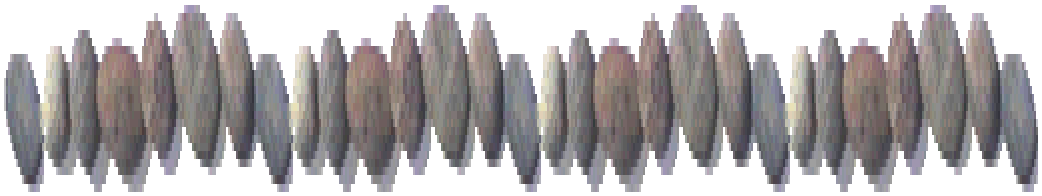
Center for Improvement
CIHQ
in Healthcare Quality

ACCREDITATION POLICIES

FOR

ACUTE CARE HOSPITALS

Effective May 2015



INTRODUCTION

The Center for Improvement in Healthcare Quality (CIHQ) accredits acute care hospitals found to be in compliance to its standards and requirements. Accredited organizations must comply with the following CIHQ policies in order to obtain and maintain their accreditation.

Hospitals that want to participate in the Medicare program must be found to be in compliance with the Conditions of Participation by the Centers for Medicare and Medicaid Services (CMS). CMS makes that determination by its own survey process through state agencies or by accepting the accreditation of a private national accreditation organization that has been approved by CMS to deem healthcare organizations in compliance with the COP'.

Hospitals that wish to use CIHQ accreditation for deemed status certification to participate in Medicare must meet the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482)

CMS CERTIFICATION NUMBER (CCN)

CIHQ will survey those sites of care and services rendered under an organization's license and/or CMS certification number (CCN) for which CIHQ has applicable standards, and for which the organization is seeking accreditation.

SURVEY OF CONTRACTED SERVICES

CIHQ will survey any patient care or support services provided under the organization's license and/or CCN that are contracted by the organization to another entity. Said entities must be in compliance with applicable CIHQ standards and requirements. If a contracted service is non-compliant to a CIHQ accreditation standard, requirement, or policy, the organization will be cited as non-compliant.

APPLICATION FOR ACCREDITATION

An organization must submit a formal application to CIHQ requesting accreditation. The application must be complete and accepted by CIHQ before an accreditation survey is considered. Once accredited, the organization is responsible for assuring that information contained in the application is current. Accredited organizations must notify CIHQ of any substantive changes to information contained in their application in a timely manner. At a minimum, the organization must inform CIHQ within 30 days of any of the following:

- A change in ownership
- Opening of a new physical location where care and treatment will be rendered
- Establishment of a new clinical program or service
- Closure of a physical location where care and treatment is rendered or closure of a clinical program or service.

BUSINESS ASSOCIATE AGREEMENT

If an organization requires CIHQ to sign a business associate agreement for HIPAA compliance, the agreement must be provided to CIHQ at the time the application is filed.

PERMISSION TO SURVEY

Any organization wishing to obtain or maintain accreditation must agree to allow CIHQ surveyors complete and unfettered access to their facility(s), documents, medical records, staff, patients, and other sources of information necessary to determine the organization's compliance to CIHQ standards and requirements. CIHQ reserves the right to immediately deny or withdraw an organization's accreditation for failure to do so. If the organization is using CIHQ accreditation for deemed-status purposes, refusal to allow survey/access may result in the Office of the Inspector General (OIG) excluding the organization from participation in all Federal healthcare programs in accordance with 42 CFR §1001.1301.

ACCREDITATION AWARD

Accreditation is awarded to an organization for a maximum of 36 months. Prior to the 36 month, the organization must undergo another full survey to maintain its accreditation status. For initial surveys, the date of accreditation will be the date that a submitted plan of correction has been accepted by CIHQ to address any identified deficiencies.

