the health care organization or other individual reports the issue to the appropriate authorities, The Joint Commission will evaluate whether it, too, should report the issue.

Additional information is made available when an organization is certified for participation in a federal or state program or licensed to operate by a state agency on the basis of its accreditation. In addition, The Joint Commission may make available information to organizations with which The Joint Commission performs coordinated survey activities. The Joint Commission may advise the organization’s chief executive officer and will provide timely notice to local, state, and federal authorities having jurisdiction. The information available to government agencies and organizations with which The Joint Commission performs coordinated survey activities includes the following:

- Notification of official decision to render Accreditation with Follow-up Survey, Contingent Accreditation, Preliminary Denial of Accreditation, or Denial of Accreditation, including the rationale for the decision.
- Complaint information requested by CMS in accordance with The Joint Commission’s deeming authority, including the content of the complaint submitted to The Joint Commission, if the allegation(s) results in an on-site visit.
- Complaint information, including the content of the complaint submitted to The Joint Commission, if the allegation(s) results in an on-site visit is shared with:
  - CMS in accordance with The Joint Commission’s deeming authority
  - A state regulatory agency that has entered into a written information-sharing agreement
  - An organization with which The Joint Commission conducts coordinated survey activities
- Upon request from CMS, the following information is shared:
  - All final Requirements for Improvement
  - A statement, if any, from the organization regarding its views on the validity of Joint Commission survey findings
  - A copy of the corrective action submitted by the organization
  - The results of any follow-up survey, if warranted
For governmental agencies, notification of upcoming full surveys and retrospective
dates of other surveys conducted, such as random unannounced or for-cause surveys,
only if the governmental agency enters into an information-sharing agreement with
The Joint Commission and agrees to maintain the confidentiality of the unan-
nounced survey dates

A copy of the *Official Accreditation Decision Report* and Decision letter
- For CMS upon request respecting deemed status determinations
- For state agencies that have entered into specific information-sharing agreements
that permit provider-authorized release of such reports to the state agency
- Upon request from state agencies that are acting on behalf of CMS as contractors

The Joint Commission will report to CMS or the Office of the Inspector General, as
appropriate, in the event that there is credible evidence of potential identification of
fraud and abuse, or other criminal or civil law violation and upon notice to the
health care organization.

**Data Release to Cooperative Accrediting Bodies**
The Joint Commission makes available to accrediting bodies with which it has formal
cooperative agreements relevant portions of Official Accreditation Decision Reports and
complaint-related information pertinent to the accrediting activities of the cooperative
partner. Judgments as to pertinence are made solely by The Joint Commission. (For a list
of organizations with which The Joint Commission has cooperative agreements, see
http://www.jointcommission.org/facts_about_the_cooperative_accreditation_initiative/.)

**Joint Commission Right to Clarify**
The Joint Commission reserves the right to clarify information, even if the information
involved would otherwise be considered confidential, when an organization disseminates
inaccurate information regarding its accreditation/certification.

**Confidential Information**
The Joint Commission keeps information received or developed during the accreditation/certification process confidential, such as:
- The *Official Accreditation Decision Report*, unless its submission is required by a
governmental agency (see “Data Release to Government Agencies and Organizations
with Which The Joint Commission Performs Coordinated Survey Activities”), is
required by organizations with which The Joint Commission performs coordinating
surveys, or is requested by an accredited body with which The Joint Commission has
a formal agreement (see “Data Release to Cooperative Accrediting Bodies”)

Shading indicates a change effective January 1, 2017, unless otherwise noted in the What's New.

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- Information learned from the organization before, during, or following the accreditation survey, which is used to determine compliance with specific accreditation standards.
- An organization’s comprehensive systematic analysis and related documents prepared in response to a sentinel event or in response to other circumstances specified by The Joint Commission.
- All other materials that may contribute to the accreditation/certification decision.
- Written staff analyses and executive leadership minutes and agenda materials.
- Any data from an organization’s participation in the ICM process and related corrective action plan.
- The identity of any individual who files a complaint about an accredited organization, except when the complaint is shared by The Joint Commission with a governmental entity, an organization with which The Joint Commission performs coordinated surveys, or accrediting organizations with which The Joint Commission has formal complaint-sharing agreements and the receiving organization has agreed to maintain the confidentiality of the complainant. In instances when the receiving organization cannot assure the confidentiality of the complainant, any complainant-identifying information shall be redacted by The Joint Commission prior to sharing.

This policy applies to all organizations with an accreditation and/or certification history, subject to any requirements of any applicable laws.

**Process for Responding to a Complaint**

The Complaint Response Unit of The Joint Commission’s Office of Quality and Patient Safety (OQPS) triages and reviews complaints, concerns, and inquiries related to accredited health care organizations, as received from a variety of sources. These complaints may be submitted by patients, families, and health care providers; by state and federal agencies in the form of reports; or through information from the media. The term *complaint* therefore covers a broad spectrum of information received by the Complaint Response Unit.

Upon Joint Commission review of a complaint, a number of actions may result. These include recording the information for trending purposes and possible action in the future, obtaining the involved health care organization’s response to the complaint, and conducting an immediate for-cause survey. If The Joint Commission determines that the organization should respond to the complaint, the organization will be so notified. The request for a response will be e-mailed to the organization’s CEO and posted to the
organization’s Joint Commission Connect™ extranet site (a secure, password-protected website intended only for Joint Commission–accredited or –certified organizations and key stakeholders). The organization’s response to the complaint also takes place through its extranet site.

The complaint information posted on the Joint Commission Connect site may be either of the following:

- The complaint itself, if the complainant has given permission to do so
- A summary of the complaint, if the complainant requested anonymity

If an accredited organization is required to respond to the complaint, it is usually required to do so within 30 calendar days of being notified. For more serious issues, the organization may be required to respond to the complaint within 7 calendar days of being notified, or sooner. When a response in a short time frame is required, the organization will be so notified.

Once a response is received, it is evaluated for compliance with the Joint Commission’s standards, National Patient Safety Goals, and APRs, as applicable. If additional information is required, the organization will be notified.

When the organization’s response is complete and has been accepted, a letter indicating acceptance is e-mailed to the CEO, and the case is considered closed.

**Early Survey Policy**

An organization seeking Joint Commission accreditation for the first time may choose the Early Survey Policy option. An organization surveyed under the Early Survey Policy will have two surveys. Sidebar 1 lists key features of the Early Survey Policy.

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**Sidebar 1. Early Survey Policy**

**First Survey**

- Conducted up to two months before opening or operating
- Licensed (according to law and regulation) or in licensing process
- Building identified, constructed, and equipped
- CEO or administrator, director of clinical or medical services (medical director), and nurse executive identified

*continued on next page*
Sidebar 1. Early Survey Policy (continued)

- Identified opening date
- Announced
- Limited set of standards (physical plant, policies and procedures)
- Outcome: Limited, Temporary Accreditation

Second Survey

- Ready date for survey selected by the organization within six months of the first survey
- Unannounced
- Full initial survey
- Outcome: Change in Limited, Temporary Accreditation decision to Accredited or Denial of Accreditation. The effective date of the accreditation decision is the day after the second survey if the organization does not receive any Requirements for Improvement (RFIs). If the organization receives at least one RFI and therefore must submit an ESC that resolves all RFIs, the effective date of the accreditation decision is the date the successful ESC is submitted. If at six months the organization is not ready for the second survey, the organization’s Limited, Temporary Accreditation decision will expire.

**Note:** Limited, Temporary Accreditation is not recognized by CMS for Medicare certification purposes (but it may be required for state licensure).

Eligibility for Limited, Temporary Accreditation

The Early Survey Policy is available to any organization that is currently not accredited—except for those that have been denied accreditation. An organization must declare during the application process that it wishes to be surveyed under this policy.

The First Survey. When an organization chooses to be surveyed under the Early Survey Policy, The Joint Commission conducts two on-site surveys. The Joint Commission can conduct the first survey as early as two months before the organization begins its operations, provided that the organization meets the following criteria:

- It is licensed (according to law and regulation) or in the licensing process.
- The building in which the services will be offered or from which the services will be coordinated is identified, constructed, and equipped to support such services.
- It has identified its CEO or administrator, its director of clinical or medical services, and its nurse executive, if applicable.
- It has identified the date it will begin operations.
Generally, the first survey uses a limited set of standards and assesses only the organization’s physical facilities, policies and procedures, plans, and related structural considerations. For this reason, organizations surveyed under this policy are not recognized by CMS as meeting the requirements for Medicare certification until the second (full) survey has been conducted and a decision of Accredited has been achieved.

**Limited, Temporary Accreditation Decision.** The Joint Commission grants Limited, Temporary Accreditation to an organization that is in satisfactory compliance with the limited set of standards and EPs assessed in the first of the two surveys conducted under the Early Survey Policy (see the “Early Survey Policy Option” [ESP] chapter for a list of these requirements). Since a Limited, Temporary Accreditation decision does not reflect an organization’s compliance with the full set of Joint Commission standards, the organization cannot use the Joint Commission’s Gold Seal of Approval*. An organization that is not in satisfactory compliance must reapply and begin the accreditation process again.

The Limited, Temporary Accreditation decision includes assignment of an additional unannounced survey against the full set of applicable standards within six months of the first survey. The survey assesses the organization’s compliance with all applicable EPs.

For organizations surveyed under the Early Survey Policy: If an organization does not receive any RFIs during the first survey, the effective date for its Limited, Temporary Accreditation decision is the day after the survey is conducted. If the organization receives at least one RFI during the first survey and therefore must submit an acceptable ESC report that resolves all RFIs, the effective date for Limited, Temporary Accreditation is the date of the acceptable ESC submission.

The Limited, Temporary Accreditation decision remains in effect until the organization has completed the second of the two surveys conducted under the Early Survey Policy (which is an unannounced full survey) or until The Joint Commission has withdrawn the Limited, Temporary Accreditation. The Joint Commission may withdraw Limited, Temporary Accreditation in the following situations:

- If an organization that was not providing services at the time of the first survey does not begin providing services when expected
- If an organization does not meet the survey eligibility criteria
- If an organization fails to accept the second survey
- If an organization is found to be not in satisfactory compliance with the applicable standards and their EPs
In any of these cases, the organization must begin the accreditation process again.

**The Second Survey.** The second survey under the Early Survey Policy is an unannounced, full, initial accreditation survey. The Joint Commission conducts this survey within six months after the first survey. If at six months the organization is not ready for the second survey, the organization’s Limited, Temporary Accreditation decision will be removed and the organization will not be accredited.

Based on survey results, the organization’s accreditation decision then changes to one of the following:

- Accredited
- Denial of Accreditation

*See “Decision Categories for Organizations Seeking Accreditation Renewal” for descriptions of accreditation decisions.*

The effective date of the accreditation decision is the day after the second survey if the organization does not receive any RFIs. If the organization receives at least one RFI and therefore must submit an acceptable ESC report that resolves all RFIs, the effective date is then retroactive to the date of the acceptable ESC submission. The organization’s accreditation cycle begins the day after the second survey was conducted, unless The Joint Commission reached a decision to deny accreditation.

**Before the Survey**
This section provides information on the steps leading to a full accreditation survey. These steps include the application process, the role of an account executive, and the Focused Standards Assessment (FSA) process.

**An Organization’s Secure Joint Commission Connect™ Site**
A key feature of The Joint Commission’s accreditation process is use of technology. The use of technology better enables The Joint Commission and accredited organizations to communicate accreditation-related information in a more efficient and timely manner.

To fully use technology in the accreditation process, The Joint Commission provides each organization with a secure, password-protected website on The Joint Commission’s extranet site for accredited organizations, *The Joint Commission Connect.* Full access to this site can only be granted through the use of the organization’s password. This site
permits an organization to complete its E-App and FSA electronically. In addition, shortly after an organization’s survey, the organization’s survey findings report and its ESC report are posted on the organization’s secure site. (See the “Stimulate Improvement” section in the INTRO chapter for more details about what is available on Joint Commission Connect.)

While full access to Joint Commission Connect can only be granted via an organization’s password, employees with an e-mail address from their Joint Commission–accredited or –certified health care organization can register themselves for guest access. Guest access enables viewers to see the Leading Practice Library, the Core Measure Solution Exchange®, and standards BoosterPaks™. Guest access does not include entry to any organization-specific data or reports.

Role of the Account Executive
The Joint Commission assigns an account executive to an organization after receiving its E-App. This person serves as the primary contact between the organization and The Joint Commission. He or she coordinates survey planning and handles policies, procedures, accreditation issues or services, and inquiries throughout the accreditation cycle. An organization can find contact information for its account executive on its Joint Commission Connect site or by calling 630-792-3007.

Electronic Application for Accreditation (E-App)
When an organization notifies The Joint Commission that it wants to become accredited, The Joint Commission provides the organization with information explaining how to access and complete the E-App on the organization’s secure Joint Commission Connect site. Initial applications are valid for one year. An organization needs to complete and submit its E-App upon initial application for survey, and will be asked to verify the information annually. An organization can provide updates to the E-App at any time, as it can access the E-App 24 hours a day, 7 days a week. (See the “Changes Affecting E-App Information” section for more information on notifying The Joint Commission of significant changes within an organization.)

The application provides essential information about the organization, including ownership, demographics, and types and volume of services provided. The E-App does the following:
- Describes the organization seeking accreditation in terms of size and scope of services
• Requires the organization to make available to The Joint Commission all official records and reports of public or publicly recognized licensing (for example, state licenses), examining, reviewing, or planning bodies during the initial on-site survey (see APR.05.01.01 in the APR chapter).
• Authorizes The Joint Commission to obtain any records and reports not possessed by the organization.
• When accepted, establishes the terms of the relationship between the organization and The Joint Commission.
• Identifies an organization’s applicable standards based on programs/services provided.
• Drives the anticipated number of survey days, number and type of surveyors, and survey agenda activities (see the “Survey Agenda” section).

**Accuracy of the Application Information**

The Joint Commission schedules surveys based on information provided in an organization’s E-App. With the information provided, The Joint Commission determines the number of days required for a survey and the number and type of surveyors. Inaccurate or incomplete information in the E-App may necessitate an additional survey, which could delay the processing of survey findings and rendering of an accreditation decision. It may also cause the organization to incur additional survey charges.

**Forfeiture of Survey Deposit**

A nonrefundable, nontransferable deposit toward accreditation fees is required for initial customers only. (If the organization already has a program accredited with The Joint Commission, a deposit is not required.) The Joint Commission applies the deposit to the organization’s open invoices until the deposit is exhausted. An organization scheduled for an initial survey forfeits its deposit if its survey is not conducted within one year of submitting its application. The organization must then reapply and submit a new deposit to begin the accreditation process again. **Note:** If it receives approval from The Joint Commission to postpone an initial survey (less than 20 days prior to a scheduled initial survey), the organization will be charged a fee to defray costs.
Accreditation Contract and Business Associate Agreement

Organizations seeking Joint Commission accreditation for the first time or reaccreditation with The Joint Commission must submit a signed accreditation contract and a signed Business Associate Agreement. The contract outlines the responsibilities of both the organization and The Joint Commission relative to the accreditation process. This contract is separate from the E-App.

Contracts are available for printing and approval via each organization’s secure Joint Commission Connect site. Governmental organizations may enter into unique contracts with The Joint Commission in accordance with the scope of programs/services available from The Joint Commission and the laws for contracting that bind that government entity.

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules, and modified by the HITECH (Health Information Technology for Economic and Clinical Health) provisions of the American Recovery and Reinvestment Act of 2009, a health care organization and The Joint Commission must have a signed Business Associate Agreement before the organization’s survey can begin. This Business Associate Agreement outlines the access, use, and disclosure of any patient-protected health information between The Joint Commission and the health care organization.

An organization will not be scheduled for survey until it signs an accreditation contract and Business Associate Agreement. When this happens, The Joint Commission will proceed with the organization’s survey plans unless the organization notifies The Joint Commission in writing of its intent to withdraw from accreditation and terminate the accreditation contract. Notification in writing is necessary to terminate the accreditation contract, cease survey scheduling, and avoid a final decision of Denial of Accreditation. If an organization fails to notify The Joint Commission in writing of its intent to withdraw from accreditation and terminate its accreditation contract before a survey, The Joint Commission’s decision rules provide for a final decision of Denial of Accreditation.

