Steven Hirsch & Associates
Accreditation News

Summer 2023

Volume 15, Issue 2

Is the Patient Considered a Transfer or an Admission?

By Joann Saporito, RN, MBA, HACP

There can be a several reasons a patient may move from one hospital facility to another. These can include tests or services not provided at the first hospital such as MRI scanning. Or perhaps the patient is being transferred to receive specialized care such as hemodialysis, cardiac, or pulmonary care and is not expected to return to the sending site. Each of these situations requires thoughtful planning and coordination between the facilities to avoid compliance issues.

For example, a patient may need to transfer from Hospital #1, a small rural hospital with no MRI scanner, to a local tertiary hospital (Hospital #2) to receive their diagnostic test with the intention of returning to Hospital #1. In this circumstance, the patient is not being "transferred" or "discharged" from Hospital #1; They are, for all intents and purposes, going for a procedure and will return to their same room at Hospital #1. In this case, the patient's Patient Account Number stays active and does not change, and their "stay" at the hospital remains continuous. To put it simply, it is as if they went to Radiology for an X-Ray.

Conversely, consider the patient who requires a higher level of care such as ongoing hemodialysis, neurology, or specialized surgery, and Hospital #1 does not have those types of providers or facilities. The facility would likely perform a facility-to-facility transfer. In this situation, the patient's provider at Hospital #1 must find an accepting Physician at Hospital #2 and give a thorough hand-off prior to the transfer. The patient would be officially discharged from Hospital #1 with a discharge disposition of "transferred to another acute care facility." Their Patient Account is closed upon the patient leaving Hospital #1. It is also important to note that EMTALA does not apply in these situations, as the patient has already been admitted to the first hospital setting and evaluated.

One might ask what if the patient is transferred from one hospital to another hospital within the same system? If the hospitals share the same CMS Certification Number (CCN), this type of transfer may be treated as if the patient were simply transferring between units within the same hospital. However, if the hospitals have unique and differing CCN numbers, this patient should be fully discharged (meaning the Patient Account Number closed) from the first facility and then admitted to the second facility.

The Medical Record Number may be the same as far as the hospital system goes, but the Patient Account Numbers would be different and each facility would bill separately. Furthermore, in this instance it would be expected that all admission assessments and screenings as required by CMS, state regulatory agencies, and any accrediting organizations are completed upon arrival to Hospital #2 as though the patient is being admitted for the first time into the hospital system.

Coordinating patient care can be complicated, especially if a patient must be transferred off-site for needed services. That holds true whether a transfer is or is not considered temporary. Making these patient moves even more complex are those transfers that occur between sister hospitals. It is important that these latter types of patient movements are appropriately handled to avoid any billing and/or subsequent compliance issues.

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This issue offers important updates on licensing issues that may impact your successful accreditation.

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What Makes an Excellent Infection Prevention and Control Program

By David Woodard, MSc, MT(AMT), CLS, CIC, FSHEA

A question that we frequently encounter when visiting hospitals is, “What makes an excellent Infection Prevention and Control Program?” A difficult question to answer to be sure, but just the nature of the question is telling. “Infection Control” as a term has become passe, as passe as the term “nosocomial” infection, and its use suggests that the program has not maintained consistent with current recommendations, guidelines, and practices.

The Centers for Medicare and Medicaid Services (CMS) provide guidance as to the components of a facility-wide Infection Prevention and Control Program. The specificity of the elements of the Program varies with each of the facility types. For example, 42 CFR 482.42 (Infection Prevention for General Acute Care Hospitals (GACH)) provides in-depth guidance for elements of the program, while 42 CFR 485.640 for Critical Access Hospitals (CAH) is less detailed. These documents serve as the core essential elements of an Infection Prevention and Control Program that will support safe patient care; it does not imply excellence. It is from these guidelines that the accreditation agencies develop standards.

Most healthcare facilities in the United States have elected to have voluntary accreditation from any one of a variety of accrediting agencies such as The Joint Commission (TJC), the most common; Healthcare Facilities Accreditation Program (HFAP), Det Norske Veritas (DNV), or Center for Improvement in Healthcare Quality (CIHQ). All these accrediting organizations provide more precise interpretation of the CMS standards, but do not establish or define an excellent program.