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USE OF CIHQ SURVEYORS AS CONSULTANTS

CIHQ surveyors are not permitted to independently serve as consultants. Organizations may not employ, retain, contract with, or otherwise utilize CIHQ surveyors for any of the following:

- Provide consulting services or standards interpretation to prepare the organization for a CIHQ accreditation survey. This does not apply to accessing CIHQ central office staff for official standards interpretation.
- Providing tools or documents to assist in accreditation compliance. This does not apply to organizations that utilize CIHQ officially approved documents obtained directly from the CIHQ resource library.
- Provide education programs on CIHQ standards. This does not apply to attendance at CIHQ officially sponsored education programs and activities
- Assist with developing and/or reviewing appeals or corrective action plans for deficiencies identified during a CIHQ accreditation survey.
- Conduct mock CIHQ accreditation surveys

RELATIONSHIP BETWEEN CIHQ STAFF / SURVEYORS & APPLICANT / ACCREDITED ORGANIZATIONS

Surveyors may not survey a hospital with which the surveyor has a professional or financial interest. CIHQ surveyors or staff may not be involved in accreditation decisions for a hospital with which the surveyor / staff person has a professional or financial interest. A surveyor / staff person is considered to have a professional or financial interest in an organization under any of the following conditions:

- The surveyor / staff person is currently employed or has been employed within the past five years by the organization
- The surveyor / staff person is currently, or has been in the past five years, on the medical staff of the organization and/or granted privileges to practice in the organization
- The surveyor / staff person has an ownership interest in, or receives monies or other compensation from the organization
- The surveyor / staff person serves on the Board of the organization or in another professional capacity.

Surveyors / staff persons are required to disclose to the Director of Survey Operations any professional or financial interest they have in an applicant / accredited organization that they may be scheduled to survey or participate in an accreditation decision so that reassignment can occur.

FALSIFICATION & MISREPRESENTATION

Honesty and the provision of truthful and accurate information, is at the heart of the accreditation process. Organizations are expected to engage in all accreditation activities in an honest and truthful manner. Information presented to CIHQ in any manner, for any reason, at any time must be accurate.

If an organization's leadership or staff intentionally misrepresents their compliance to standards and regulations, lies, falsifies documents or medical records, or is otherwise dishonest or untruthful, CIHQ reserves the right to immediately designate the organization's accreditation status at risk.

TYPES OF SURVEYS / SURVEY PROCESS

There are two basic types of surveys; full surveys and focused surveys. If an organization is using CIHQ accreditation for deemed-status purposes, all surveys are unannounced:

FULL SURVEYS

Initial Survey

This is a full survey conducted the first time an organization applies for accreditation. The survey process is described in detail in the CIHQ *Accreditation Survey Activity Guide*. This guide is available free-of-charge to all applicant and accredited organizations. Information contained in the *Accreditation Survey Activity Guide* is considered part of CIHQ accreditation policy.

- For new enrollees in the Medicare program that intend to use CIHQ accreditation for deemed status purposes, the applicant organization must submit evidence of its 855A completeness notification by CMS. A survey may only be scheduled if the applicant organization has received their 855A enrollment completeness notification from CMS.
- If an organization sustains a condition level deficiency during an initial survey and has never been accredited by another deeming authority or certified by Medicare, then a full re-survey is required. If the organization is currently accredited by another deeming authority or is already Medicare certified, then a focused follow up survey is required.

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- In addition, the organization will be issued a letter denying accreditation due to non-compliance with the applicable Medicare Conditions of Participation and may not be recommended for Medicare deemed status until the organization comes into compliance with the applicable Condition(s) of Participation.

Triennial Survey
This is a full survey conducted for existing accredited organizations. The survey is conducted no later than 36 months after the organization's last full survey. The survey process is described in detail in the CIHQ *Accreditation Survey Activity Guide*. This guide is available free-of-charge to all applicant and accredited organizations. Information contained in the *Accreditation Survey Activity Guide* is considered part of CIHQ accreditation policy.

FOCUSED SURVEYS

Mid-Cycle Survey
This is an abbreviated survey conducted between 16 - 20 months from the organization's last full survey. The survey is usually one to two days in length and is conducted by one or two surveyors. The survey focuses on the organization's compliance to new or revised standards / requirements, as well as standards / requirements that address high-risk patient care processes. The agenda and scope of the survey is developed annually.

Complaint Survey
This is a focused survey performed in response to a complaint received about an accredited organization from a patient or surrogate decision maker. The survey is usually one day in length and is conducted by a single surveyor. The scope of the survey is designed to validate the accuracy and substance of the complaint. There is no set agenda. The time frames for performing complaint surveys are outlined in the "Complaint Process" section of this document.

Follow-Up Survey
A follow-up survey is conducted whenever any of the following occur:
- The organization sustains an immediate threat to health and safety deficiency.
- The organization sustains a condition level deficiency. Follow up surveys will be conducted within 45 calendar days from the survey end-date of the survey in which the condition level deficiency was cited.