Annual and Survey Fees

The Joint Commission uses a subscription billing system for all accreditation programs. Fees are determined annually and are based on the need to secure sufficient resources to cover the costs of operation. The Joint Commission generally bases individual
organization annual fees on the volume and type of services provided and the sites to be included in the organization’s accreditation survey. Questions about all fees can be directed to the Pricing Unit (pricingunit@jointcommission.org) or by calling 630-792-5115.

The Joint Commission’s fee structure includes a nonrefundable, nontransferable annual fee, which recognizes the provision of substantial accreditation-related services on a continuous basis between on-site surveys. The annual fees, billed each January, are determined by the organization’s size and complexity. The annual fee for organizations applying for accreditation for the first time will be prorated, based on the quarter in which the application is submitted.

In addition to annual fees, organizations are also billed an on-site fee within two days after the survey has been conducted. The on-site fee is designed to cover the direct costs of performing a survey.

Organizations requiring additional surveys, such as to evaluate a patient safety event, will be assessed a separate survey fee.

Electronic invoices will be posted to the organization’s secure Joint Commission Connect site and are due upon receipt. The Joint Commission accepts payment for all fees in any of the following ways:

- Electronic payment using Visa, MasterCard (credit or debit), American Express, Discover, or e-check by logging on the organization’s Joint Commission Connect accreditation home page and clicking on the “What’s Due” tab or by calling Accounts Receivable staff at 630-792-5662
- Check or money order by mail to PO Box 92775, Chicago, IL 60675-2775, or overnight to One Renaissance Boulevard, Oakbrook Terrace, IL 60181
- Wire transfer by calling Accounts Receivable staff at 630-792-5662

Failure to provide timely payment of any Joint Commission fees may result in the loss of accreditation. Please note that The Joint Commission no longer uses certified mail to notify health care organizations of failure to pay annual survey fees and/or on-site fees; instead, letters of nonpayment are posted to the health care organization’s Joint Commission Connect extranet site. For help in making a payment, please contact Accounts Receivable staff at 630-792-5662.
During the Survey
During an accreditation survey, The Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving patient outcomes. The survey process focuses on assessing performance of important patient-centered and organization functions that support the safety and quality of care, treatment, and services. This assessment is accomplished through evaluating an organization’s compliance with the applicable standards in this manual, based on the following activities and information:

- Tracing the care, treatment, and services delivered to patients
- Verbal and written information provided to The Joint Commission
- On-site observations and interviews by Joint Commission surveyors
- Review of documents provided by the organization

The Joint Commission’s accreditation process seeks to help organizations identify and correct problems and improve the safety and quality of care, treatment, and services provided.

A survey is designed to be individualized to each organization, to be consistent, and to support the organization’s efforts to improve performance. The Joint Commission determines the length of a survey based on information supplied in the E-App that describes the organization’s size and scope of services. In addition, Joint Commission surveyors may conduct some survey activities on evenings, nights, and weekends, as necessary. These “off-shift” visits do not occur before the opening conference at the start of the survey.

The On-Site Survey
This section, which provides an overview of the survey process, includes information relevant to an organization that has applied for an accreditation survey and is ready for the survey process.

The Joint Commission’s accreditation process focuses on systems critical to the safety and the quality of care, treatment, or services. It represents a focus on continuous operational improvement by encouraging hospitals to incorporate the standards as a guide for routine operations.
Under this accreditation process, the full survey is the on-site evaluation piece of a continuous process. The accreditation process encourages organizations to embed the standards into routine operations to achieve and maintain excellent operational systems on an ongoing basis. Initiatives such as the annual FSA facilitate this, as well as help identify and manage risk.

### Unannounced Surveys

The Joint Commission generally conducts surveys in an unannounced fashion except for situations in which it would not be logical or feasible to conduct an unannounced survey. Table 1 outlines specific exceptions to unannounced surveys and the length of advance notice.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Exception</th>
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</thead>
<tbody>
<tr>
<td>Early Survey Policy—1st survey</td>
<td>Announced</td>
</tr>
<tr>
<td>Organizations undergoing ICM Option 2 and Option 3 surveys</td>
<td>Announced (unless the organization requests the survey to be unannounced)</td>
</tr>
<tr>
<td>Department of Defense facilities</td>
<td>7-day notice</td>
</tr>
</tbody>
</table>

An organization will undergo an unannounced survey between 18 and 36 months after its previous full survey.

With an **unannounced survey**, an accredited organization will receive *no notice* of its survey date prior to the start of the survey. In concert with the unannounced survey process, the following procedures will be implemented:

- Accredited organizations will be able to identify, in their 27-month E-App, up to 15 days in their survey eligibility range (between 18 and 36 months after their last full survey) in which an unannounced survey should be avoided. Once the 27-month E-App has been submitted, these dates cannot be modified. These 15 days should not include federal holidays but may include regional events during which it may be difficult to conduct a survey. The Joint Commission will make every effort to accommodate the organization regarding avoiding these 15 days. However, The

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§§ In this table, 7 days refers to 7 business days.
Joint Commission reserves the right to conduct a survey during an “avoid period” if the reason(s) given to avoid a survey at that time is such that a survey can be reasonably accomplished.

- An organization is required to demonstrate how it communicates on an ongoing basis to its public that if members of the public have any quality-of-care or safety concerns, they should notify The Joint Commission (see APR.09.01.01 in the APR chapter).

- On the day of the unannounced survey, by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories), The Joint Commission will post on the organization’s secure Joint Commission Connect site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the survey. For organizations outside of these locations, notifications will be posted by 7:00 A.M. eastern time.

- If an organization knows of a surveyor who works (or has worked) at the organization or a competing organization or has had personal experience with the survey or that represents a potential conflict, the organization is asked to identify the individual(s) in its E-App or notify The Joint Commission via phone or e-mail as soon as possible so that another surveyor may be assigned.

### Initial and Full Survey Team Composition

Based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by one surveyor or a team of surveyors, with a minimum of at least one clinical surveyor assigned to the event. The composition of an organization’s survey team is based on the information provided in its E-App.

On surveys with more than one surveyor, one of the surveyors is designated as the “team leader.” The team leader is responsible for integration, coordination, and communication of on-site survey activities. In addition to being one of the surveyors conducting the survey, the team leader serves as the primary point of on-site contact between the organization and The Joint Commission. Among other responsibilities, the team leader leads the opening conference and the daily and exit briefings.

### Life Safety Code® Surveyor Scope of Service

A Life Safety Code® Surveyor will be part of every hospital survey. The Life Safety Code Surveyor is responsible for evaluating specific environment of care and Life Safety Code accreditation criteria and educating the organization during the survey about related
compliant and not compliant areas, opportunities for improvement, and remedial action that may be required. The Life Safety Code Surveyor is always accompanied by at least one clinical surveyor during the initial and full survey events.

**Survey Agenda**

The Joint Commission reviews the data in a hospital’s E-App and posts a sample agenda on the organization’s secure Joint Commission Connect site. Also available on the secure site is the Survey Activity Guide, which includes a list of initial materials that the surveyor will request to review at the onset of the survey.

The organization’s Joint Commission account executive will contact the hospital and provide the anticipated number of days and number of surveyors that will be assigned for the on-site survey. On the first day of an on-site survey, the surveyor(s) will work with the hospital to ensure the schedule considers the organization’s operations and needs. During the survey, the surveyor(s) will work to minimize any disruption to patient care when conducting survey activities.

The on-site survey process focuses on continuous operational improvement in support of safe, high-quality care, treatment, and services. The survey agenda will include the elements described in the following paragraphs.

**Surveyor Arrival and Preliminary Planning Session.** Upon arrival, surveyors will check in with reception, present their identification, and indicate their purpose for visiting. Staff should be prepared with a plan and instructions for how to proceed. The surveyor(s) will want to get settled in and begin reviewing the documentation identified in the Document List as soon as possible.

**Opening Conference and Orientation to the Organization.** During the opening conference, the surveyor(s) describes the structure and content of the survey to organization staff, while the organization staff provides the surveyor(s) with information about the organization. At this time, the hospital will briefly explain its structures, mission, vision, and relationship with the community. This provides the surveyor(s) with baseline information about the organization that can help focus subsequent survey activities.

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Please see the Survey Activity Guide on the Joint Commission Connect site or at http://www.jointcommission.org/organization_survey_activity_guide/ for more detailed information on the survey process.
Surveyor Planning Session. During this session, the surveyor(s) will review data and information about the hospital to plan the survey agenda. This will include any information from previously conducted Joint Commission activities and other hospital documents that have been gathered for review. The surveyor(s) will select the first patients for tracing based on what he or she learns from the review of data and information during this session.

Individual Tracer Activity. During the individual tracer activity, the surveyor(s) will do the following:

- Follow the course of care, treatment, or services provided to the patient by the hospital from preadmission through post-discharge
- Assess the interrelationships among disciplines and services/programs and the important functions in the care, treatment, or services provided
- Evaluate the performance of processes relevant to the care, treatment, or service needs of the patient, with particular focus on the integration and coordination of distinct but related processes
- Identify vulnerabilities in the care processes

See the “Tracer Methodology” section for more information about individual tracer activity.

System Tracers. System tracers are interactive sessions with the surveyor(s) and organization staff that explore the performance of important patient-related functions that cross the organization. The surveyor(s) will explore critical risk points with organization staff and provide education when indicated during the system tracer sessions. System tracers may include the following:

- Data management
- Infection control
- Medication management, if within the scope of the organization
- Program-specific areas (see the “Accreditation Program–Specific Tracers” section)

As surveyors perform individual tracers (see section above) to determine standards compliance as it relates to care delivered to the selected patient, they also begin to learn about the organization’s overall systems. Information gathered during individual tracers is then considered from a multi-patient, cross-organization perspective during system tracers for high-risk processes. See the “Tracer Methodology” section for more information.
**Program-Specific Tracers.** Program-specific tracers will be conducted if they apply to the organization being surveyed and at the surveyor’s discretion. These program-focused activities take place during the time noted on the agenda for individual tracer activity. See the “Tracer Methodology” section for more information.

**Issue Resolution.** This session provides an opportunity for the surveyor(s) to follow up on potential findings that could not be resolved in other survey activities.

**Surveyor Team Meeting/Planning Session.** This time is reserved for the surveyor(s) to review and analyze the information gathered throughout the day and plan for upcoming survey activities.

**Daily Briefings.** During the daily briefing session, surveyors will communicate to organization staff their observations on the previous day’s survey findings and any significant patterns or trends that are becoming evident in the survey, if requested to do so. During the daily briefing, the surveyor(s) will do the following:

- Facilitate leaders’ understanding of the survey process and the findings that contribute to the accreditation decision
- Report on findings from the previous day’s survey activities
- Emphasize patterns or trends of significant concern that could lead to noncompliance determinations
- Highlight any positive findings or exemplary performance
- Allow the organization to supply additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI
- Review the agenda for the survey day ahead and make any necessary adjustments based on hospital needs or the need for more intensive assessment of an issue

If the organization has additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI, the organization should supply that information to the surveyor(s) as soon as possible.

**Medical Staff Credentialing and Privileging.** This activity will help the hospital and the surveyor(s) identify specific issues and do the following:

- Evaluate the process the hospital uses to collect relevant data for decisions for credentialing and privileging
- Evaluate the consistent implementation of the credentialing and privileging process
- Evaluate processes for the granting of and the appropriate delineation of privileges
- Determine whether practitioners practice within the limited scope of delineated privileges
Comprehensive Accreditation Manual for Hospitals

- Link results of peer review and focused monitoring to the credentialing and privileging process
- Identify vulnerabilities in the credentialing, privileging, and appointment process
- Evaluate ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) processes

**Competence Assessment.** This review activity focuses on the hospital’s processes for ensuring the appropriate knowledge and competence of staff providing patient care, treatment, and services. The surveyor(s) and the organization will discuss and review topics such as these:

- Processes for verifying required professional licenses, registrations, and certifications
- Orientation and training process for staff
- Methods for assessing competence of staff
- In-service and other education and training activities for staff

Surveyors will request a sample of personnel records representing a variety of disciplines encountered throughout the survey. With authorized organization staff, the surveyor will review these records to validate through documentation what they have heard from both leaders and staff related to the topic of initial and ongoing competence assessment.

**Environment of Care.** This session is an opportunity for the surveyor and hospital to review and evaluate the following:

- The processes in place for managing risk in the physical environment (for example, safety and security, fire safety, hazardous materials and wastes, medical equipment)

**Emergency Management.** This survey activity will allow the organization and the surveyor(s) to do the following:

- Discuss the four emergency management categories: mitigation, planning, response, and recovery
- Review and discuss organization plans for managing critical areas of their operations so that they can effectively respond regardless of the emergency
- Review emergency management processes, such as identifying risks, interactions with other health care organizations, interactions and communication with the community, and drills, critiques, and performance improvement

**Facility Orientation—Life Safety Code Surveyor.** This survey activity is performed by a Life Safety Code Surveyor. In addition to assessing the main fire alarm panel and becoming familiar with the building layout, the surveyor will evaluate the effectiveness of processes for the following:
The Accreditation Process

- Identifying and resolving *Life Safety Code* problems
- Developing and implementing activities to protect occupants during periods when a building does not meet the *Life Safety Code* or during construction periods
- Maintaining fire safety equipment and fire safety building features
- Maintaining and testing emergency power systems
- Maintaining and testing medical gas and vacuum systems

**Life Safety Code Building Assessment.** This session includes a building tour that will help the *Life Safety Code* Surveyor determine the degree of compliance with relevant *Life Safety Code* requirements. The surveyor will assess the following:
- Pressure relationships in operating rooms
- Required fire separations
- Required smoke separations
- Hazardous areas (and spaces above their ceilings) such as soiled linen rooms, trash collection rooms, and oxygen storage rooms
- Fire exits
- Kitchen grease–producing cooking devices and laundry and trash chutes
- Emergency power systems and equipment
- Medical gas and vacuum system components

**Leadership Session.** During the leadership session, surveyors will explore leadership’s responsibility for creating and maintaining the organization’s systems, infrastructure, and key processes that contribute to the quality and safety of patient care, treatment, or services. The session is intended to be interactive; therefore, surveyors and organization leaders will engage in a discussion, using organization-specific examples, of the following topics:
- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust Process Improvement®
- Observations that may be indicative of system-level concerns

**Surveyor Report Preparation.** The surveyor(s) will use this time to compile, analyze, and organize the data he or she has collected throughout the survey into a preliminary Summary of Survey Findings Report reflecting the organization’s compliance with standards (*see* the “Summary of Survey Findings Report” section).

**Exit Briefing and Organization Exit Conference.** The surveyor will offer to meet with the most senior leader, usually the CEO or administrator, or the leadership team to conduct a private Exit Briefing. During the Exit Briefing, the surveyor will present the
survey findings and review the preliminary Summary of Survey Findings Report, discuss any concerns senior leaders have with the report, and determine the need for any special arrangements for the Organization Exit Conference.

During the Organization Exit Conference the surveyor(s) will review the survey findings (if desired by senior leaders), review the issues of standards compliance that have been identified during the survey, and review required follow-up actions, as applicable.

**Tracer Methodology**

The tracer methodology is the cornerstone of The Joint Commission on-site survey. The tracer methodology incorporates the use of information the organization supplies in the E-App to follow the experience of care, treatment, or services for a number of individuals through the organization’s entire health care delivery process. Tracers allow the surveyor(s) to identify performance issues in one or more steps of the process, or in the interfaces between processes. Tracer types are described in the following sections.

**Accreditation Program–Specific Tracers**

The goal of the program-specific tracer activity is to identify safety concerns within different levels and types of care, treatment, or services. Program-specific tracers focus on important issues relevant to the organization (for example, clinical services offered and high-risk, high-volume patient populations).