Infection Prevention and Control Programs are unique in the healthcare environment. By their very nature they must penetrate the entire fabric of the organization – a horizontal function in a vertical environment. The Infection Prevention and Control Program must originate from the Governing Body as it has the overall responsibility and authority for all the operations within its domain. It must set and define the expectations of the Infection Prevention and Control Program, and then evaluate the Program in terms of meeting or exceeding the expectations.

When expecting excellence in the Infection Prevention and Control Program (IPP), the Chief Executive Officer (CEO) should assure that the program is positioned in the facility to ensure that all operations are addressed in the IPP plans, program, and practices. These are some telling clues of how the Infection Prevention and Control Program is viewed within the organization.

One of the initial assessments for excellence is: To whom does the Infection Prevention and Control Program report administratively? Historically, the Infection Prevention Programs were within the Nursing Department because the practitioner was commonly a nurse (and in some states all nurses must report to a nurse administrator). As quality in healthcare has expanded and become a greater focus, the Infection Prevention and Control Program has been housed, as a subordinate, in the Quality Department. We find this to be the most common organizationally, but not necessarily the optimal leadership position.

As the Infection Prevention and Control Program interacts with all the departments, programs, and services within the hospital and with all the clinical care services provided, consideration should be given to the reporting structure be it either to the Chief Operating Officer role, or the Chief Medical Officer., as a large percentage of the decisions are patient oriented.

Who is the Infection Preventionist (IP)? The excellence of a program is generally the result of the actions and activities of the IP(s) and their education, ability to develop, implement, monitor, and evaluate a comprehensive program and effect change (acting as a change agent) are critical. The ability of the IP to develop a program that is compliant with the myriad of requirements for an Infection Prevention and Control Program, e.g. surveillance of all 28 NHSN surgeries as required in California, COVID-19 response program including limiting transmission, patient care environment, immunization and PPE requirements; water management programs; antimicrobial stewardship program; Environment of Care; cleanliness of the hospital environment; laundry services; education and training. It is critical that the IP is able to ensure that all the moving parts are organized, evidence-based, and can be managed by the organization is essential in an “excellent” program.

Choosing an Infection Prevention and Control Program leader is problematic on several fronts. The published educational requirements are ill-defined: an individual who has a Master of Public Health degree does not make them an excellent choice if the focus of their degree is Epidemiology and Biostatistics, and they have never seen the inside of a hospital. A physician who does not have a US license may be an excellent choice based on their clinical knowledge, however, they often have limited skills in the areas outside of direct patient care and their risks. An individual with an entry-level degree may not have the skills for critical thinking and being a change agent. Thus, selecting a broad-based, well-trained, and experienced practitioner can be extremely difficult.

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- Clinical laboratory management and CLIA
- Performance improvement (CQI) and Patient Safety consultation
- Management of the Environment of Care (including Life Safety Assessment)

What Makes an Excellent Infection Prevention and Control Program

Continued...

In summary, the excellence of an Infection Prevention and Control Program can be seen when looking at the hospital from all angles. Is the hospital sparkling clean, high-touch surfaces without fingerprints, furniture arm rests clean, and corners of the hallways free of dirt and debris? What are the infection rates? Ideally, they should be zero and there should be evidence of sustained success. Is there evidence that the Infection Preventionist has made their presence known in all the areas including facilities spaces, medical staff meetings, board meetings, and regular presence at leadership meetings?

I have created a scorecard that is somewhat based on the data discussed above as well as what can be ascertained as "important" or "critical" based on survey reports and discussions with board-certified and experienced hospital epidemiologists and IP program leaders. Evaluate your program for each of the categories to see your final score. This document can also be used as a PERT chart. This will permit a more visual reflection of strengths and potential deficiencies or shortfalls in the current Infection Prevention and Control Program.

See attached:

Infection Prevention and Control Program Scorecard Template

(pages 4-5)

To estimate the excellence of your Infection Prevention and Control Program using the attached "Infection Prevention and Control Program Scorecard," a program would need to attain a score of 247.5 (90% of possible score). A score of 192.5 (70%) is a functioning program with significant room for growth. A program with a score of less than 137.5 (50%) is putting the patients and the organization in jeopardy and those areas that are in the lowest scoring blocks should have immediate attention.