The survey is usually one day in length and is conducted by a single surveyor. The scope of the survey is designed to validate implementation of the corrective action plan submitted by the organization. There is no set agenda.

COMPLAINT PROCESS

INFORMING PATIENTS OF THE COMPLAINT PROCESS

Organizations using CIHQ accreditation for deemed-status purposes must inform patients, or their surrogate decision-maker, of the right to file complaints regarding quality of care concerns or safety issues to CIHQ. The patient / surrogate decision-maker is not required to notify the organization prior to filing the complaint. Information on how to contact CIHQ to file a complaint must be provided as follows:

By Phone
(866) 324-5080

By Fax
(805) 934-8588

By Mail
Center for Improvement in Healthcare Quality
P.O. Box 848
Round Rock, TX 78680

By E-mail
complaint@cihq.org

In-Person by Appointment
Contact CIHQ at (866) 324-5080 for instructions.

This information must be posted on the organization's website (if there is one), and in registration areas at all of the organizations sites of care (both inpatient and outpatient).

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Upon receipt, CIHQ will review the complaint to determine if it has any basis regarding the organization's compliance to CIHQ accreditation standards, requirements, or policies. If the complaint is without basis, the complainant will be notified and the issue considered closed.

If the complaint has basis, then the organization will be notified of the complaint. The identity of the complainant will remain confidential. The organization will be provided with sufficient information to understand the substance and nature of the complaint, as well as the applicable CIHQ standard(s), requirement(s), or policy(s) that apply to the complaint.

COMPLAINTS INDICATING POTENTIAL STANDARD-LEVEL DEFICIENCY(S)
For complaints that indicate potential standard-level deficiency, CIHQ will inform the organization in writing and require the organization to investigate the complaint and provide a written response. CIHQ reserves the right to conduct an on-site survey within ten business days following receipt of the complaint. If deficiencies are identified, the organization will be required to submit an acceptable plan of correction within the established time frame.

COMPLAINTS INVOLVING POTENTIAL CONDITION-LEVEL DEFICIENCY(S)
For complaints that indicate potential condition-level deficiency, CIHQ will conduct an on-site survey within one week following receipt of the complaint. If deficiencies are identified, the organization will be required to submit an acceptable plan of correction within the established time frame.

COMPLAINTS INVOLVING POTENTIAL IMMEDIATE THREAT TO HEALTH & SAFETY
If the nature of the complaint indicates a potential immediate threat to health and safety, an onsite survey will be conducted within two business days of receipt. If deficiencies are identified, the organization will be required to submit an acceptable plan of correction within the established time frame.

NOTIFICATION TO THE COMPLAINANT
If CIHQ determines that the complaint is without basis, the complainant will be notified that an investigation was conducted and the organization was found to be in substantial compliance to CIHQ standards, requirements, or policies.
If CIHQ determines that the complaint has basis, the complainant will be notified in writing that an investigation was conducted, non-compliance to a CIHQ standard, requirement, and/or policy was identified, and an acceptable plan of correction was submitted by the organization.

SHARING OF COMPLAINTS WITH CMS OR OTHER FEDERAL AGENCIES
For organizations using CIHQ for deemed-status purposes, complaints may be forwarded to CMS or other federal agencies as required by law or CMS regulations. In addition, CIHQ will forward to CMS at the frequency required by them, the number of complaints received on accredited organizations broken down by:

- Number of written resolutions
- Number of focused surveys and follow-up actions
- Number of complaints that have taken greater than 90 days to resolve and the reason for the delay, and the average resolution time for complaints

See policy section on "Coordination of Accreditation Activities with Appropriate Licensing Bodies & Ombudsmen Programs" for additional information.

COMPLIANCE TO CIHQ ACCREDITATION STANDARDS, REQUIREMENTS, & POLICIES
Organizations are expected to be in continuous compliance to CIHQ standards, requirements, and policies. Full compliance is expected upon the effective date of the standard, requirement, or policy including the effective date of any revisions thereto.

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NOTIFYING ORGANIZATIONS OF CHANGES TO ACCREDITATION STANDARDS, REQUIREMENTS, & POLICIES

All changes to CIHQ accreditation standards, requirements, and policies will be communicated to accredited organizations in writing. The notification will include the effective date of implementation. In addition, all notifications will be posted on the CIHQ website and permanently archived for review.