Topics for the program-specific tracers were identified through a review of expert literature, research, input from the field, and subject matter expertise. Accreditation program–specific tracers evaluate program-specific issues and compliance with relevant standards that impact patient safety. Table 2 contains hospital-specific tracer activities, including applicability and objectives.

**Note:** Program-specific tracers, which occur during the Individual Tracer Activity, are conducted only if they apply to the organization being surveyed.

**Table 2. Hospital-Specific Tracer Applicability and Objectives**

*continued on next page*
### Individual Tracer Activity

The individual tracer activity is conducted during an on-site survey and is designed to “trace” the care experiences that a patient had while at the hospital. The tracer methodology is a way to analyze a hospital’s system of providing care, treatment, or services using actual patients as the framework for assessing standards compliance. The surveyor(s) will use the following general criteria to select initial individual tracers:

- Patients whose tracers would allow for the evaluation of identified program-specific risk areas/categories (EPs with the R icon).
- Patients who cross programs (for example, home care patients discharged from a hospital or individuals served by behavioral health care organizations who present at an ambulatory care facility in complex organizations).
Patients who will contribute greater understanding to system tracer topics (see the “System Tracer Activity” section), such as infection control or medication management

Patients receiving complex services, such as surgery or treatment in an intensive care unit

Patients selected for initial individual tracer activity will likely be those whose diagnosis, age, or type of services received may enable the best in-depth evaluation of the hospital’s processes and practices. In conducting a patient’s tracer, the surveyor(s) will follow specific patients through the hospital’s processes. A surveyor will not only examine the individual components of a system but will also evaluate how the components of a system interact with each other. In other words, a surveyor will look at the care, treatment, or services provided by each department/unit/program and service, as well as how departments/units/programs and services work together. The surveyor(s) usually starts where the patient is currently located. He or she can then move to where the patient first entered the organization’s systems; an area of care provided to the patient that may be a priority for that organization; or to any areas in which the patient received care, treatment, or services. The location and order will vary. Along the way, the surveyor(s) will speak with the health care staff member(s) who actually provided the care to that individual tracer patient—or, if that staff member(s) is not available, will speak with another staff member(s) who provides the same type of care, treatment, or services.

Surveyors use individual patient tracers and systems tracers to review patient medical records. For hospitals seeking deemed status, surveyors will review inpatient records for 10% of the average daily census but not fewer than 30 inpatient records, or for small general hospitals (with an average daily census of 20 patients or less) not fewer than 20 inpatient records. For specialty hospitals (such as cardiac, orthopedic, or surgical hospitals), the minimum is 30 inpatient records regardless of average daily census.

Based on the findings of the surveyor(s), he or she may select similar patients to trace. The tracer methodology permits surveyors to further investigate if there is a reason to believe that an issue needs further exploration.

Please see the Survey Activity Guide on the Joint Commission Connect site for more detailed information on other program-specific criteria for tracer selection.
Risk Areas
A surveyor conducting any type of tracer at a hospital might notice something that requires a more in-depth look. At that point, the surveyor will look at all processes at a system level by asking more detailed questions or spending more time looking at a particular risk area. The focused evaluation includes processes or procedures that, if not planned or implemented correctly, have significant potential for affecting/impacting patient safety. Topics in hospitals that surveyors might need to explore in more detail include, but are not limited to, the following:

- Assessing, planning, and coordinating care
- Emergency management
- Environment of care
- Infection control
- Life safety
- Medical staff
- Medication management
- Operative and invasive procedures
- Restraints

System Tracer Activity
System tracers explore one specific system or process across the organization, focusing, when possible, on the experiences of specific patients or activities relevant to specific patients. This differs from individual tracers in that during individual tracers, the surveyor(s) follows a patient through his or her course of care, evaluating all aspects of care as opposed to a “system.” During the system tracer sessions, the surveyor(s) evaluates the system or process, including the integration of related processes and the coordination and communication among disciplines and departments in those processes.

A system tracer includes an interactive session (involving a surveyor and relevant staff members) in tracing a “system” within the organization based on information from individual tracers. Points of discussion in the interactive session include the following:

- The flow of the process across the hospital, including identification and management of risk points, integration of key activities, and communication among staff/units involved in the process
- Strengths in the process and possible actions to be taken in areas needing improvement
- Issues requiring further exploration in other survey activities
- A baseline assessment of standards compliance
Education by the surveyor, as appropriate

The three topics evaluated with system tracers are data management, infection control, and medication management. Whether all system tracers are conducted varies based on survey length, but the data use system tracer is performed on every hospital survey. If survey length does not permit the conduct of an infection control or medication management system tracer, the given area is assessed through other survey activities.

**Data Management.** The data management system tracer focuses on how the hospital collects, analyzes, interprets, and uses or manages data to improve patient safety and care.

**Infection Control.** The infection control individual-based system tracer explores the hospital’s infection control processes. The goals of this session are to assess the hospital’s compliance with the relevant infection control standards, identify infection control issues that require further exploration, and determine actions that may be necessary to address any identified risks and improve the safety of patients.

**Medication Management.** The medication management individual-based system tracer explores the hospital’s medication management processes while focusing on subprocesses and potential risk points (such as handoff points). This tracer activity helps the surveyor(s) evaluate the continuity of medication management from procurement of medications through the monitoring of their effects on patients.

**Patient Flow Tracer**
The patient flow tracer addresses potential treatment delays, medical errors, and unsafe practices that may occur during periods of patient congestion and if “patient flow” does not occur smoothly throughout the hospital.

The only standard that specifically includes the words “patient flow” is Leadership Standard LD.04.03.11. However, patient flow problems stress the hospital’s entire system. When this occurs, noncompliance with many Joint Commission standards, core measures, and National Patient Safety Goals may be evident.

Patient flow Standard LD.04.03.11 details leadership responsibilities for evaluating patient flow, accepting responsibility, and making necessary changes to improve throughput. Leaders must develop and implement plans to evaluate patient flow in the entire organization. They must identify problems in the hospital and take action to prevent barriers to patient flow. If patient flow problems are identified during the survey, the surveyor will interview hospital leaders about actions they have taken to mitigate consequences of patient congestion, how they have shared accountability with medical
staff, evidence of their shared accountability, inpatient flow indicators throughout the hospital, how indicator results are reported to leadership, and how this information has been used to improve patient flow.

When evaluating patient flow, Joint Commission surveyors will look for compliance with all standards and requirements. Standard LD.04.03.11 addresses patient flow from a performance improvement perspective. Surveyors will ensure that a hospital is not just looking at one area (for example, emergency department, laboratory, or radiology), but at its processes in its entire system. Literature shows that patient flow problems emerge in various departments and units in different hospitals; therefore, the hospital needs to evaluate all of its areas to identify where it needs to focus. In addition to Standard LD.04.03.11, there are many other standards and EPs that can be cited when the flow of patient care is disrupted.

The Role of Staff in Tracer Methodology
To help the surveyor(s) in the tracer methodology process, staff will be asked to provide the surveyor(s) with a list of active patients, including the patients’ names, current locations in the hospital, and diagnoses/conditions, as appropriate. The surveyor(s) may request assistance from hospital staff for selection of appropriate tracer patients. As the surveyor(s) moves around a hospital, he or she will ask to speak with the staff members who have been involved in the tracer patient’s care, treatment, or services if available. If those staff members are not available, the surveyor(s) will ask to speak to another staff member who would perform the same function(s) as the member who has cared for or is caring for the tracer patient. Although it is preferable to speak with the direct staff member, it is not mandatory because the questions that will be asked are questions that any staff member should be able to answer in providing care, treatment, or service to the patient being traced.

Immediate Threat to Health or Safety
The Joint Commission defines Immediate Threat to Health or Safety as “a threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served.” Such a situation may occur anywhere in an organization. (See Accreditation Participation Requirement [APR].09.04.01.) For organizations using the deemed status option, the finding(s) that contributes to the Immediate Threat situation will be documented as a Medicare Condition-level deficiency.
If a surveyor identifies any condition that he or she believes poses a serious threat to public or patient health or safety, he or she will notify the organization’s CEO and Joint Commission headquarters staff immediately. The president of The Joint Commission, or his or her designee if the president is unavailable, can then issue an expedited Preliminary Denial of Accreditation decision based on the threat. An organization notified of a Preliminary Denial of Accreditation decision due to an Immediate Threat to Health or Safety situation does not have a right to “clarify” the survey findings relative to the situation. Since a Preliminary Denial of Accreditation is an official accreditation decision category, the decision is posted on Quality Check.

The organization’s CEO and appropriate governmental authorities are informed of this decision and the findings that led to this action. In deemed status scenarios where the survey is utilized to demonstrate compliance with the Medicare Conditions of Participation, The Joint Commission will provide written notification of the immediate threat to CMS within 24 hours of confirming the immediate threat and subsequently within 10 calendar days with additional information concerning the immediate threat. After notification of the Preliminary Denial of Accreditation decision, an organization has up to 72 hours to do the following:

- Eliminate the Immediate Threat to Health or Safety situation entirely
- If the situation is such that it will take the organization more time to fully eliminate it (such as situations involving building construction), then the organization must implement emergency interventions†† to abate the risk to patients (for example, cease performing a certain procedure, implement additional safety measures) within 72 hours. If the situation is not fully eliminated within 72 hours, the organization will have a maximum of 23 calendar days to do so.

Executive leadership confirms or reverses the Preliminary Denial of Accreditation decision at its next meeting. Executive leadership may take into consideration an organization’s corrective actions or responses to a serious threat situation. The...
organization can provide information to demonstrate that a serious threat to health or safety has been corrected prior to executive leadership’s consideration of the Preliminary Denial of Accreditation decision.

In these situations, the corrective action is considered when a single issue leads to the adverse finding and the organization demonstrates that it did the following:

- Took immediate action to completely remedy the situation
- Adopted systems changes to prevent a future recurrence of the problem

If the organization demonstrates that it has taken corrective action, The Joint Commission will conduct an abatement survey to validate the implementation of the corrective action and that the immediate threat situation is no longer present.

The results of the abatement survey will help The Joint Commission executive leadership determine whether to remove the Preliminary Denial of Accreditation decision (assuming there are no other reasons for the Preliminary Denial of Accreditation). Therefore, the sooner an organization eliminates the Immediate Threat to Health or Safety situation, the shorter the period of time the organization may be in Preliminary Denial of Accreditation.

Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation to Contingent Accreditation (following review by executive leadership) and remain as such until an accreditation follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

See Figure 2 for a visual representation of the process flow for Immediate Threat to Health or Safety situations at organizations seeking reaccreditation.

**Immediate Threat to Health or Safety During Initial Survey**

There are only two possible outcomes—Accredited or Denial of Accreditation—for an organization undergoing its first, or initial, Joint Commission survey; therefore, initial organizations that have an Immediate Threat to Health or Safety situation will receive a Denial of Accreditation decision with no opportunity for an appeal. Once the Immediate Threat to Health or Safety situation is identified, the organization will not be able to withdraw from the accreditation process. In addition, The Joint Commission will notify CMS (if the organization had planned on using its Joint Commission accreditation for meeting deemed status requirements) or other licensing authority having jurisdiction that
the organization was denied accreditation due to the Immediate Threat to Health or Safety. If the organization decides to reapply after the appropriate time interval (a minimum of four months), it will undergo a survey to demonstrate that it has abated the Immediate Threat to Health or Safety. This survey may be conducted before—or in conjunction with—the full survey.

![Diagram](image-url)

**Figure 2.** Process flow for Immediate Threat to Health or Safety (ITHS) situations at organizations seeking reaccreditation.
The Summary of Survey Findings Report
Following evaluation of an organization’s performance of functions and processes, the surveyor (or survey team) reviews the results of integrated individual findings. Then, with the use of laptop-based decision support software, the surveyor (or survey team) posts the organization’s preliminary Summary of Survey Findings Report to the organization’s extranet site. Included in this preliminary report is the Survey Analysis for Evaluating Risk™ (SAFER™) matrix, which gives a visual representation of the risk level of each RFI. If requested, the surveyor (or survey team leader) and the organization’s CEO meet prior to the closing conference to determine how the report will be shared (in terms of detailed, summary, or general comments) at the closing conference. The surveyor (or survey team) uses the report contents in making closing conference presentations.

Shortly after a survey, an organization’s report of survey findings is posted on the organization’s secure Joint Commission Connect site. The report includes RFIs, as appropriate. Each observation reported by a surveyor will be plotted on the SAFER matrix according to the risk level of the finding—that is, the likelihood of the finding to cause harm to patients, staff, and/or visitors and the scope at which the RFI was observed. If a hospital does not receive any RFIs, its accreditation decision is rendered at the same time that the hospital’s preliminary Summary of Survey Findings Report is available, and it is effective the day after the completion of the survey. If a hospital does receive RFIs, then its accreditation decision is rendered following the submission of an acceptable ESC report. (See the “Accreditation Effective Date” section and the “Evidence of Standards Compliance [ESC] Process” section for more information.)

After the Survey
This section includes information relevant to an organization that has recently participated in an accreditation survey. Material includes information on scoring, the types of accreditation decisions, the ESC and clarification processes, how to request the review of an accreditation decision, how to appeal an accreditation decision, and how to use and display an accreditation award.

The Scoring Process
The performance expectations for determining if a standard is in compliance are included in its EPs. If an EP is determined to be out of compliance, then it will be cited as an RFI. Each RFI is placed in the SAFER matrix according to how likely it is that the RFI will harm a patient(s), staff, and/or visitor (low, moderate, high) and the scope, or prevalence,
at which the RFI was cited (limited, pattern, widespread). As the risk level of a finding or an observation increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level). Figure 3 is a representation of the SAFER matrix.

![Survey Analysis for Evaluating Risk (SAFER) matrix](image)

**Figure 3.** Survey Analysis for Evaluating Risk (SAFER) matrix.

If a standard is not applicable (NA) to the organization, it will be marked “NA” and not placed within the SAFER matrix.

**How Accreditation Decisions Are Made**

Accreditation decisions are made based on the premise that the immediacy of risk to quality of care and patient safety—as shown by noncompliance with Joint Commission standards and EPs—varies. All insufficiently compliant EPs will be cited as RFIs. In addition, all RFIs must be addressed via the ESC submission process. The time frame for
completing the ESC submission is within 60 calendar days. (For organizations recommended for Preliminary Denial of Accreditation, the submission of an ESC will be required within 45 calendar days.)

The organization’s accreditation decision will be held in abeyance pending submission of ESC within the established time frame. Failure to resolve the instances of insufficient compliance with the associated EPs through the ESC process will lead to progressively more severe accreditation decisions: Accreditation with Follow-up Survey, Contingent Accreditation, and Preliminary Denial of Accreditation. For situations that constitute more immediate risks to quality of care and patient safety, a more severe accreditation status will be applied. In these scenarios, the two accreditation classifications defined below will be utilized:

- Immediate Threat to Health or Safety
- Decision Rules

**Immediate Threat to Health or Safety.** Immediate Threat to Health or Safety situations that are identified on site have or may potentially have serious adverse effects on the health or safety of patients. Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation to Contingent Accreditation (following executive leadership review) and remain as such until a follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

Immediate Threat to Health or Safety situations are cited at Accreditation Participation Requirement APR.09.04.01, EP 1.

**Decision Rules.** Decision rules determine an accreditation decision that appropriately represents an organization’s overall performance as measured by noncompliance with the applicable standards. Decision rules are applied when a heightened risk to patient care and safety is determined as a result of on-site survey findings. There are times when situations will automatically trigger a recommendation for Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey based on such issues as loss of facility licensure, provision of care by unlicensed individuals who require such a license, and failure to implement corrective action in response to identified Life Safety Code deficiencies. In follow-up to these situations, organizations must demonstrate resolution of the situation through the ESC process. An on-site survey is conducted to validate implementation of corrective action.
For more information regarding decision rules, see the “Decision Rules for Organizations Seeking Reaccreditation” and “Decision Rules for Organizations Seeking Initial Accreditation” sections later in this chapter.