For more information on how to create and maintain an excellent

Infection Prevention and Control Program

at your facility

contact **Steven Hirsch & Associates** at (800) 624-3750

About Steven Hirsch & Associates

Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987. Beyond accreditation and licensure survey preparedness, our healthcare consulting team can provide assistance in a number of areas including Medicare certification, performance improvement, nursing management, infection prevention and control, Life Safety Code compliance, medical staff services (including credentialing and independent peer review), clinical lab management and compliance with HIPAA. For more information on how Steven Hirsch & Associates can assist you with accreditation and licensure preparedness, Medicare certification and other management challenges, please contact us at (800) 624-3750 or visit our website at www.shassociates.com.

Infection Prevention and Control Program Scorecard

Status of the Incumbent: **(Score all that apply. Maximum 30 Points)**	**Point Score**	**Comment: (*use this field to document possible improvement actions e.g. "New IP – recruit @ University School of Public Health")***
A graduate degree in a Healthcare, Public Health, Biological Science, or related program	10	
A bachelor's degree in a Healthcare, Public Health, Biological Science, or related program	5	
An associate degree in a Healthcare, Public Health, Biological Science, or related program	3	
Is the incumbent Certified by the Certification Board of Infection Prevention (CIC)?	10	
Associate ICP (AICP)	5	
Is the incumbent Board Certified by either SHEA (FSHEA) or APIC (FAIPC)?	10	
Does the incumbent attend external infection prevention training, workshops? (Maximum 5 Points)		
None	0	
0-2 times/year	2	
3-5 times/year	5	
Evidence that the IP program and practitioner have been active in department education (Maximum 50 Points)		
Patient Care	10	
Environment of Care	5	
Environmental Services	10	
Laboratory Services	5	
Radiology Services	5	
Therapy Services	5	
Food and Nutrition (Dietary)	5	
Pharmaceutical Services	5	
Based on observation and staff interviews, is there evidence that the IP program and practitioner have been active in the education of hospital leaders? (Maximum 80 Points)		
Leadership	10	
Medical Staff (physicians/LP)	10	
Governing Body	20	
Is there evidence that the education provided to the Facility Staff is based on current available material?	10	
Is there evidence that the activities of the Program are reported in the various Medical Staff Department meeting minutes?	10	
Is there evidence that the activities of the Program are reported in the Medical Executive Committee (or equivalent)?	10	
Is there evidence that the activities of the Program are reported to the Governing Body?	10	

Infection Prevention and Control Program Scorecard

Is there evidence of Infection Prevention participation in the following committees? (Maximum 70 Points)		
Environment of Care Committee	10	
Water Management Committee	10	
Infection Prevention Committee	10	
Quality and Performance Improvement Committee	10	
Antimicrobial Stewardship Committee	10	
Patient Care Services	10	
Emergency Management	10	
Organizationally, to whom does the Program lead report? (Maximum 40 Points)		
Select one of the three below :		
CMO/COO/CEO	10	
CNO	7	
Quality Department lead	5	
Select one of the three below :		
Is the Program lead's compensation equivalent to a Director in the organization?	10	
Is the Program lead's compensation equivalent to a Manager in the organization?	7	
Is the Program lead's compensation equivalent to other leadership positions?	3	
Select one of the two below :		
Is the organization program staffing ratio 1:100 occupied beds?	10	
Is the organization program staffing ratio 1:200 occupied beds?	5	
Select one of the two below :		
Does the Department have full-time clerical support?	10	
Does the Department have half-time clerical support?	5	
Total Possible Score Points 275		
Points to Lose		
Immediate jeopardy finding in IP	***-50***	
Two or more general findings in survey for which IP is singularly and solely responsible	***-25***	
Failure in data validation survey	***-25***	

Note: A score of 247.5 (90% of possible score) is an excellent program. A score of 192.5 (70%) is a functioning program with significant room for growth. A score of less than 137.5 (50%) is putting the patients and the organization in jeopardy and those areas that are in the lowest scoring blocks should have immediate attention.