Interpretation of Existing Accreditation Standards, Requirements, & Policies

CIHQ may from time to time issue official interpretation of existing accreditation standards, requirements, and policies. These interpretations will be posted on the CIHQ website and are accessible to accredited organizations. It is the accredited organization's responsibility to access this information.

Requests for Interpretation of Existing Accreditation Standards, Requirements, & Policies

Organizations may request official interpretation of an existing accreditation standard, requirement, or policy. Requests must be made in writing. Information on submitting a written request is available on the CIHQ website. CIHQ will provide a written response to each request within 5 business days of submittal.

HOW DEFICIENCIES ARE IDENTIFIED / SCORED

Deficiencies are identified through survey and complaint review activities by assessing the organization's compliance to CIHQ standards, requirements, and policies. Failure to meet CIHQ standards, requirements, or policies results in a deficiency. There are three levels of deficiency. Assigning a deficiency to a specific level is based on the pervasiveness and severity of the finding and its impact on care and safety.

1. Standard Level Deficiencies

   A deficiency is at the standard level is issued when there is noncompliance with a single standard or several standards, or non-compliance with a requirement(s) within one or more standards that are not of such character as to substantially limit a facility's capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of patients if the deficient practice recurred.

2. Condition Level Deficiencies

   A deficiency at the condition level is issued due to noncompliance with a single standard or several standards, or non-compliance with a requirement(s) within one or more standards that substantially limit a facility's capacity to furnish adequate care, or which would jeopardize or adversely affect the health or safety of patients if the deficient practice recurred.

3. Immediate Threat to Health & Safety Deficiencies

   A deficiency at the immediate threat to health and safety (immediate jeopardy) is issued when a situation in which the organization's non-compliance with one or more CIHQ standards/requirements or requirements under the CMS Conditions of Participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient. Such a deficiency will automatically result in a condition level deficiency under the applicable Medicare Condition(s) of Participation

RECTIFIED DURING SURVEY

CIHQ allows organizations to correct identified deficiencies while the survey is occurring. In order for such correction to be acceptable, it must meet the following criteria:

- The deficiency is minor, isolated, and easily correctable.
- Correcting the deficiency does not require developing or modifying existing policies, processes, or documents.
- Correcting the deficiency does not require new or remedial education, training, or competency validation of staff, physicians, or other individuals.

Deficiencies rectified during survey will still be cited and entered into the organization's report. However, surveyors will note in the report that the deficiency was corrected. The organization will still be required to submit a corrective action plan, but the plan may re-state the actions that were taken during the survey.

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IMMEDIATE THREAT TO HEALTH & SAFETY
An onsite survey will be initiated within two working days of notice to CIHQ of a potential immediate threat to health and safety (e.g. “immediate jeopardy”) in an accredited organization.

Should surveyors identify an actual or potential immediate threat to health and safety they shall immediately notify the team leader.

The team leader will immediately notify the organization’s leadership and the Executive Director or the Director of Survey Operations of CIHQ The Director of Survey Operations or the Executive Director of CIHQ (senior staff) will determine if an immediate threat to health and safety deficiency should be issued after taking into consideration all available information, as well as input from the survey team and leadership of the organization.

If such a deficiency is issued, the team leader will determine – in collaboration with CIHQ senior staff – the specific actions that the organization must take immediately to mitigate the deficiency. These actions will then be communicated to the organization’s leaders.

The team leader will monitor the organization to assure that the actions are implemented as required.

The deficiency is to be noted in the survey report regardless of actions taken by the organization, and a corrective action plan will still be required in accordance with CIHQ policy.

Issuance of an immediate threat to health and safety deficiency will automatically change an organization’s accreditation status to “Accreditation at Risk” until such time as the deficiency is corrected.

CIHQ will notify CMS immediately of any deficiency that constitutes an actual immediate threat to health and safety or an allegation thereof that requires further investigation. Notification will be made to the CMS central office via e-mail and shall contain at least the following information:

- Facility name, including d/b/a and/or corporate names, as appropriate
- Full address
- CCN
- Date of the survey/identification of potential immediate jeopardy
- Planned date for on-site survey
- Date of the organization’s last full accreditation survey
- A brief summary of the issue. Information on the suspected deficient practice shall be included to provide CMS with sufficient information to understand the situation. The appropriate Condition(s) of Participation/Condition(s) for Coverage citation shall be included.