The Accreditation Decision Process
The goal of the accreditation decision and reporting approach is to focus attention on the issues that pose the greatest risk to quality of care, treatment, and services and to patient safety. Key elements of the accreditation decision process include the following:

- Levels of compliance with Joint Commission standards are identified on the SAFER matrix.
- The surveyor(s) leaves a preliminary Summary of Survey Findings Report on site. (For special surveys, no report is left on site.)
- The Accreditation Survey Findings Report will be posted on the hospital’s secure Joint Commission Connect site within 10 business days of completing the survey.
- If RFIs are cited, the organization has a 60-day window to submit an ESC report to address correction of the RFIs. (For organizations recommended for Preliminary Denial of Accreditation, the submission of an ESC will be required within 45 calendar days.)

The “Joint Commission Findings” section of the Accreditation Survey Findings Report includes the RFIs and associated findings cited during the on-site survey. In addition, Joint Commission EPs that were initially identified as less-than-fully compliant but were corrected before the conclusion of the survey will be designated as Observed but Corrected On-site (OOO), and the RFI will remain in the survey report.

For more information on the scoring process, see the section “The Scoring Process.”

Central Office Review of Summary Reports
Some Summary of Survey Findings Reports may require further review in the Joint Commission’s Central Office. Reports that meet a decision rule that automatically trigger a Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey decision are always stopped for further review.

Reports may be reviewed if there is a unique issue, such as a possible CMS Condition-level deficiency, possible noncompliance with an APR, or an unusual question or circumstance that could not be resolved during the survey.
Based on the review, staff may recommend a decision of Accreditation with Follow-up Survey, Contingent Accreditation, or Preliminary Denial of Accreditation. The Joint Commission’s chief medical officer must review and approve the recommendation before sending it to the Joint Commission’s executive leadership, which has final authority for assigning the accreditation decision.

**Decision Categories for Organizations Seeking Accreditation Renewal**

The Joint Commission’s decision categories are designed to help distinguish organizations with serious patterns and trends in the provision of care, treatment, or services—which require follow-up more quickly—from those with less serious compliance issues. There are five possible decision categories for organizations undergoing a Joint Commission survey for reaccreditation. Figure 4 illustrates the continuum of accreditation decisions possible following resurvey activity. The Joint Commission’s five accreditation decision categories for organizations seeking renewal of accreditation are as follows:

1. **Accredited.** The organization is in compliance with all applicable requirements at the time of the on-site survey or has successfully addressed all RFIs in an ESC within 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.

2. **Accreditation with Follow-up Survey.** The organization is not in compliance with specific standards that require a follow-up survey within 30 days to 6 months. The health care organization also must successfully address the identified problem area(s) in an ESC submission. An organization that plans to resolve a deficiency through a PFI or a Survey Plan for Improvement (SPFI) must meet the required 60-day time frame in order to avoid receiving a decision of Accreditation with Follow-up Survey.

3. **Contingent Accreditation.** The organization has successfully abated an Immediate Threat to Life (ITL) situation through direct observation or other method, fails to successfully address all requirements of the Accreditation with Follow-up Survey decision, and/or shows some evidence of engaging in possible fraud or abuse. In most cases, a follow-up survey in 30 days will be required to show resolution of the issues that led to the decision.

††† There is a sixth decision category for organizations seeking initial accreditation: Limited, Temporary Accreditation. As explained in the “Early Survey Policy” section earlier in this chapter, an organization receives this decision if it demonstrates compliance with the limited set of standards surveyed in the first survey under the Early Survey Policy.
4. **Preliminary Denial of Accreditation.** There is justification to deny accreditation to the organization as evidenced by

- An Immediate Threat to Health or Safety to patients or the public, and/or
- Submission of falsified documents or misrepresented information, and/or
- Lack of a required license or similar issue at the time of survey, and/or
- Failure to resolve the requirements of Contingent Accreditation, and/or
- Failure to resolve the requirements of Accreditation with Follow-up Survey, and/or
- Significant noncompliance with Joint Commission standards.

The decision is subject to review and appeal by the organization prior to the determination to deny accreditation. (See the “Review and Appeal Procedures” section.)

5. **Denial of Accreditation.** The organization has been denied accreditation. All review and appeal opportunities have been exhausted.

![Diagram]

**Figure 4.** Continuum of survey activity outcomes for organizations seeking renewal of accreditation.

### Decision Outcomes for Organizations Seeking Initial Accreditation

For organizations undergoing their full first, or initial, Joint Commission survey, the decision process may result in only two possible outcomes—Accredited or Denial of Accreditation. Initial organizations receive an Accredited decision when they are in
compliance with all applicable requirements at the time of the on-site survey or when they have successfully addressed all RFIs in an ESC within 60 days; if they do not successfully address all RFIs in an ESC within 60 days, they receive a Denial of Accreditation decision. During the 60-day time frame, the decision is pending and the process is as follows:

- Organizations found out of compliance with Joint Commission requirements during their initial survey are required to submit corrective action through an ESC. A successful ESC will then result in an Accredited decision; an unsuccessful ESC will result in a decision of Denial of Accreditation.

- Organizations found with Condition-level deficiencies during their initial survey are required to undergo a second initial Medicare survey. If no deficiencies—whether related to Joint Commission requirements or Medicare Conditions of Participation—are found during this second initial Medicare survey, the organization receives an Accredited decision.

- If Condition-level deficiencies are found during the second initial Medicare survey, the organization receives a Denial of Accreditation decision. However, if the second initial Medicare survey results in findings of deficiencies with Joint Commission requirements, the organization’s decision is again pending the submission of corrective action through an ESC. A successful ESC will then result in an Accredited decision; an unsuccessful ESC at this point will result in a decision of Denial of Accreditation.

**Accreditation Effective Date**

For organizations undergoing a resurvey, the effective date of the accreditation decision varies based on the type of and acceptance of follow-up activities. (See the “Evidence of Standards Compliance [ESC] Process” section for more information.) For organizations that do not receive any RFIs, the accreditation decision will be effective the day after the last day of survey. Otherwise, an accreditation decision is rendered once all RFIs have been resolved following the submission of an acceptable ESC and evidence of a successful Medicare deficiency follow-up survey if Medicare Condition-level deficiencies are identified, which is retroactive to the day after the last day of the full survey.

The accreditation effective date for an organization that undergoes an initial survey is the date on which the last acceptable ESC was submitted, if the organization has an RFI. If there are no RFIs, the effective date is the day after the last day of the survey.
When an organization’s accreditation decision becomes official, it is publicly disclosable and is posted on Quality Check. RFIs will be posted also for those organizations that receive a decision of Accreditation with Follow-up Survey, Contingent Accreditation, or Preliminary Denial of Accreditation.

**Withdrawing or Closing After Undergoing a Resurvey**

An organization’s request to withdraw from the accreditation process after undergoing a resurvey (or that closes after undergoing survey) but before a final decision has been made does not terminate the decision-making process. The Joint Commission then issues a final accreditation decision.

**Withdrawing from Initial Survey**

An organization has the opportunity to withdraw from an initial survey up until the time it submits an ESC—which could be on site or shortly thereafter. If the organization requests to withdraw from the survey after it submits an ESC, the request will be denied and the organization will receive a decision of Denial of Accreditation.

**Evidence of Standards Compliance (ESC) Process**

An ESC is a report submitted by a surveyed hospital that details the action(s) that it took to bring itself into compliance with a standard. The ESC report is available for completion on the hospital’s secure Joint Commission Connect site at the same time that the hospital’s Summary of Survey Findings report is posted.

After the survey, the surveyor(s) transmits his or her survey findings to the Joint Commission’s Central Office. The organization’s official Accreditation Survey Findings Report will be posted on its secure Joint Commission Connect site within 10 business days of completing a survey.

Every standard found not in compliance at the time of survey will generate an RFI. When a hospital receives an RFI, it can choose to go directly to corrective action or to try and clarify the RFI. However, the hospital must submit either a corrective ESC or a clarification for every RFI cited in a hospital’s Accreditation Survey Findings Report (see the “Standards Clarification” section). Challenging specific surveyor observations will not result in the automatic removal of an RFI. The time frame for submitting a corrective ESC is 60 days. A corrective ESC must address compliance at the EP level for all applicable corrections.
For those findings of a higher risk level, additional fields will be required within the ESC for the organization to provide a more detailed description of the leadership involvement and preventive analysis that will assist in sustaining the compliance plan. In addition, these higher risk findings will be provided to surveyors for possible review or on-site validation during any on-site surveys up until the next full triennial survey occurs. The sample SAFER matrix in Figure 5 provides a representation of possible ESC follow-up activities for RFIs of varying risk levels.

<table>
<thead>
<tr>
<th>SAFER Matrix™ Placement</th>
<th>Required Follow-up Activity</th>
</tr>
</thead>
</table>
| HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD | 60-day Evidence of Standards Compliance (ESC)  
- ESC will include Who, What, When, and How sections  
- ESC will also include two additional areas surrounding Leadership  
Involvement and Preventive Analysis  
- Finding will be highlighted for potential review by surveyors on subsequent on-site surveys up to and including the next full survey |
| MODERATE/PATTERN, MODERATE/WIDESPREAD | 60-day Evidence of Standards Compliance (ESC)  
- ESC will include Who, What, When, and How sections  
- ESC will also include two additional areas surrounding Leadership  
Involvement and Preventive Analysis  
- Finding will be highlighted for potential review by surveyors on subsequent on-site surveys up to and including the next full survey |
| MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD | 60-day Evidence of Standards Compliance (ESC)  
- ESC will include Who, What, When, and How sections |
| LOW/LIMITED | 60-day Evidence of Standards Compliance (ESC)  
- ESC will include Who, What, When, and How sections |

Note: If an Immediate Threat to Health and Safety, also known as Immediate Threat to Life (ITL), is discovered during a survey, the organization immediately receives a Preliminary Denial of Accreditation (PDA) and, within 72 hours, must either entirely eliminate the ITL or implement emergency interventions to abate the risk to patients (with a maximum of 23 days to totally eliminate the ITL).

Figure 5. SAFER matrix placement and required follow-up activities.

**Standards Clarification**

After a survey event, organizations have the opportunity to submit clarifying ESC if they believe that their organization was in compliance with a particular standard at the time of survey. (This process does not include EPs initially identified as noncompliant but corrected before the survey’s conclusion. Also not included in this process is the placement of a finding within the SAFER matrix; that is, an organization can clarify the finding as a whole but cannot change where the finding is placed within the matrix.)
The “clarification” is part of the ESC process and must be submitted within 10 business days following the posting of the organization’s report on the Joint Commission Connect site. The submission of a clarification does not negate the requirement for submission of a corrective ESC within 60 days if the RFI continues, nor does it provide an organization with additional time to submit its ESC. Therefore, if an organization submits clarification and still has to submit an ESC, the organization will have up 60 days in total to submit both the clarification and the corrective ESC.

When submitting clarifying ESCs after a survey event, it is important to follow the directions in the submission tool. Address each prompt, detailing why the organization was in compliance at the time of survey. Remember to address the EP as well as the actual surveyor observation. (A finding of “lack of required documentation at the time of survey” is not eligible for clarification.)

**Corrective ESC**

An acceptable corrective ESC report must detail the following:

- Action(s), along with the date of such action(s), that the organization took to bring itself into compliance with a requirement
- Titles of staff members responsible for implementing the corrective actions or approving a revised policy, procedure, or process
- Compliance at the EP level

An acceptable ESC report is due within 60 calendar days following the posting of the Accreditation Survey Findings Report. (For organizations recommended for Preliminary Denial of Accreditation, the submission of an ESC will be required within 45 calendar days.) The required time frame will be specified in the survey report. Following a successful submission of the ESC report, the organization receives an accreditation decision. However, the organization’s accreditation decision is retroactive to the day after the last day of the survey, unless the organization is undergoing its first Joint Commission survey. The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has any RFIs. If there are no RFIs, the effective date is the day after the last day of the survey. If there is an adverse accreditation decision, such as Contingent Accreditation or Preliminary Denial of Accreditation, the effective date of the adverse decision is the day of the executive leadership meeting or when an acceptable ESC resolving all RFIs is submitted (if that occurs after the executive leadership meeting).
If the organization implements acceptable actions to address its RFIs, the organization’s accreditation decision is Accredited. If an organization’s ESC report does not acceptably address its RFIs, then the organization’s accreditation decision is Accreditation with Follow-up Survey, which can eventually lead to a Contingent Accreditation or Preliminary Denial of Accreditation decision.

The organization’s ESC submission(s) will be evaluated by Central Office staff using the same scoring guidelines used by the surveyors at the time of survey and by health care organizations when they conduct their FSA. The Joint Commission will consider the ESC acceptable when the hospital has demonstrated resolution of all RFIs. If the hospital has not met a rule for Accreditation with Follow-up Survey, Contingent Accreditation, or Preliminary Denial of Accreditation, and the ESC submission(s) is determined to be acceptable, its decision will be Accredited.

**On-Site ESC.** Usually, the ESC will be an electronic submittal to The Joint Commission, but there will be times when a review of the ESC also will be conducted on site by a surveyor. If an on-site evaluation is required to assess compliance with the relevant standards following electronic submittal, a copy of the hospital’s electronic ESC is provided to the surveyor conducting the on-site ESC. The on-site ESC process provides the opportunity to evaluate the organization’s success in correcting the issues. It also allows the surveyor to provide coaching and guidance to the organization, supporting its efforts to achieve and maintain compliance with the standards.

A final decision letter will be posted to the hospital’s secure, password-protected *Joint Commission Connect* site when its ESC has been reviewed and an accreditation decision has been rendered. A Quality Report will then be posted on Quality Check on The Joint Commission’s website. For more information, see “The Joint Commission Quality Report” (QR) chapter.

**The Process for Accreditation with Follow-up Survey, Contingent Accreditation, or Preliminary Denial of Accreditation**

If an organization is notified that it has met the criteria for Accreditation with Follow-up Survey, Contingent Accreditation, or Preliminary Denial of Accreditation, the organization has 10 business days following this notification to provide information to clarify any of the RFIs cited in its Accreditation Survey Findings Report through its ESC report and demonstrate that it was in fact in compliance with one or more standards in question at
the time of survey. A Clarification Validation Survey (CVS) may be conducted to ensure that the organization was, in fact, in compliance with Joint Commission standards at the time of survey rather than relying solely on information submitted by the organization. (See the “Clarification Validation Survey” section for more information.)

Under this process, whenever an organization submits written or electronic information after receiving a Preliminary Denial of Accreditation decision, The Joint Commission may conduct a CVS to validate the information and assure compliance with Joint Commission standards before making a final decision to remove the organization from the Preliminary Denial of Accreditation decision. Inclusion of the CVS with the appeal process helps maintain the integrity of the accreditation decision process and ensures that Joint Commission–accredited organizations are providing safe, high-quality care.

If the organization does not meet a rule for Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey, it will be awarded accreditation (if it is compliant with all standards) or it will be required to submit an ESC (if it still has RFIs). However, if the organization continues to meet a decision rule for Preliminary Denial of Accreditation or Contingent Accreditation, The Joint Commission staff will recommend to executive leadership that the organization remain in Preliminary Denial of Accreditation or Contingent Accreditation. The organization will have 5 business days from receipt of notification to submit a written response directly to executive leadership.

See Figures 6 and 7 for a visual representation of the processes for Preliminary Denial of Accreditation and Contingent Accreditation.
Figure 6. Process flow for a Preliminary Denial of Accreditation (PDA) decision (shaded steps are specific to process flow for decision rule PDA02).
Figure 7. Process flow for a Contingent Accreditation (CONT) decision.

Preliminary Denial of Accreditation Due to Patterns, Trends, or Repeat Findings

If an organization’s patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings, Joint Commission staff may initiate the Preliminary Denial of Accreditation process under decision rule PDA02 (see the “Decision Rules for Organizations Seeking Reaccreditation” section).