In addition, CIHQ will provide to CMS; organization demographic information, issues identified, monitoring required, corrective action taken by the facility to abate the jeopardy and CIHQ’s final decisions regarding accreditation/deem status. A copy of notification letter to the organization and the survey report will to be included in the report to CMS. This information shall to be forwarded to CMS at the same time the organization has been notified of CIHQ’s final determination.

The information will be reviewed and forwarded to the appropriate CMS Regional Office (RO) so that the RO can determine if any action is required by CMS.

SURVEY REVIEW PROCESS
ISSUANCE OF A SURVEY REPORT
Following the conclusion of the survey, the team leader will collect information from the individual team members, integrate the information, and produce a preliminary report. The preliminary report will then be reviewed by either the Director of Survey Operations or the Executive Director of CIHQ. The purpose of the review is to assure the following:

- There is sufficient information in a finding to appropriately assign a deficiency
- The deficiency has been assigned to the appropriate CIHQ standard
- The deficiency has been assigned an appropriate level of severity

The survey report will be modified as necessary as a result of the review process.

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DETERMINATION OF AN ACCREDITATION DECISION
Based on the findings contained in the final report, an accreditation decision will be rendered. The decision is a collaborative one involving the survey team leader, the Director of Survey Operations, and the Executive Director of CIHQ. A consensus decision is desirable. However, in the event of disagreement, the decision will be made by the Executive Director of CIHQ. The final accreditation decision is based on the final survey report in which the organization meets all requirements and CIHQ has received an acceptable plan of correction.

NOTIFICATION TO THE ORGANIZATION
Upon completion of the review, the final report and the accreditation decision will be communicated in writing in electronic form to the contact person listed on the organization's accreditation profile. Unless there are extenuating circumstances, final report and accreditation decision will be provided within 10 business days following completion of the survey.

CORRECTIVE ACTION PLANS
SUBMISSION OF A CORRECTIVE ACTION PLAN
The organization is required to submit an acceptable corrective action plan (CAP) to CIHQ within 10 calendar days following receipt of their survey report for any deficiencies identified,

- An immediate threat to health and safety deficiency requires submission of an acceptable plan of correction within 72 hours of determination.

A CAP must be developed and submitted for each deficiency identified. In order for the CAP to be accepted, it must address at least the following:

- The specific steps that the organization has taken (or will take) to correct the deficiency. The plan must address both the specific finding and the processes that led to the deficiency.
- A description of how the CAP was (or will be) implemented
- The monitoring process that has been (or will be) put in place to assure ongoing implementation of the CAP. Documentation must include the frequency and duration of monitoring, sample size, and target thresholds.
- The title of the person responsible for implementing the CAP; and
- The date the CAP was (or will be) implemented.

The CAP should be implemented as quickly as possible. The expectation is that – whenever possible – corrective action has already occurred by the time the CAP is submitted.

Due dates for completion of corrective actions should not exceed 60 days for standard level deficiencies, and 30 days for condition level deficiencies, from the date that the CAP is received by the organization. If specific actions require a longer timeframe, please notify CIHQ for assistance and direction.

- The CAP addressing an immediate threat to health and safety deficiency must be fully implemented at the time of submittal. Under extenuating circumstances, a longer time frame may be permitted by the Executive Director of CIHQ.
- If a CAP addressing compliance to the NFPA Life Safety Code will take longer than 60 days to implement, the organization must submit a time limited waiver request to CIHQ. See CIHQ policy on waivers to the NFPA life safety code for details.

REVIEW / ACCEPTANCE OF CORRECTIVE ACTION PLANS
<u>For Standard & Condition Level Deficiencies</u>
Upon submission, the CAP will be reviewed by senior CIHQ staff. If a determination is made that the corrective action plan is acceptable, the organization will be notified in writing and no further corrective action on the part of the organization will be required.

- If a determination is made that the CAP is unacceptable, the organization will be notified in writing of the reason(s) for declination, and the specific modifications necessary for the plan to be accepted. The organization will then be required to submit a second CAP within 7 calendar days.
- If the second corrective action plan is unacceptable, the organization will be notified in writing of the reasons for declination and the specific modifications necessary for the plan to be accepted. The organization will then be required to submit a third and final CAP within 5 calendar days.
- If the third and final corrective action plan is unacceptable, then the organization's accreditation status will be changed to: "Accreditation at Risk".

A full or focused follow-up survey will be conducted by CIHQ to validate implementation of the CAP for any condition-level deficiencies.

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For Immediate Threat to Health & Safety Deficiencies
Upon submission, the CAP will be reviewed by senior CIHQ staff. If a determination is made that the CAP is acceptable, the organization will be notified in writing and no further corrective action on the part of the organization will be required. A full or focused follow-up survey will be conducted by CIHQ to validate implementation of the CAP.

- If a determination is made that the CAP is unacceptable, the organization will be notified in writing of the reason(s) for declination and the accreditation status of the organization will be changed to "Accreditation Denied / Withdrawn

Request for Extension of the Corrective Action Plan
If an organization is unable to implement a corrective action(s) within the time frame submitted/accepted, it must request a one-time extension from CIHQ prior to the action(s) due date. The request must include the reason why the original date of completion cannot be met, as well as any supporting evidence justifying the request. Granting of an extension is at the sole discretion of CIHQ. Failure to request an extension in a timely manner may result in a change of accreditation status to "Accreditation at Risk".

Failure to Implement a Corrective Action Plan
Failure to implement a corrective action plan within the time frame submitted/accepted, may result in a change of accreditation status to "Accreditation at Risk".

Validation of the Corrective Action Plan
CIHQ may, at its sole discretion, require an organization to submit evidence that the accepted CAP has actually been implemented. If requested, the organization is required to submit the evidence within the requested time frame. Failure to submit evidence that a CAP has been implemented will result in a change of accreditation status to "Accreditation at Risk".

APPEAL PROCESS
CIHQ has established an appeals process for accredited organizations wishing to contest a deficiency and/or accreditation decision. There are two levels to the appeal process

FIRST LEVEL APPEAL PROCESS
Appealing the Validity of a Deficiency or Assignment of a Level of Severity
If an organization wishes to appeal a finding, it must notify CIHQ in writing within 10 calendar days following receipt of the report. The appeal is to be submitted on-line. Senior staff will review the appeal, contact the organization for any questions, discussion, further information, etc. and issue a determination in writing of the organization's compliance to the standard/requirement in question.

Appealing an Accreditation Decision
If an organization wishes to appeal an accreditation decision, it must notify CIHQ in writing within 10 business days following issuance of the decision. There is no specific format for the appeal. The content must specifically address the following:

- The basis for appealing the accreditation decision
- Why the organization believes that the accreditation decision was incorrectly rendered
- The specific relief being requested

The written request must be submitted to:
Center for Improvement in Healthcare Quality
P.O. Box 848
Round Rock, TX 78680

Senior staff at CIHQ will make the decision with respect to any appeal submitted. In making this decision, the following will be carefully considered:

- Information that led to the accreditation decision
- The position and any information provided by the organization as part of the appeal
- Input and feedback from senior staff

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SECOND LEVEL APPEAL PROCESS
If the organization does not accept the results of the first level appeal process, it may request –in writing to the Executive Director of CIHQ – that its appeal be reviewed by the CIHQ Accreditation Review Board (ARB). The ARB is an independent three-member panel comprised of a physician, nurse, and community representative. The ARB is not comprised of CIHQ staff. Panel members may not have any professional or personal involvement with the organization. If there is a potential conflict of interest, the affected panel member will be removed and replaced with an alternate.

The ARB will review the information originally submitted by the organization during the first level appeals process, as well as the survey findings and first level appeal decision. No additional information may be submitted.

The organization will be informed in writing of the date and time that the appeal will be considered. If requested, the organization may present their appeal directly to the ARB. This will usually be accomplished by an audio conference call. However, the organization may request that they present their appeal in person. The organization will be responsible for all costs related to convening the ARB – including professional fees, and travel expenses if an in-person meeting is requested.

The organization will be informed of the decision by the ARB in writing. The decision of the ARB is final.

AFFECT OF THE APPEAL PROCESS ON SUBMISSION OF A CORRECTIVE ACTION PLAN
Initiating the appeal process does not obviate the organization from submitting an acceptable plan of correction within required time frames. Except for an immediate threat to health and safety deficiency, the organization may submit due dates for completion on deficiencies they wish to appeal with enough lead time to allow the appeal process to occur and still implement corrective actions in a timely manner should the appeal be denied. The organization should contact CIHQ for assistance in this regard.

ACCREDITATION DECISION / CATAGORIES
CIHQ accreditation surveys are pass/fail. Accreditation decisions are made following consideration of all available information provided by the survey team, and the applicant / accredited organization. There are three categories of accreditation:

ACCREDITED
The organization is in compliance with all CIHQ standards, requirements, and policies at the time of survey, or has successfully submitted an acceptable plan of correction for any identified deficiencies in accordance with CIHQ policy and within required time frames.