For these organizations, all corrective ESCs are due to The Joint Commission within 45 days of the organization being notified of the recommendation for a PDA decision. After the ESC is determined to be acceptable (an organization has two opportunities to submit an acceptable ESC), a follow-up survey is conducted to validate that the organization has fully implemented the improvements identified in its ESC submission. If, at the time of the follow-up survey, the organization demonstrates resolution of all the RFIs that resulted in the PDA recommendation, staff will recommend to executive leadership that the organization’s accreditation history be revised to reflect a “time-limited” PDA decision. This decision continues from the date following the last day of the accreditation survey through the date of the follow-up survey. In addition, the organization’s
accreditation status will be upgraded to Contingent Accreditation or Accreditation with Follow-up Survey. This includes a second follow-up survey to evaluate the organization’s sustained implementation of corrective action.

However, if (at the time of the follow-up survey) the organization does not demonstrate resolution of all the RFI that resulted in the PDA recommendation, staff will recommend to executive leadership that the organization receive a PDA decision and thus continue down the track toward Denial of Accreditation.

**Preliminary Denial of Accreditation for Organizations Without Proper License, Certificate, or Permit**

If a hospital does not possess a license, certificate, and/or permit, when required by applicable law and regulation, to provide the health care services for which the hospital is seeking accreditation, Joint Commission staff may initiate the Preliminary Denial of Accreditation process under decision rule PDA04 (see the “Decision Rules for Organizations Seeking Reaccreditation” section).

In some instances, the hospital may not be aware that a license, certificate, or permit has expired or that one is required in their state or a state other than the one in which it is physically located. If the hospital takes appropriate action as soon as it becomes aware of the need, and obtains the required license, certificate, or permit before being presented to executive leadership or can show proof of application for such, the decision rule will be removed. However, the RFI will remain in the survey report so The Joint Commission can be assured that the hospital will have a process in place to ensure that licenses, certificates, or permits will be acquired or renewed in a timely fashion in the future.

The process for Preliminary Denial of Accreditation in such circumstances is as follows:

- If at the time of survey the hospital does not have a required license, certificate, or permit, the hospital will be notified that it meets a rule for Preliminary Denial of Accreditation, and The Joint Commission will initiate such action.
- The hospital will also be notified that if it obtains the required license, certificate, or permit or is able to provide proof of application during the clarification process, the PDA decision will be removed, but the RFI will remain in the survey report.
- The hospital will not be presented to executive leadership unless it meets a decision for Preliminary Denial of Accreditation or Contingent Accreditation based on another decision rule.
Accreditation Award Display and Use

The Joint Commission provides each accredited organization with one certificate of accreditation per accreditation program. There is no charge for the initial certificate(s). Additional certificates may be purchased. Such requests should be sent to the certificate coordinator in the Division of Accreditation and Certification Operations at The Joint Commission.

The certificate and all copies remain The Joint Commission’s property. They must be returned if either of the following situations occurs:
- The organization is issued a new certificate, reflecting a name change
- The organization’s accreditation decision is changed, withdrawn, or denied for any reason

Accreditation award certificates include language about educating patients and their families on how to contact The Joint Commission. An organization accredited by The Joint Commission must be accurate in describing to the public the nature and meaning of its accreditation and its award (see APR.08.01.01 in the APR chapter). When an organization receives an accreditation award, The Joint Commission sends the organization guidelines for characterizing the accreditation award.

An organization may not engage in any false or misleading advertising of an accreditation award. Any such advertising may be grounds for The Joint Commission to deny accreditation. For example, an organization may not represent its accreditation as being awarded by any of The Joint Commission’s corporate members. These include the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. The Joint Commission has permission to reprint the seals of its corporate members on certificates of accreditation. However, these seals must not be reproduced or displayed separately from the certificate.

Any organization that materially misleads the public about any matter relating to its accreditation must undertake corrective advertising to a degree acceptable to The Joint Commission in the same medium in which the misrepresentation occurred. If an organization fails to undertake the required corrective advertising following the communication of false or misleading advertising about its accreditation decision, the organization may be subject to loss of accreditation.

The Joint Commission’s logo is a registered trademark. An accredited organization may use the logo if it follows these guidelines:
The logo must remain in the same proportional relationship as provided and should not be displayed any larger than an organization’s own logo.

The logo’s format cannot be changed, the name may not be separated from the symbol, and the logo must be printed in the original color.

Graphic devices such as seals, other words, or slogans cannot be added to the logo, except for the words “Accredited by.”

These guidelines apply to logo use on all print materials, Internet webpages, and promotional items, such as coffee mugs, T-shirts, and notepads.

Contact The Joint Commission Department of Communications at 630-792-5631 for questions about using The Joint Commission logo or access the Accreditation Publicity Kit online at http://www.jointcommission.org.

Top Performer on Key Quality Measures® Program

Since its launch in September 2011, The Joint Commission’s Top Performer on Key Quality Measures® program has recognized Joint Commission–accredited hospitals that attain and sustain excellence in accountability measure performance. Top Performer hospitals have been identified annually based on an aggregation of accountability measure data reported to The Joint Commission through the ORYX® program during the previous calendar year.

The Top Performer program has utilized the results of a fixed set of designated accountability chart-based performance measures to compare performance and determine top hospitals. However, the retirement of some accountability measures, the heterogeneity of measure sets reported by hospitals, and the fact that performance rates for electronic clinical quality measures (eCQMs) may not be equivalent to performance rates on chart-based measures make it difficult to compare hospitals and identify top performers.

For these reasons, the Top Performer program is on hiatus while The Joint Commission reevaluates the evolving national measurement environment. In the interim, The Joint Commission Pioneers in Quality program has been created to provide continued support for accredited hospitals on their journey towards using eCQMs. Key components of the Pioneers in Quality program include the following:

- Webinars providing education about eCQMs
- Comprehensive eCQM resource portal
- Recognition categories for eCQM pioneers
- Pioneers in Quality advisory panel
- Modified annual report focusing on the evolution of eCQM measurement
- Outreach through Joint Commission Speakers Bureau
- Modified Core Measure Solution Exchange® including eCQMs
- Strong focus on partnering with hospitals to provide the highest level of quality care for patients and their families

ORYX® flexible reporting options remain in place during the hiatus. For additional information, please visit [http://www.jointcommission.org/topics/pioneers_in_quality.aspx](http://www.jointcommission.org/topics/pioneers_in_quality.aspx) or send an e-mail to pioneersinquality@jointcommission.org.

### Medicare Certification Recommendation Letter
For hospitals that use Joint Commission accreditation for deemed status purposes, in addition to the official accreditation award letter The Joint Commission will issue a Medicare recommendation letter to inform CMS that a new or existing Medicare provider has participated in a deemed status survey and that The Joint Commission is making a recommendation regarding Medicare certification as a result. The letter includes information on the dates of the survey, the outcome of the survey, the effective date of accreditation, and the locations included in the scope of the accreditation survey. The Joint Commission provides a copy of the letter to the CMS central office and appropriate regional office. The regional office then makes the final determination regarding the Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Hospitals new to accreditation are encouraged to share the Medicare recommendation letter with their state survey agency.

### Between Accreditation Surveys
This section provides information that is relevant to organizations between Joint Commission surveys. Material includes the duration of an accreditation award, the process for continuing accreditation, the FSA process, how to notify The Joint Commission in the event of organization changes, and information on other types of surveys.
Duration of Accreditation Award
An accreditation award is continuous until the organization has its next full survey, which will be between 18 and 36 months after its previous full survey, unless accreditation is revoked for cause or as otherwise outlined in this chapter. An organization may request a full accreditation survey more frequently than when it is due to have a survey. The Joint Commission, at its discretion and in accordance with its mission, determines whether to honor the request. An organization should send such a request to its Joint Commission account executive.

An organization’s accreditation cycle is continuous, as long as the organization:
- Has a full, unannounced survey within 36 months of its last survey; and
- Continues to meet all accreditation-related requirements as required, including, but not limited to, submission of an FSA (see “Focused Standards Assessment [FSA]”, following) and an annual subscription payment.

Continuous Compliance
The Joint Commission expects an accredited organization to be in continuous compliance with all applicable standards and EPs. It may ask an organization to supply, in writing, information about compliance with applicable standards. The Joint Commission may conduct a survey if an organization fails to respond to a request for more information. It may also survey an organization at any time in response to complaints, media coverage, or other information that raises questions about the adequacy of patient health and safety protections. For organizations using The Joint Commission for deeming purposes, the survey will be unannounced. (See the “For-Cause Surveys” section for more information.)

The Joint Commission may view an organization’s failure to permit a survey as the organization no longer wanting to participate in the accreditation process. In such a case, The Joint Commission begins proceedings to deny accreditation to the organization (see APR.02.01.01 in the APR chapter).

Intracycle Monitoring
To assist accredited organizations with their continuous compliance efforts, The Joint Commission makes the Intracycle Monitoring (ICM) Profile available on The Joint Commission Connect extranet site. The ICM Profile identifies high-risk areas and related
standards for hospitals. These standards are displayed within the FSA tool with a special risk icon. The FSA tool enables organizations to conduct their own self-assessment of standards compliance throughout the triennial accreditation cycle.

The Joint Commission identifies critical systems/processes that could lead to adverse effects if they become weak or fail. Risk is assessed by a system’s proximity to the patient, probability of harm, severity of harm, and number of patients at risk. Risk categories in the FSA are related to the following three categories:
1. National Patient Safety Goals
2. Accreditation program-specific risk areas
3. RFIs identified during current accreditation cycle survey events

**Focused Standards Assessment (FSA)**

The FSA process is designed to help hospitals incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process. A hospital has access to its FSA tool on a continuous basis throughout its accreditation cycle. The FSA tool becomes available to a hospital seeking accreditation for the first time after submitting its E-App and deposit. The FSA tool permits the hospital to evaluate compliance with all applicable Joint Commission standards and EPs. For every noncompliant standard, the hospital must identify a Plan of Action (POA) at the EP level, identifying how it plans to come into compliance with the requirement(s).

The FSA is a management tool that helps an accredited hospital review applicable standards, APRs, and applicable National Patient Safety Goals; assess compliance; develop and implement POAs; and identify measures by which it can gauge success in carrying out those plans. By participating in the FSA, a hospital will be better able to incorporate Joint Commission standards into routine operations, which in turn will help to ensure the provision of safe, high-quality care on an ongoing basis.

The FSA must be completed electronically on the hospital’s secure Joint Commission Connect site and submitted to The Joint Commission by its due date 12 and 24 months following its triennial survey. (Note that leadership of an organization with a PDA02 decision—a decision based on significant and pervasive patterns of noncompliant

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Footnote:

The FSA tool is in the process of being updated to reflect the new processes surrounding the SAFER matrix, which will be available starting January 1, 2017. Until that time, organizations should continue to utilize the current FSA tool.
standards—is required to participate in the ICM process.) Following receipt of the evaluation and POA, and if requested by the hospital, staff from the Joint Commission’s Standards Interpretation Group will schedule a telephone call with the hospital to discuss and agree on an acceptable POA. The timeline for the FSA is such that the hospital should have sufficient time to implement the actions identified in the POA. The track record will be based on the POA implementation date. (The FSA submission is not required of hospitals undergoing initial survey.)

There are several options for completing the FSA. Organizations submitting a Full FSA use the FSA tool to conduct a self-assessment of standards compliance. Full FSA submission requires that at least a minimum subset of standards be scored (the minimum subset comprises all standards identified with the icon). Organizations may choose to submit one of three options to the Full FSA. Organizations submitting FSA Option 1 may use the FSA tool to conduct and score their standards self-assessment but may elect not to submit the data to The Joint Commission; however, they may still submit general Topics for Discussion as part of the submission process and engage in a conference call with the Standards Interpretation Group. Organizations also have the option to submit a request for an on-site Option 2 or 3 survey. The Option 2 survey results in a written report of findings that the organization follows up with POAs as appropriate. An Option 3 survey provides the organization with a verbal report of survey findings, but it does not result in any historical written documentation. Both the Option 2 and Option 3 surveys involve additional survey fees.

Due dates for FSA submission occur at 12 months and 24 months after the hospital’s last full survey. For example, if a hospital had its full survey end on January 10, 2016, its 12-month FSA would be due January 10, 2017, and the 24-month FSA would be due January 10, 2018. No FSA submission is due at 36 months because the next accreditation cycle’s full survey typically occurs by that point of the triennial cycle. Because full surveys can occur at any time between the 18th and 36th month of the triennial accreditation cycle, should a full survey occur before a hospital’s anticipated FSA due date, the FSA due date will be reset accordingly.

Sidebar outlines some of the activities in each of these FSA options.
Sidebar 2: Focused Standards Assessment Options

Full FSA

- Organization uses the automated FSA tool to assess and score compliance with elements of performance (EPs) for each applicable standard.
- Organization creates a Plan of Action (POA) addressing each EP scored partial or insufficient compliance within any standards found not compliant.
- Organization submits an FSA to The Joint Commission annually, with the exception of the year the organization is due to have its triennial survey.
- Organization may elect to participate in a conference call with Joint Commission staff to discuss POAs or other standards-related issues of its choosing. If a conference call is not requested, the data will be reviewed by Joint Commission staff. Should staff determine a conference call is needed, the hospital will be contacted to schedule a call.
- Because The Joint Commission may request a conference call even if an organization does not request one, all organizations submitting the Full FSA with not compliant standards need to enter their conference call “avoid dates” when they submit their FSA. “Avoid dates” are dates on which the organization prefers that the conference call not be scheduled.
- Joint Commission staff reviews and approves POAs during Central Office review or a conference call.

FSA Option 1

- Organization uses the automated FSA tool to assess and score compliance with EPs for each applicable standard if it chooses to do so.
- Organization affirms that it has completed an assessment of its compliance with applicable EPs and developed POAs as necessary, but does not submit data to The Joint Commission.
- Organization can submit standards-related issues in the ICM Profile for telephone discussion with Joint Commission staff, if desired.

FSA Option 2

- Organization uses the FSA tool, indicating it has decided not to participate in the Full FSA and instead intends to undergo an FSA survey.
- Organizations that choose an FSA survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.

Continued on next page

A Plan of Action details the action(s) an organization will take to come into compliance with each standard identified as not compliant.

Shading indicates a change effective January 1, 2017, unless otherwise noted in the What's New.
Sidebar 2. (continued)

- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program–specific risk areas; all standards are subject to review.
- Surveyor leaves a written report of findings with the organization.
- Within 30 days of the FSA survey, organization submits the post-survey FSA tool again and addresses not compliant standards, “avoid dates” for an optional conference call, and any other topics the organization wishes to discuss with Joint Commission staff. Organization creates a POA for each standard scored partial or insufficient compliance.
- Organization may elect to participate in a conference call with Joint Commission staff to discuss the POAs. If a conference call is not requested, the data will be reviewed by Joint Commission staff. Should they determine a conference call is needed, the organization will be contacted to schedule a call.
- Joint Commission staff reviews and approves POAs during conference call.

FSA Option 3

- Organization uses the FSA tool, indicating it has decided not to participate in the Full FSA and instead intends to undergo an FSA survey.
- Organizations that choose an FSA survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.
- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program–specific risk areas; all standards are subject to review.
- Surveyor delivers an oral report of findings at the closing conference of the on-site survey. No written report of findings will be left at the organization.

The FSA will affect a hospital’s accreditation decision only if the hospital fails to participate in the FSA process, whether the Full FSA or one of the three options, or an Immediate Threat to Health or Safety situation is identified through the FSA process and a special survey is conducted. If you need more information while completing the FSA, please contact your account executive at 630-792-3007.

Plan of Action (POA)

A POA is a detailed description of how a hospital plans to bring into compliance any standard identified as “not compliant” in the FSA. The POA must include the planned action to be taken and target implementation dates.
Sentinel Event Follow-up
Accredited hospitals are expected to identify and respond appropriately to all sentinel events. The hospital is required to conduct a thorough and credible comprehensive systematic analysis and develop an action plan in a manner and time frame acceptable to The Joint Commission as specified in the Sentinel Event Policy and submit them to The Joint Commission or otherwise provide evidence of an acceptable response to the sentinel event. (See the “Sentinel Events” [SE] chapter for more information.)