- For organizations that are already accredited by CIHQ, accreditation will remain in good standing while identified deficiencies are in the process of being corrected.
- For initial accreditation, an organization will not be considered accredited until corrective action plans for all identified deficiencies have been accepted.

ACCREDITATION AT RISK
An organization's accreditation status may be placed at risk when an organization:

- Fails to submit a required corrective action plan and/or related documentation or if established reasonable timelines in a corrective action plan are not met
- Fails to notify CIHQ of substantive changes to their application in a timely manner
- Makes false public claims regarding its accreditation. (e.g., accreditation is used in a way that is unjustifiable or deceptive in advertising.)
- Violates CIHQ policy on falsification and misrepresentation
- Uses a CIHQ surveyor to provide CIHQ accreditation consulting services
- Allows an individual to provide patient care without a current state or federally mandated license, certification, or registration
- Has an immediate threat to health and safety deficiency identified
- Fails to request extension for implementing a corrective action plan in a timely manner
- Fails to implement a corrective action plan within the time frame submitted/accepted
- Fails to submit evidence that a corrective action plan has been implemented if requested to do so.

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The requirements that an organization must meet to be removed from the “Accreditation at Risk” category will depend on the nature, extent, and severity of the issue. These requirements will be communicated to the organization in writing. The length of time that an organization is permitted to remain on “Accreditation at Risk” will also depend on the nature, extent, and severity of the issue. The allowed length of time will be communicated in writing to the organization. If an organization is using CIHQ for deemed-status purposes, CIHQ will notify CMS anytime an “Accreditation at Risk” designation is made.

DENIAL / WITHDRAWAL OF ACCREDITATON

The organization is denied or has withdrawn its accreditation. All opportunities and mechanisms to obtain or maintain accreditation have been undertaken. CIHQ may – at its sole discretion – deny / withdraw an accreditation award whenever an organization:

- Ultimately fails to submit an acceptable corrective action plan to an identified deficiency(s) as outlined in CIHQ policy
- Fails to meet the requirements necessary to be removed from an “Accreditation at Risk” designation within the required time frame
- Refuses to allow CIHQ access to its facilities, records, staff, patients, or other information necessary to determine compliance to CIHQ standards, requirements, and policies.
- Fails to pay invoices in a timely manner

The organization will be notified in writing that its accreditation has been denied / withdrawn and the effective date of such action. If an organization is using CIHQ accreditation for deemed status purposes, CIHQ will notify CMS promptly whenever accreditation is denied / withdrawn.

COORDINATION OF ACTIVITIES WITH APPROPRIATE LICENSING BODIES & OMBUDSMEN PROGRAMS

For hospitals using CIHQ accreditation for deemed-status purposes, CIHQ shall make available specific accreditation-related information to federal, state, local, or other government certification or licensing agencies, and public health agencies. Information shall be made available under the following circumstances:

- CIHQ identifies an immediate threat to the health and safety of patients or the public and takes action to deny or withdraw an organization’s accreditation
- CIHQ identifies an event that may have, or has, placed the health and safety of patients or the public at serious risk. Such events include, but are not necessarily limited to:
  - Intentional falsification of a patient’s medical record
  - Abuse of patient
  - Unethical treatment of a patient
  - Denial of care to a patient
  - Patient “dumping” by the organization
  - The provision of surgical or invasive procedures on a patient without the patient’s consent

In addition, CIHQ shall make available complaint information requested by CMS or state agencies in accordance with deemed status or other recognition requirements – including the actual complaint and actions taken by the organization. The Executive Director of CIHQ shall be responsible for the timely coordination of survey activities and information-sharing with the above noted agencies.

COLLECTION OF INFORMATION ABOUT AN ACCREDITED ORGANIZATION

CIHQ maintains a current database on all accredited organizations. The information stored in the database allows CIHQ to track and monitor the organization’s ongoing compliance to CIHQ standards, requirements, and policies. The Information in the database includes, but is not limited to, an organization’s:

- Current accreditation application
- Current accreditation status
- Dates of last initial or triennial survey
- Dates of focus surveys within the current triennial survey cycle
- Survey reports – including noting of deficiencies by CIHQ standard and level of severity.
- Status / outcome of corrective action plans required for any identified deficiency
- Status / outcome of any appeals submitted

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For those organizations that use CIHQ accreditation for deemed-status purposes, the database will also include:

- Number of complaints received about the organization broken down by:
  - Number of written resolutions
  - Number of focused surveys and follow-up actions
  - Number of complaints that have taken greater than 90 days to resolve and the reason for the delay, and the average resolution time for complaints
- Notification to/from CMS about the organization's accreditation status being:
  - Accreditation at Risk
  - Accreditation Denied / Withdrawn

All information is considered confidential and, except when required by law and regulation, will not be shared with any outside entity without the written permission of the organization

INFORMATION THAT IS PUBLICLY SHARED BY CIHQ

CIHQ will make the following information public to interested parties upon request:

- Verification that the organization is accredited or is seeking accreditation by CIHQ
- The organization's current accreditation status
- The dates of the organization's initial or last full triennial survey
- The expiration date of the organization's current accreditation

SHARING OF ACCREDITATION INFORMATION WITH CMS & OTHER FEDERAL AGENCIES

For organizations using CIHQ accreditation for deemed-status purposes, CIHQ will share information with CMS and/or other federal agencies as required by law or regulation. The frequency and manner of submitting information is determined by CMS or other federal agencies. This information includes, but is not necessarily limited to, the following:

- Organizations that have been surveyed or are scheduled to be surveyed
- The date(s) of surveys conducted or to be conducted
- The type(s) of surveys conducted (full, focused, complaint, etc) or to be conducted
- The organization's accreditation decision and status
- Any deficiency identified as an immediate threat to health and safety.
- A copy of the organization's final accreditation report and accepted plan(s) of correction
- Any withdrawal or denial of accreditation of an organization by CIHQ
- Any withdrawal of accreditation by an organization
- The number, percentage, and related Medicare tag number of the top ten deficiencies identified during survey activity

CIHQ will report to CMS and/or the Office of the Inspector General credible evidence involving potential Medicare Fraud & Abuse or criminal activities by an organization seeking accreditation. The organization will be informed that a report is being made.

GENERAL INSTRUCTIONS TO SURVEYORS

CIHQ has developed a set of instructions that guide surveyors in on-site activities. These instructions are available to accredited organizations on the CIHQ website, and by this reference, are considered official CIHQ policy.

ACCREDITATION FEES

Accreditation fees are billed on an annual or quarterly basis as preferred by the organization. The amount is based on the size and complexity of the organization. Accreditation fees cover initial, triennial, and mid-cycle surveys and associated travel expenses.

There is no additional fee for complaint surveys (first two in a given calendar year) or follow-up surveys. Travel expenses for such surveys will be billed.

All invoices are due within 30 days of receipt.

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INDEMNIFICATION

Organizations agree that CIHQ accreditation does not constitute a warranty of compliance with the accreditation standards and further that accreditation is not a substitute for self-monitoring and assessment of the services and the quality and safety of care provided by the organization.

The organization agrees to indemnify and hold harmless the CIHQ, its commissioners, officers, agents, employees, and member organizations from any and all professional liability claims of other parties against CIHQ, its commissioners, officers, agents, employees, or member organizations arising from its accreditation program, process, policies, and survey activities, including all judgments, settlements, costs, expenses, and reasonable attorneys' fees, unless and until any such judgments, settlements, costs, expenses and attorneys' fees are found by a final judgment of a court of competent jurisdiction to have resulted solely from negligence or wrongdoing on the part of the CIHQ.

This indemnification and hold harmless provision shall apply only to professional liability claims, i.e., claims based on the CIHQ's performance of its professional services, and not to general liability claims for bodily injury or property damage arising out of the CIHQ's negligence or intentional misconduct.

The organization agrees that in the event of any error or omission in connection with or as a result of CIHQ's performance of accreditation services including, but not limited to, the scheduling and conduct of any accreditation survey, the processing of the results of any accreditation survey, and the disclosure of any accreditation survey results, the CIHQ's liability to the organization for any loss or damage arising therefrom, shall be limited to the total fees paid or payable for any accreditation services provided.

This limitation of liability shall apply to the fullest extent permitted by law regardless of whether the organization's claim for loss or damage is based upon contract, tort, strict liability, or otherwise, and shall constitute CIHQ's sole liability to the organization and the organization's exclusive remedy against the CIHQ in the event of any such error or omission.

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