Notifying The Joint Commission About Organization Changes
Accreditation is neither automatically transferred nor continued if significant changes occur within a hospital. Hospitals must notify The Joint Commission promptly, in writing, when an additional service is contemplated so any potential impact to accreditation can be determined. Medicare-certified organizations must also notify the Medicare Administrator Contractor promptly, in writing, when an additional service is contemplated. Once the change has actually occurred, the E-App must be updated to reflect the change as well.

Changes Affecting E-App Information
At any time during the accreditation process, a hospital may undergo a change that modifies the information reported in its E-App (see APR.01.03.01 in the APR chapter). Hospitals must notify The Joint Commission promptly, in writing, when an additional service or location is contemplated so any potential impact to accreditation can be determined. Medicare-certified organizations must notify the Medicare Administrator Contractor promptly, in writing, when an additional service is contemplated. Once the change has actually occurred, the hospital must update its E-App within 30 calendar days. Information that must be reported includes any of the following:

- A change in ownership
- A change in location
- A significant increase or decrease in the volume of services or individuals served
- The addition of a new type of health service, program, or site of care
- The deletion of an existing health service, program, or site of care

***An organization is considered to have “contemplated” a change when leadership within the organization has approved moving forward with the proposed change and identified a time frame for implementing that change.
- The acquisition of a new component
- The deletion of an existing component

The Joint Commission may conduct an additional survey at a later date if its surveyor or survey team arrives at the hospital and discovers that a change was not reported. The Joint Commission may also survey any unreported services and sites addressed by its standards during the survey as appropriate. The Joint Commission makes the final accreditation decision for the hospital only after surveying all or an appropriate sample of all services, programs, and sites provided by the hospital for which The Joint Commission has standards. Information reported in the E-App is subject to The Joint Commission’s Information Accuracy and Truthfulness Policy.

**Changes to the Site of Care, Treatment, or Services**

When a hospital offers its services or programs at a new location or in a significantly altered physical plant, the hospital must evaluate for *Life Safety Code* deficiencies and document the corrective actions (to be completed within 60 days of notification to The Joint Commission) and Interim Life Safety Measures (ILSM) implemented to protect the building occupants while the deficiencies are being corrected. Failure to provide timely notification to The Joint Commission of these conditions may result in the hospital’s loss of accreditation. If the corrective actions cannot be accomplished within 60 days of notification to The Joint Commission, the hospital will need to contact its Account Executive.

**Mergers, Consolidations, and Acquisitions**

In the case of a merger, consolidation, or acquisition, The Joint Commission may decide that the hospital responsible for services must have a survey. If, after a hospital receives an accreditation decision, the hospital’s structure changes whereby one or more of its services, programs, or related hospitals are no longer part of the hospital that was originally surveyed, the service, program, or related hospital is no longer included in the hospital’s accreditation.

See the “Extension Surveys” section for more information on what The Joint Commission expects to accomplish on these surveys.
Accreditation Status of Organizations That Cease Services After a Disaster

Following a disaster that requires a Joint Commission–accredited hospital to cease the provision of services for a period of time, The Joint Commission will work with the affected hospital to address the impact that the cessation of services will have on the hospital’s accreditation status and to ensure that the hospital is prepared to provide safe, quality care upon resumption of services. If after six months the hospital cannot resume services, The Joint Commission will discontinue the accreditation of the hospital. The impact of the cessation of services for a period of time on the accreditation status of organizations that experience a disaster is described below.

Cease Services Up to 30 Days. For hospitals that resume services within the first 30 days after a disaster and/or the hospital’s decision to cease operations, the hospital’s original Joint Commission accreditation status will stay in effect. The time frame for complying with any outstanding Joint Commission requirements (such as the FSA or ESC) will pause until the hospital resumes operation. In most cases, The Joint Commission will not need to survey the affected hospital to reassess its level of standards compliance. If The Joint Commission decides to conduct a survey, however, the hospital’s accreditation decision will be driven by the interim survey findings.

Cease Services Up to 90 Days. For hospitals that resume services from 31 to 90 days after a disaster, The Joint Commission will conduct an extension survey to determine the hospital’s accreditation status. The circumstances surrounding the hospital’s closure will determine the survey’s length and scope.

Cease Services Up to Six Months. For hospitals that resume services from 91 days up to six months after a disaster, The Joint Commission will require an on-site survey to assess the environment of care. This survey will preferably take place one to two weeks after services are resumed. These hospitals must receive clearance to operate from the fire marshal, if appropriate, and other local/state authorities before resuming services. In addition, The Joint Commission will conduct a second on-site survey approximately four months after services have been resumed to evaluate sustained compliance with Joint Commission standards and requirements. The track record requirement for demonstrating standards compliance will be four months.

*Can be natural or man-made; any situation that causes cessation of services.
More Than Six Months. For hospitals that do not resume services within six months after a disaster or decide to cease operations, The Joint Commission will discontinue its accreditation. If the hospital resumes services, it must reapply to become accredited. In such cases, the accreditation process will involve at least two surveys. The first survey will be conducted at the hospital’s request and will assess the hospital’s ability to provide safe patient care. The hospital may qualify for an accreditation award as a result of this survey. However, at this point, the hospital will not be recognized by CMS as meeting the requirements for Medicare certification. The second survey will be conducted approximately four months later to assess sustained compliance with Joint Commission requirements. The track record requirement for demonstrating standards compliance will be four months.

The Joint Commission will continue to post on Quality Check all affected hospitals as Accredited up to six months after a disaster, unless interim survey findings dictate otherwise.

While working with affected hospitals in the aftermath of a catastrophic event, The Joint Commission will be sensitive to these hospitals’ needs and will work with responsible state and federal agencies to help reestablish the hospitals’ operations as well as their qualification for accreditation.

If, following a disaster, a hospital provides services at an alternate site, The Joint Commission will determine whether an extension survey or a full survey is required based on the scope of services being provided at the alternate site and the expected period of time that the services will be provided at the site.

If your hospital is affected by a natural disaster, please notify your hospital’s account executive as soon as possible. Once notified, The Joint Commission can cancel any accreditation-related events and offer assistance, if needed. If you don’t know who serves as your hospital’s assigned account executive, please call 630-792-3007.

The above policy outlines a framework that The Joint Commission will generally follow when an organization is required to cease services for a period of time following a disaster. Depending on the unique circumstances of each situation, The Joint Commission may choose to modify this approach accordingly. In addition, The Joint Commission may coordinate its response with local, state, and/or federal officials having jurisdiction over the organization, as appropriate.
Accreditation Status of Organizations That Cease Services or Do Not Have Patients for a Period of Time

Joint Commission–accredited hospitals may stop providing care, treatment, and services to patients or may not have any patients for a period of time for reasons other than natural or man-made disasters. When a hospital ceases to provide patient care services, it is required to notify The Joint Commission. The Joint Commission will work with the affected hospital to address the impact that the cessation of services or the lack of patients will have on the hospital’s accreditation status and to ensure that the hospital is prepared to provide safe, quality care upon resumption of services. If after six months the hospital cannot resume services, The Joint Commission will terminate the accreditation of the hospital.

**Up to 60 Days.** If a hospital does not have any patients for up to 60 days, The Joint Commission will continue the hospital’s current accreditation status.

**Up to Six Months.** If a hospital does not have any patients from 60 days to less than six months, but then resumes patient services within six months, The Joint Commission will continue the hospital’s current accreditation status only if the hospital has an extension survey. This extension survey would generally take place as soon as possible in accordance with the hospital’s request. The purpose of this survey is to evaluate the hospital’s capability for resuming services and whether it is performing at current accreditation levels. If the hospital refuses an extension survey, the accreditation will be terminated.

**More Than Six Months.** If a hospital does not have any patients for six months or longer, The Joint Commission will terminate the hospital’s accreditation. If the hospital resumes services, it will have to reapply for accreditation and have a full survey in order to evaluate its current compliance with Joint Commission standards.

**Reentering the Accreditation Process**

For a previously accredited hospital to be designated as “new,” it must not have participated in the accreditation process during the previous four months. If a hospital is reentering the accreditation process before four months have passed, it must demonstrate a continuous 12-month track record of compliance with the standards.
Additional Surveys

This section describes additional surveys that may occur during the accreditation cycle, including extension surveys, for-cause surveys, and other follow-up surveys. A new service includes the request for the Primary Care Medical Home certification option.

Extension Surveys

The Joint Commission conducts an extension survey when an accredited hospital acquires a new service, program, or site for which The Joint Commission has standards or significantly alters how it delivers care, treatment, or services. Extension surveys are done to ensure that the accreditation decision previously awarded to the hospital is still appropriate under the changed conditions. The results of an extension survey may affect the hospital’s accreditation status.

An extension survey is conducted at an accredited hospital or at a site that is owned and operated by the hospital if the accredited hospital’s current accreditation is not due to expire for at least 9 months and when at least one of the following conditions is met:

- Changed ownership and has a significant number of changes in the management and clinical staff or operating policies and procedures
- Offered services at a new location or in a significantly altered physical plant
- Expanded capacity to provide services by 50% or more, as measured by patient volume, pieces of equipment, or other relevant measures. This criterion will generate an extension survey only if there are also other changes at the organization.
- Provided a more intensive level of service

An extension survey will be conducted within 6 months to allow the hospital time to bring a new service or site up to the accredited hospital’s standard of performance. If the hospital uses Joint Commission accreditation for deemed status purposes, the results of the extension survey will immediately affect its accreditation status. If the hospital does not use accreditation for deemed status, the survey findings resulting from the extension survey are maintained separately from, and are not reflected in, the accreditation decision of the acquiring hospital for 12 months following the acquisition. The newly acquired component will be considered accredited during that period. After the extension survey, any outstanding standards compliance problems in the acquired component(s) are reflected in the accreditation decision of the acquiring hospital.
For-Cause Surveys

The Joint Commission may perform a for-cause survey when it becomes aware of potentially serious standards compliance or patient care, treatment, service, or safety issues or when it has other valid reasons for surveying an accredited hospital (see APR.02.01.01 in the APR chapter).

Note: While The Joint Commission may conduct a for-cause survey within a full survey (as these surveys may be referred to the full survey team for investigation), for-cause unannounced surveys should not be confused with the regular unannounced surveys described in the “Unannounced Surveys” section.

Such a survey can either include all the hospital’s services or only those areas where a serious concern may exist.

A for-cause survey can take place at any point in an organization’s accreditation cycle. For organizations using The Joint Commission for deeming purposes, the survey will be unannounced. No on-site summary report is generated after a for-cause survey.

Note: A hospital is charged for a for-cause survey. A hospital can determine the cost of such a survey by calling the Joint Commission’s Pricing Unit at 630-792-5115.

The Joint Commission may deny a hospital accreditation if the hospital does not allow The Joint Commission to conduct an unscheduled or unannounced survey (see APR.02.01.01 in the APR chapter).

Clarification Validation Survey (CVS)

A CVS may be conducted as part of the appeal process whenever a hospital submits written or electronic information to demonstrate compliance with Joint Commission standards at the time of survey, and therefore shows it no longer meets a rule for Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey. (The appeal procedures are set forth in the “Review and Appeal Procedures” section.) If the results of the on-site CVS suggest that the hospital knowingly falsified its clarifying information, Joint Commission staff will recommend to executive leadership that the Information Accuracy and Truthfulness Policy should apply.

After reviewing the hospital’s clarifying information and determining that the hospital has no longer met the decision rule for Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey, The Joint Commission may follow up with an on-site CVS to do the following:
Seek to validate the clarifying information submitted and determine if such information or data was available to the previous on-site survey team.

Determine whether the hospital does or does not meet a decision rule for Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey.

Random Validation of Evidence of Standards Compliance
On an annual basis, a 2% random sample of all hospitals that have been required to submit an ESC will be selected for an unannounced on-site validation survey that will take place soon after the ESC submission. The purpose of this survey is to maintain the credibility of the ESC process by validating statements made in the ESC submission. The surveyor will evaluate areas that were the subject of each RFI to determine whether the stated corrective actions were implemented as stated.

On-site Follow-up Survey for a Condition-level Deficiency
The Joint Commission will conduct an on-site follow-up survey whenever a Medicare Condition of Participation is found not to be in compliance at the time of a Joint Commission survey.

If a Condition-level deficiency is found in a “new” (or initial) hospital or a hospital that is seeking a new CCN, then The Joint Commission will not make a recommendation to CMS that the hospital be Medicare certified. The hospital will be required to undergo an additional unannounced initial Medicare survey to evaluate whether it meets Medicare requirements. For all other hospitals, when a Condition-level deficiency is found, The Joint Commission will conduct a follow-up survey within 45 calendar days to evaluate the hospital’s implementation of corrective action to demonstrate compliance with the Condition(s) of Participation in question. If this survey is unsuccessful, the hospital will have a second survey within 30 calendar days. If the second survey is unsuccessful, CMS will be notified that the organization is no longer recommended for continued Medicare certification, and a recommendation for Preliminary Denial of Accreditation will be made to executive leadership.
Decision Rules for Organizations Seeking Reaccreditation

The Joint Commission makes accreditation decisions by applying decision rules to the scored standards. Decision rules determine an accreditation decision that appropriately represents an organization’s overall performance as measured by evidence of compliance with the applicable standards. Decision rules are approved by executive leadership. Executive leadership may exercise reasonable discretion in individual cases to determine whether to vary from applicable decision rules in furtherance of The Joint Commission’s mission to help health care organizations to continuously improve health care for the public.

The decision rules for hospitals follow.

Note: Accreditation decision rules are numbered sequentially across all Joint Commission accreditation programs. Some accreditation decision rules do not apply to hospitals and are therefore not included in this accreditation manual. Consequently, gaps may appear in the sequence of the decision rules included in this section.

Denial of Accreditation

Denial of Accreditation will be recommended when one or more of the following conditions are met:

DA01 The hospital does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

DA02 The hospital has failed to resolve an Accreditation with Follow-up Survey or Contingent Accreditation status prior to withdrawing from the accreditation process.

DA03 The hospital has failed to submit payment for survey fees or annual fees.

DA04 The hospital has repeatedly failed to submit an ESC.

Preliminary Denial of Accreditation

Preliminary Denial of Accreditation will be recommended when one or more of the following conditions are met:
PDA01 An Immediate Threat to Health or Safety exists for patients, staff, or the public within the hospital. (APR.09.04.01, EP 1)

PDA02 The hospital’s patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.

PDA03 The hospital’s patients have been placed at risk for a serious adverse outcome because either an individual who does not possess a license, registration, or certification is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification. (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

PDA04 The hospital does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide the health care services for which the hospital is seeking accreditation. (LD.04.01.01, EP 1)

PDA05 The Joint Commission is reasonably persuaded that the hospital submitted falsified documents or misrepresented information in seeking to achieve or retain accreditation. Information provided by a hospital and used by The Joint Commission for accreditation purposes must be accurate and truthful and may be received in the following ways:

- Provided verbally, in writing, or electronically
- Obtained through direct observation by, or in an interview with, or via any other type of communication with a Joint Commission employee
- Derived from documents supplied by the hospital to The Joint Commission including, but not limited to, its application for accreditation or its comprehensive systematic analysis in response to a sentinel event
- Submitted electronically to The Joint Commission including, but not limited to, data or documents provided as part of the ICM process or the electronic application process

If accreditation is denied following implementation of this rule, the hospital shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)
PDA06 The hospital with a decision of Contingent Accreditation has failed to clear noncompliant standards as a result of the follow-up survey.

**Contingent Accreditation**
Contingent Accreditation will be recommended when one or more of the following conditions are met:

**CONT01** If the Immediate Threat to Health or Safety abatement survey through direct observation or other determining method has demonstrated that the hospital has implemented sufficient corrective action to warrant removal of the Immediate Threat, executive leadership may change the decision to Contingent.

**CONT02** The hospital with a decision of Accreditation with Follow-up Survey has failed to resolve all requirements after two opportunities.

**CONT03** There is some evidence that the hospital may have engaged in possible fraud or abuse. (LD.04.02.03, EP 3)

**Accreditation with Follow-up Survey**

**Note:** The Accreditation with Follow-up Survey could occur within 30 days or up to six months after the decision is rendered.

Accreditation with Follow-up Survey will be recommended when one or more of the following conditions are met:

**AFS01** The hospital demonstrates systemic patterns, trends, and repeat findings primarily with risk-related standards.

**AFS03** The hospital fails to successfully address all RFIs in an ESC after two opportunities.

**AFS04** At least two on-site ESC demonstrate the need for continued monitoring to assess whether the hospital sustains improvements.

**AFS05** The hospital, which has failed to resolve one or more of its original RFIs, may be scheduled for a second Accreditation with Follow-up Survey.

**AFS06** The hospital fails to participate in Intracycle Monitoring requirements.
AFS08 The hospital fails its Medicare follow-up survey as a result of one or more Conditions of Participation scored as a Condition-level deficiency.

**Note:** This rule applies only to hospitals that use accreditation for deemed status purposes.

AFS09 An individual who does not possess a license, registration, or certification is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification. (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

**Note:** Except as provided under rule PDA03.

AFS10 The hospital has failed to implement or make sufficient progress toward the Plan for Improvement (PFI) described in a Statement of Conditions that was previously accepted by The Joint Commission; or has failed to develop and implement the interim life safety measures (ILSM) policy and its criteria associated with evaluation and compensation for increased safety. (LS.01.01.01, EP 3; LS.01.02.01, EP 1)

**Medicare Survey**

A Medicare survey will be performed when the following condition is met:

CLD01 The hospital has one or more Conditions of Participation scored as a Condition-level deficiency.

**Note:** This rule applies only to hospitals that use accreditation for deemed status purposes. Hospitals currently not Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have a new, second initial unannounced Medicare survey to demonstrate full compliance with all Medicare requirements. Hospitals currently Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have an unannounced Medicare Deficiency follow-up survey to demonstrate full compliance with Medicare requirements.
One-Month Survey
A one-month survey will be performed when the following condition is met:

**FOC01** A full laboratory survey will be conducted when a hospital providing laboratory services cannot demonstrate to The Joint Commission that its laboratory accreditation decision is in good standing with a Joint Commission–recognized accreditor or the accreditation is more than 24 months old.

Evidence of Standards Compliance (ESC)
An ESC will be required when one or more of the following conditions are met:

**ESC01** A hospital has one or more noncompliant standards at the time of a survey event.

**ESC02** A hospital that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.

**ESC03** An on-site evaluation may be scheduled to validate compliance with the relevant standards in a written ESC.

Accredited
Accreditation will be recommended when one or more of the following conditions are met:

**A01** The hospital is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.

**A02** The hospital, as a result of an on-site follow-up survey, is compliant with the original survey RFIs.

*Note: Should additional RFIs be identified, appropriate decision rules apply.*

Primary Care Medical Home Certification
The following rules will be used for Joint Commission–accredited hospitals that choose to apply for Primary Care Medical Home Certification:
PCMH01 A Joint Commission–accredited hospital will be certified for the Primary Care Medical Home program if it is in compliance with all Primary Care Medical Home Certification standards at the time of the on-site survey.

PCMH02 A Joint Commission–accredited hospital will be certified for the Primary Care Medical Home program if it has successfully addressed all Primary Care Medical Home Certification RFIs in its ESC submission.

PCMH03 A Joint Commission–accredited hospital will not be certified for the Primary Care Medical Home program if it does not meet all Joint Commission standards for Primary Care Medical Home Certification either at the time of its on-site survey or following submission of an ESC.

Decision Rules for Organizations Seeking Initial Accreditation

Denial of Accreditation
Denial of Accreditation will be recommended when one or more of the following conditions are met:

**DA01** The hospital does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

**DA03** The hospital has failed to submit payment for survey fees or annual fees.

**DA04** The hospital has repeatedly failed to submit an ESC.

**DA05** A hospital undergoing its first Joint Commission survey has placed patients at risk for a serious adverse outcome(s) due to significant and pervasive patterns and trends in survey findings.

**DA06** An Immediate Threat to Health or Safety exists for patients, staff, or the public within the hospital undergoing its first Joint Commission survey. (APR.09.04.01, EP 1)

**DA07** The Joint Commission is reasonably persuaded that the hospital submitted falsified documents or misrepresented information in seeking to achieve accreditation. Information provided by a hospital and used by The Joint Commission for accreditation purposes must be accurate and truthful and may be received in the following ways:
Provided verbally, in writing, or electronically
- Obtained through direct observation by, or in an interview with, or via any other type of communication with a Joint Commission employee
- Derived from documents supplied by the hospital to The Joint Commission including, but not limited to, its application for accreditation or its comprehensive systematic analysis in response to a sentinel event
- Submitted electronically to The Joint Commission including, but not limited to, data or documents provided as part of the ICM process or the electronic application process

If accreditation is denied following implementation of this rule, the hospital shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)

DA08 The hospital undergoing its first Joint Commission survey fails to successfully address all RFIs in an ESC after two opportunities.

DA09 The hospital undergoing its first Joint Commission survey fails its Medicare follow-up survey as a result of one or more Conditions of Participation scored as a Condition-level deficiency.

Medicare Survey
A Medicare survey will be performed when the following condition is met:

CLD01 The hospital has one or more Conditions of Participation scored as a Condition-level deficiency.

Note: This rule applies only to hospitals that use accreditation for deemed status purposes. Hospitals currently not Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have a new, second initial unannounced Medicare survey to demonstrate full compliance with all Medicare requirements. Hospitals currently Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have an unannounced Medicare Deficiency follow-up survey to demonstrate full compliance with Medicare requirements.
One-Month Survey
A one-month survey will be performed when the following condition is met:

FOC01 A full laboratory survey will be conducted when a hospital providing laboratory services cannot demonstrate to The Joint Commission that its laboratory accreditation decision is in good standing with a Joint Commission–recognized accreditor or the accreditation is more than 24 months old.

Evidence of Standards Compliance (ESC)
An ESC will be required when one or more of the following conditions are met:

ESC01 A hospital has one or more noncompliant standards at the time of a survey event.

ESC02 A hospital that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.

ESC03 An on-site evaluation may be scheduled to validate compliance with the relevant standards in a written ESC.

Limited, Temporary Accreditation
Limited, Temporary Accreditation will be recommended when the following condition is met:

LTA01 The hospital has demonstrated compliance with the selected standards used in the first survey conducted under the Early Survey Policy.

Accredited
Accreditation will be recommended when one or more of the following conditions are met:

A01 The hospital is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.

A02 The hospital, as a result of an on-site follow-up survey, is compliant with the original survey RFIs.
Note: Should additional RFIs be identified, appropriate decision rules apply.

**Primary Care Medical Home Certification**

The following rules will be used for Joint Commission–accredited hospitals that choose to apply for Primary Care Medical Home Certification:

**PCMH01** A Joint Commission–accredited hospital will be certified for the Primary Care Medical Home program if it is in compliance with all Primary Care Medical Home Certification standards at the time of the on-site survey.

**PCMH02** A Joint Commission–accredited hospital will be certified for the Primary Care Medical Home program if it has successfully addressed all Primary Care Medical Home Certification RFIs in its ESC submission.

**PCMH03** A Joint Commission–accredited hospital will not be certified for the Primary Care Medical Home program if it does not meet all Joint Commission standards for Primary Care Medical Home Certification either at the time of its on-site survey or following submission of an ESC.

**Review and Appeal Procedures**

After any Preliminary Denial of Accreditation decision, the organization has the right to make a detailed presentation before a Review Hearing Panel. Executive leadership then reviews the findings of the Review Hearing Panel and either denies accreditation to the organization or selects an appropriate alternative accreditation decision. The organization may appeal any Preliminary Denial of Accreditation decision of the executive leadership before the decision becomes the final decision of The Joint Commission. See Figure 8 for a visual representation of the process flow for appeal of a Preliminary Denial of Accreditation decision.

The outline in this section details the review and appeal procedures for any accreditation decision.
Figure 8. Process flow for the appeal of a Preliminary Denial of Accreditation decision.
I. Evaluation by Joint Commission Staff

A. Review and Determination by Joint Commission Staff.

Following any survey activity, Joint Commission staff shall review survey findings, survey documents, and any other relevant materials or information received from any source. Except as provided in sections I.B, I.C, and I.D, Joint Commission staff shall, in accordance with decision rules approved by executive leadership, take one of the following actions:

1. Determine or recommend to executive leadership that the organization be Accredited, as described in section VIII of these procedures
2. Determine or recommend to executive leadership that the organization receive Accreditation with Follow-up Survey
3. Recommend to executive leadership that the organization receive Contingent Accreditation
4. Recommend to executive leadership that the organization receive Preliminary Denial of Accreditation
5. Defer consideration while additional information regarding the organization’s compliance status is reviewed by Joint Commission staff
6. Determine or recommend to executive leadership that the organization be granted Limited, Temporary Accreditation in accordance with the Early Survey Policy
7. Recommend to executive leadership that the organization initially be denied Limited, Temporary Accreditation in accordance with the Early Survey Policy

B. Determination to Recommend Contingent Accreditation Based on Full or Other Survey Activity.

1. Notification to Organization of Areas of Noncompliance with Standards. If Joint Commission staff, based on survey findings, survey documents, and any other relevant materials or information received from any source, determine in accordance with decision rules approved by executive leadership to recommend that the organization receive Contingent Accreditation, it will outline its findings and determination. The organization may take either of the following actions:
   a. Accept the findings and determination of the staff through submission of the ESC
   b. Submit to The Joint Commission, through ESC, any clarification of its compliance with Joint Commission standards at the time of the survey that is not reflected in the Accreditation Survey Findings Report, along with an explanation of why such documentation was not available for review at the time of the survey
2. Consideration of the Organization’s Response. Joint Commission staff shall review the organization’s submission of any additional information and shall, in accordance with decision rules approved by executive leadership, take one of the following actions:

a. Determine or recommend that the organization receive Accreditation with Follow-up Survey
b. Recommend to executive leadership that the organization receive Contingent Accreditation
c. Recommend to executive leadership that the organization receive Preliminary Denial of Accreditation
d. Determine or recommend to executive leadership that the organization be Accredited, as described in section VIII of these procedures

C. Determination to Recommend Preliminary Denial of Accreditation Based on Full or Other Survey Activity.

1. Notification to Organization of Areas of Noncompliance with Standards. If Joint Commission staff, based on survey findings, survey documents, and any other relevant materials or information received from any source, determine in accordance with approved decision rules to recommend to executive leadership that the organization receive Preliminary Denial of Accreditation, it will outline its findings and determination. The organization may take either of the following actions:

a. Accept the findings and determination of the staff through submission of the ESC
b. Submit to The Joint Commission, through the ESC, any clarification of its compliance with Joint Commission standards at the time of the survey that is not reflected in the Accreditation Survey Findings Report, along with an explanation of why such information was not available for review at the time of the survey

2. Consideration of the Organization’s Response. Joint Commission staff members shall review the organization’s submission of any additional information and shall, in accordance with approved decision rules, take one of the following actions:

a. Determine or recommend that the organization receive Accreditation with Follow-up Survey
b. Recommend to executive leadership that the organization receive Contingent Accreditation
c. Recommend to executive leadership that the organization receive Preliminary Denial of Accreditation
d. Determine or recommend to executive leadership that the organization be Accredited, as described in section VIII of these procedures
D. Decisions by the President of The Joint Commission.
1. Immediate Threat to Health or Safety. Notwithstanding anything outlined in sections I.A through I.C of these procedures to the contrary, if the findings of any survey identify any condition that poses a threat to public or patient health or safety, the president of The Joint Commission, or his or her designee if the president is unavailable, may promptly decide that the organization immediately be placed in Preliminary Denial of Accreditation. This action and the findings that led to this action shall be reported by telephone and in writing to the organization’s chief executive officer and in writing to the authorities having jurisdiction. The president’s or his or her designee’s decision shall be promptly reviewed by executive leadership in accordance with section II of these procedures.

II. Review by Executive Leadership
A. Scope of Review. Executive leadership shall consider The Joint Commission president’s or his or her designee’s decision and Joint Commission staff’s report and recommendation and may review the survey findings, survey documents, and any other relevant materials or information received from any source, including any additional information supplied by the organization in response to this information or, in the case of a Preliminary Denial of Accreditation decision by the president or his or her designee, information supplied by the organization regarding corrective actions taken in response to the identification of a serious threat to patient or public health or safety.

B. Action by Executive Leadership. Following such consideration, executive leadership shall take one of the following actions:
1. Accredit the organization, as described in section VIII of these procedures
2. Place the organization in Accreditation with Follow-up Survey
3. Place the organization in Contingent Accreditation
4. Place the organization in Preliminary Denial of Accreditation or confirm a decision by the president or his or her designee to preliminarily deny accreditation†
5. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff

†A decision of Preliminary Denial of Accreditation that confirms a decision by the president or his or her designee to preliminarily deny accreditation may be time-limited to the date that corrective actions taken by the organization are validated by Joint Commission staff. This decision may be followed by a decision of Accredited, Accreditation with Follow-up Survey, or Contingent Accreditation.
6. Order a resurvey or partial resurvey of the organization and an evaluation of the results, to the extent appropriate, by Joint Commission staff. Thereafter, Joint Commission staff shall transmit its report and recommendation to executive leadership for action, as provided in paragraph II.C of these procedures.

7. Grant the organization Limited, Temporary Accreditation in accordance with the Early Survey Policy

8. Initially deny Limited, Temporary Accreditation to the organizations applying in accordance with the Early Survey Policy

C. Deferred Consideration. When executive leadership defers consideration pursuant to paragraph II.B.5 or II.B.6 of these procedures, Joint Commission staff shall review and report to executive leadership concerning the organization’s compliance decision. Executive leadership may order any resurvey or partial resurvey necessary to determine such decision. Following such consideration and review, executive leadership shall take one of the following actions:

1. Accredit the organization, as described in section VIII of these procedures
2. Place the organization in Accreditation with Follow-up Survey
3. Place the organization in Contingent Accreditation
4. Place the organization in Preliminary Denial of Accreditation or confirm a decision of the president or his or her designee to preliminarily deny accreditation
5. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff
6. Order a resurvey or partial resurvey of the organization and an evaluation of the results, to the extent appropriate, by Joint Commission staff. Thereafter, Joint Commission staff shall transmit its report and recommendations to executive leadership for action, as provided in paragraphs II.C.1–4 of these procedures.
7. Grant the organization Limited, Temporary Accreditation in accordance with the Early Survey Policy
8. Initially deny Limited, Temporary Accreditation to the organizations applying in accordance with the Early Survey Policy

III. Contingent Accreditation

A. Survey to Determine Implementation of ESC. Within approximately 30 days or up to 6 months from the date the organization is notified of its Contingent Accreditation decision, The Joint Commission shall conduct a survey of the organization to determine
the degree to which deficiencies have been corrected or improvements implemented, although The Joint Commission upon occasion may shorten that time period, as appropriate.

**B. Review and Determination by Joint Commission Staff.** Joint Commission staff shall review the survey findings, survey documents, and any other relevant materials or information received from any source. In accordance with approved decision rules, Joint Commission staff shall take one of the following actions:

1. Determine or recommend to executive leadership that the organization be Accredited, as described in section VIII of these procedures
2. Determine or recommend to executive leadership that the organization receive Accreditation with Follow-up Survey
3. Recommend to executive leadership that the organization continue Contingent Accreditation
4. Recommend to executive leadership that the organization receive Preliminary Denial of Accreditation
5. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff. At the conclusion of this review, one of the recommendations outlined in section III.C of these procedures shall be made to executive leadership.

**C. Action by Executive Leadership.** Following review of the recommendations of Joint Commission staff, executive leadership shall take one of the following actions:

1. Accredit the organization, as described in section VIII of these procedures
2. Place the organization in Accreditation with Follow-up Survey
3. Keep the organization in Contingent Accreditation
4. Place the organization in Preliminary Denial of Accreditation
5. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff
6. Order a resurvey or partial resurvey of the organization and an evaluation of the results, to the extent appropriate, by Joint Commission staff. Thereafter, Joint Commission staff shall transmit its report and recommendation to executive leadership for action, as provided in this section.

**D. Charges to the Organization.** The full costs of all surveys shall be borne by the surveyed organization.
IV. Accreditation with Follow-up Survey

A. Survey to Determine Implementation of ESC. Within approximately 30 days or up to 6 months from the date the organization is notified of its Accreditation with Follow-up Survey decision, The Joint Commission shall conduct a survey of the organization to determine the degree to which deficiencies have been corrected or improvements implemented, although The Joint Commission upon occasion may shorten that time period, as appropriate. For existing Medicare-certified organizations using the deemed status option, any Medicare Condition-level deficiencies identified during the unannounced, on-site survey will require an unannounced Medicare Deficiency Follow-up Survey within 45 calendar days from the survey where the deficiency was identified.

B. Review and Determination by Joint Commission Staff. Joint Commission staff shall review the survey findings, survey documents, and any other relevant materials or information received from any source. In accordance with approved decision rules, Joint Commission staff shall take one of the following actions:

1. Determine or recommend to executive leadership that the organization be Accredited, as described in section VIII of these procedures
2. Determine or recommend to executive leadership that the organization continue Accreditation with Follow-up Survey
3. Recommend to executive leadership that the organization receive Contingent Accreditation
4. Recommend to executive leadership that the organization receive Preliminary Denial of Accreditation
5. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff. At the conclusion of this review, one of the recommendations outlined in section IV.C of these procedures shall be made to executive leadership.

C. Action by Executive Leadership. Following review of the recommendations of Joint Commission staff, executive leadership shall take one of the following actions:

1. Accredit the organization, as described in section VIII of these procedures
2. Keep the organization in Accreditation with Follow-up Survey
3. Place the organization in Contingent Accreditation
4. Place the organization in Preliminary Denial of Accreditation
5. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff

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6. Order a resurvey or partial resurvey of the organization and an evaluation of the results, to the extent appropriate, by Joint Commission staff. Thereafter, Joint Commission staff shall transmit its report and recommendation to executive leadership for action, as provided in this section.

D. Charges to the Organization. The full costs of all surveys shall be borne by the surveyed organization.

V. Review Hearings
A. Right to a Review Hearing. Upon request, an organization that has received a Preliminary Denial of Accreditation (PDA) by executive leadership is entitled to a review hearing. A PDA decision will become a Denial of Accreditation unless the organization requests a review hearing to demonstrate why it should not be denied accreditation.

B. Purpose of the Review Hearing. The review hearing is an opportunity for an organization to present facts and/or arguments in person before a Review Hearing Panel, comprising two outside health care professionals and one member of executive leadership. Presentations are limited to the following:
1. Facts in existence at the time of survey
2. Facts in existence within the time periods established by the ESC process and the on-site survey to validate ESC submission (clarification and correction processes) (see the “Evidence of Standards Compliance [ESC] Process” section for more information)
3. The organization’s response submitted to executive leadership prior to the five (5)-day submission deadline and/or
4. Arguments regarding actions taken by The Joint Commission that demonstrate a failure to follow its policies, procedures, or decision rules before, or at the time, executive leadership made its PDA decision

The Preliminary Denial of Accreditation decision, if subsequently changed to other than Denial of Accreditation following review and action by executive leadership, will not be disclosed as part of the organization’s accreditation decision history.
While The Joint Commission strongly encourages health care organizations to address Requirements for Improvements and implement improvements toward patient safety and quality of care on an ongoing basis, corrective ESC actions taken subsequent to the five (5)-day submission deadline for response to executive leadership, prior to the PDA decision, are not an acceptable basis for an appeal of that decision.

C. Requesting a Review Hearing; Notice of Time and Place. An organization must submit a written request for a review hearing within five (5) business days of The Joint Commission’s notification of executive leadership’s PDA decision. For the purpose of this section, the date of a notification is the date a notice was posted to the organization’s Joint Commission Connect extranet site. The review hearing is held at The Joint Commission’s headquarters except when the president of The Joint Commission, or his or her designee, determines otherwise, for good cause shown due to extreme and unusual circumstances. At least thirty (30) calendar days before the review hearing, The Joint Commission shall post notice of the time and place of the review hearing. The organization will receive supplemental documents that it does not already have that were provided to executive leadership. Similarly, the documents sent to the Review Hearing Panel members in advance of the review hearing will also be provided to the organization. The notice shall advise the organization of the agenda. If the organization intends to submit a written response, or other documents limited to the parameters established above in section V.B, to be considered by the Review Hearing Panel, such response and documents must be submitted at least ten (10) business days prior to the review hearing. The Review Hearing Panel is under no obligation to consider late submissions.

D. Charges to the Organization. The organization will be charged a nonrefundable fee for the review hearing, as published in the accreditation and certification pricing schedule found on the Joint Commission Connect extranet site. The fee, along with any other outstanding invoices due to The Joint Commission, must be paid in full at the time an organization requests a review hearing.

E. Procedure for the Conduct of a Review Hearing. Review hearings are limited to three (3) hours. After introductions, Joint Commission staff will summarize the historical facts that led to the PDA decision. The organization will then have an opportunity to make its presentation to the Panel. The organization’s presentation should be limited to the parameters established above in section V.B. The Panel may ask questions of the organization and of Joint Commission staff. In addition, the organization may ask questions of Joint Commission staff or panel members.
The organization may choose to retain a transcriptionist, at its own expense. The organization shall provide a copy of any transcript to The Joint Commission, at the organization’s expense, at or around the same time the transcript is made available to the organization. Transcripts of Joint Commission proceedings are confidential and shall remain confidential. Any disclosures to a third party require the express written permission of The Joint Commission.

**F. Participants at the Review Hearing.** A review hearing may proceed with only two of the three panel members present, provided one of them is the member of executive leadership. A Joint Commission surveyor who participated in the survey will ordinarily participate at the review hearing, as well as staff from SIG and administrators. Legal staff from The Joint Commission will be present to address procedural matters and will not ask questions of the organization’s representatives. Organizations are encouraged to limit representatives at the review hearing to individuals who are knowledgeable about the organization in the standards areas found noncompliant. An organization may choose to bring legal counsel and/or consultants; however, this type of representative is permitted to address procedural matters only and is not to speak on matters regarding substantive issues of the organization’s standards compliance or question Joint Commission staff.

**G. Report of the Review Hearing.** After a review hearing, the Review Hearing Panel will prepare and submit a written report that summarizes its findings on factual matters with a recommendation to executive leadership. The recommendation will include one of the following:

1. Proceed with a Denial of Accreditation
2. Vote for Contingent Accreditation
3. Vote for Accreditation with Follow-up Survey
4. Grant Accreditation

The Joint Commission shall send the organization a copy of the report approximately ten (10) business days before the meeting of executive leadership at which the report will be considered. The SIG staff will also have an opportunity to comment on the report, and a copy of the comments will be sent to the organization. The organization will be informed of the executive leadership meeting date along with the organization’s right to submit a written response to the report and any documents limited to the parameters established above in section V.B, that have not already been submitted, for consideration by executive leadership. Any such written responses must be received by The Joint Commission at least five (5) business days before the meeting of the executive leadership.
and should be limited to the newly submitted documents, what was discussed during the review hearing, the content of the review hearing report, and comments submitted by SIG, if any. Executive leadership is under no obligation to consider late submissions.

VI. Executive Leadership Review Following Review Hearing

A. Scope of Review. After the review hearing, executive leadership will consider the Review Hearing Panel’s findings and recommendation, the responses of the organization, any newly submitted documents limited to the parameters established above in section V.B, and comments of SIG, if any, to the Review Hearing Panel’s findings and recommendations. In addition, executive leadership may reconsider any information previously submitted and specifically identified by the organization in its response as relevant.

B. Action by Executive Leadership. After such consideration, executive leadership shall take one of the following actions:

1. Place the organization in Accreditation with Follow-up Survey
2. Place the organization in Contingent Accreditation
3. Place the organization in Denial of Accreditation
4. Defer consideration while additional information regarding the organization’s compliance status is gathered and reviewed by Joint Commission staff
5. Defer consideration and order a resurvey or partial resurvey of the organization and an evaluation of the results, to the extent appropriate, by Joint Commission staff

VII. Final Review & Appeal Request

A. Final Review & Appeal Request. An organization that has received Denial of Accreditation after the second consideration by executive leadership is entitled to a Final Review & Appeal. The Joint Commission must receive the organization’s request for review within five (5) business days after the organization receives notice of executive leadership’s final decision.

B. Composition and Participation. The Final Review & Appeal Committee is composed of five (5) members of executive leadership. No member of the Final Review & Appeal Committee who previously participated in the accreditation decision or review hearing for the organization shall participate in the deliberations or vote during the Final Review & Appeal Committee meeting. This provision shall not preclude any
commissioner who participated in the review hearing from presenting and responding to questions about the report of the Review Hearing Panel. Unlike the procedure of Review Hearing Panels, the organization does not make a presentation to the Final Review & Appeal Committee; however, Joint Commission staff is available during the meeting to answer any questions.

C. Notice of Time and Procedure for Review. The Joint Commission shall post a notice of the date of the meeting at least thirty (30) calendar days before the meeting of the Final Review & Appeal Committee at which the organization’s request for review will be considered. Three (3) members of the Final Review & Appeal Committee will constitute a quorum. This meeting will generally be held by teleconference, except when it is held in conjunction with meetings of the Board of Commissioners or other committee(s) of the Board of Commissioners. The organization may, but is not required to, submit comments to the Final Review & Appeal Committee along with any documents not previously submitted limited to the parameters established above in section V.B. Any comments must be submitted at least ten (10) business days prior to the meeting and should specifically identify any relevant documents previously submitted for the purpose of demonstrating its compliance with standards or The Joint Commission’s failure to follow its policies, procedures, or decision rules before, or at the time, executive leadership made its final decision.

D. Action by the Final Review & Appeal Committee. The Final Review & Appeal Committee shall review the decision of executive leadership, the organization’s responses, any materials specifically identified as relevant by the organization, and other information it deems relevant, and shall take one of the following actions:

1. Retain the organization in Denial of Accreditation after finding that there is substantial evidence to support executive leadership’s decision

or

2. Make an independent evaluation of executive leadership’s decision and then decide to grant Contingent Accreditation, Accreditation with Follow-up Survey, or Accreditation to the organization, as described in section VIII of these procedures

The action taken by the Final Review & Appeal Committee shall constitute the final accreditation decision of The Joint Commission.
VIII. Procedure Relating to Not Compliant Standards and Determination of Corrected Not Compliant Standards

A. Review and Determination by Joint Commission Staff. A decision of Joint Commission staff pursuant to paragraph I.A.1, I.B.2.d, or I.C.2.d of these procedures, of executive leadership pursuant to paragraph II.B.1, II.C.1, III.B.1, or III.C.1 of these procedures, or of a Final Review & Appeal Committee, pursuant to paragraph VII.D of these procedures, to grant Accredited status to an organization may be made contingent upon satisfactory correction of not compliant standards or, when appropriate, upon compliance with interim life safety measures. The organization may receive Accreditation with Follow-up Survey or Contingent Accreditation or its accreditation may be withdrawn if it does not correct or document the correction of the specified not compliant standards within the time specified in the notice of the decision to the organization or, when applicable, fails to demonstrate compliance with the interim life safety measures. Joint Commission staff, through the use of surveys or partial surveys or through other means, such as an ESC, shall determine whether the organization has corrected the not compliant standards within the time provided or, when applicable, has demonstrated compliance with interim life safety measures, and shall report its findings to the organization. If The Joint Commission staff determines that the organization has not corrected the not compliant standards within the time provided or, when applicable, has not demonstrated compliance with interim life safety measures, The Joint Commission shall report its findings to the organization. After reviewing any comments of the organization, as appropriate, and in accordance with approved decision rules Joint Commission staff will take one of the following actions:

1. Provide another opportunity to the organization to correct or document the correction of not compliant standards, as provided in any applicable decision rules approved by executive leadership
2. Determine or recommend that the organization receive Accreditation with Follow-up Survey
3. Determine or recommend that the organization receive Contingent Accreditation
4. Recommend to executive leadership that the organization receive Preliminary Denial of Accreditation if certain not compliant standards, specified in approved decision rules, have not been corrected or the correction of which has not been documented after the specified number of opportunities given to the organization to do so, and, when applicable and as specified in approved decision rules, the organization has failed to demonstrate compliance with interim life safety measures
B. Submission of Recommendation to Executive Leadership. If Joint Commission staff determines to recommend to executive leadership that the organization receive Preliminary Denial of Accreditation in accordance with paragraph VIII.A.4, or receive Accreditation with Follow-up Survey or Contingent Accreditation in accordance with paragraph VIII.A.2 or VIII.A.3, the staff shall submit its recommendation and any comments of the organization to executive leadership for action, as provided in paragraph II.B.1 through II.B.8.

IX. Final Accreditation Decision
A. Action by Joint Commission Staff. The action taken by Joint Commission staff shall constitute the final decision of The Joint Commission to make one of the following accreditation decisions:
1. Accredited, when taken pursuant to paragraph I.A.1, I.B.2.d, or I.C.2.d of these procedures
2. Limited, Temporary Accreditation, when taken pursuant to paragraph I.A.6 of these procedures

B. Action by Executive Leadership. The action taken by executive leadership shall constitute the final decision of The Joint Commission to make one of the following accreditation decisions:
1. Accredited, when taken pursuant to paragraph II.B.1, II.C.1, or III.C.1 of these procedures
2. Accreditation with Follow-up Survey, when taken pursuant to paragraph II.B.2, II.C.2, or III.C.2 of these procedures
3. Contingent Accreditation, when taken pursuant to paragraph II.B.3, II.C.3, or III.C.3 of these procedures
4. Denial of Accreditation, when taken pursuant to paragraph II.B.4, II.C.4, III.C.4, or VIII.B of these procedures and when the organization does not request the opportunity to make a presentation before a Review Hearing Panel pursuant to paragraph V.A of these procedures
5. Limited, Temporary Accreditation, when taken pursuant to paragraph II.B.7 of these procedures
6. Deny Limited, Temporary Accreditation, when taken pursuant to paragraph II.B.8 of these procedures and when the organization applying in accordance with the Early Survey Policy does not request the opportunity to make a presentation before a Review Hearing Panel pursuant to paragraph V.A of these procedures
C. Action of the Final Review & Appeal Committee. The action taken by the Final Review & Appeal Committee shall constitute the final decision of The Joint Commission to make one of the following decisions:
1. Accredited, Accreditation with Follow-up Survey, Contingent Accreditation, or Denial of Accreditation, when taken pursuant to paragraph VII.D of these procedures

X. Status of the Organization Pending a Final Decision and Effective Date of a Final Decision

A. Interim Accreditation Status. The accreditation status of an accredited organization shall continue in effect pending any final accreditation decision.

B. Effective Date of Final Decision Other Than Denial of Accreditation. A final decision of Accredited; Limited, Temporary Accreditation; Accreditation with Follow-up Survey; or Contingent Accreditation for an organization that follows an initial executive leadership decision of Preliminary Denial of Accreditation pursuant to paragraphs II.B.4, II.C.4, or III.C.4 shall be considered effective as of the first day after completion of the organization’s survey from which the decision results.

C. Effective Date for Denial of Accreditation. A final decision of Denial of Accreditation or to deny Limited, Temporary Accreditation to an organization shall become effective as follows:
1. As of the date of the decision made by the Final Review & Appeal Committee pursuant to paragraph VII.D of these procedures
2. At the expiration of the time during which an organization may request a review by the Final Review & Appeal Committee but does not, pursuant to paragraph VII.A of these procedures
3. At the expiration of the time during which an organization may request the opportunity to make a presentation before a Review Hearing Panel but does not, pursuant to paragraph V.A of these procedures
4. On receipt by The Joint Commission, before a final decision, of notification from the organization that it withdraws its request for review of a Preliminary Denial of Accreditation decision before a Review Hearing Panel or its request for appeal of a Denial of Accreditation decision before the Final Review & Appeal Committee

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XI. Notice
Any notice required by these accreditation procedures to be given to an organization shall be addressed to the organization via the organization’s secure Joint Commission Connect extranet site.