Accreditation Guide for Critical Access Hospitals
Dear Colleague,

Thank you for looking to The Joint Commission when it comes to your quality and accreditation concerns. Joint Commission recognition is a visible demonstration to your patients, their families, your staff and the community of your commitment to the highest level of safety and quality.

*The Accreditation Guide for Critical Access Hospitals* is designed to help you learn about the Joint Commission’s accreditation process. This guide provides information about several important areas including eligibility, how to request accreditation and prepare for the process, the on-site survey process, and accreditation decisions.

We hope that you will find this guide helpful in understanding the accreditation process. If you have questions, or would like to speak with someone directly, please contact me.

Sincerely,

Jeff Conway
Associate Director,
Accreditation and Certification Operations
630-792-5717
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**Telephone and Website Directory**

**Critical Access Hospital Program** ................................................................. (630) 792-5717
To receive an initial Application for Accreditation, or for general information about critical access hospital accreditation.

**Your Joint Commission Account Executive** ............................................... (630) 792-3007
Call to inquire about your completed Application for Accreditation, survey date or schedule or for assistance with specific problems related to your accreditation.

**Joint Commission Resources (JCR) Customer Service Center (Toll Free) (877) 223-6866**
To register for, or receive information about education programs and to purchase or inquire about publications. JCR is an affiliate of The Joint Commission. Online registration and ordering is available at www.jcrinc.com.

**Standards Help Desk** .................................................................................. (630) 792-5900
For information about interpreting and applying specific critical access hospital standards or to inquire about the Statement of Conditions, Life Safety Code, or equipment and utilities management. *Please request assistance from a critical access hospital specialist.*
An online form is available at www.jointcommission.org/Standards/OnlineQuestionForm/.

**Joint Commission Pricing Unit** ................................................................. (630) 792-5115
For information on accreditation fees, or to handle your application deposit fee via credit card payment. Also available via e-mail at pricingunit@jointcommission.org.

**Joint Commission Website: www.jointcommission.org**
- Current Joint Commission news
- Information about revisions to standards
- Quality Check®, a searchable list of health care organizations within a city or state, or by type of setting, with information about accreditation status (www.qualitycheck.org)
- Helpful tips for publicizing accreditation status
- Listing of Liability Insurers that recognize Joint Commission accreditation
- Frequently asked questions (FAQs)
Resources for Critical Access Hospitals

Business Development Support Staff
Business Development staff work closely with organizations preparing for their first accreditation. Any questions that you have about the overall accreditation process and your preparation efforts should be directed to (630) 792-5717.

Standards Help Desk
The Standards Interpretation Group (SIG) is responsible for answering specific questions about any standards and how they are interpreted. This is a no-cost service accessed over the phone or through the Joint Commission website. Call (630) 792-5900 or use the online form at www.jointcommission.org/Standards/OnlineQuestionForm/. Be sure to request assistance from a critical access hospital specialist.

Frequently Asked Questions
The Joint Commission website contains frequently asked questions (FAQs) for many areas of potential concern for critical access hospitals. Many of these questions are posted by the Standards Help Desk under “Standards” on the website, so you may find answers by checking the FAQs before calling.

Survey Activity Guide
Once you request an Application for Accreditation, you will gain access through a secure log-in to the Joint Commission extranet site, “Joint Commission Connect®”. There you will find a Survey Activity Guide, which goes into great detail on the surveyor’s agenda and provides further preparation for the on-site review.
The Joint Commission Snapshot

Introduction
The Guide for Critical Access Hospital Accreditation is designed to help you learn about the Joint Commission’s critical access hospital accreditation process. This guide provides important information about The Joint Commission, eligibility for accreditation, on-site surveys, survey preparation and accreditation decisions.

Our Mission
To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

The Joint Commission: Who Are We?
The Joint Commission was founded in 1951 under the auspices of the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons, with the later addition of the American Dental Association, to act as an independent accrediting body for hospitals nationwide. As such, The Joint Commission currently accredits over 80% of U.S. hospitals.

The Joint Commission established the Critical Access Hospital Accreditation Program in 2001 to support the delivery of safe, high quality patient care. Today’s health care environment is changing rapidly, and providers are experiencing new competitive pressures in marketplace. Providing safe, high quality care to patients and continually improving performance are benchmarks of success.

Why Choose The Joint Commission?
Today, Joint Commission accreditation of a critical access hospital is a widely recognized standard for evaluating and demonstrating high quality services. Payers, regulatory agencies, and managed care contractors may require Joint Commission accreditation for reimbursement, certification and licensure, or as a key element of their participation agreements. Joint Commission accreditation represents the “Gold Seal of Approval™” in health care and provides the most comprehensive evaluation process in the industry. Joint Commission accreditation also benefits your organization by:

- **Strengthening community confidence**
  Achieving accreditation is a visible demonstration to the community that your hospital is committed to providing high quality services, as reviewed by an external group of specialists.

- **Validating quality care to your patients and their families**
  Joint Commission standards are focused on one goal: raising the safety and quality of care to the highest possible level. Achieving accreditation is a strong validation that you have taken the extra steps to ensure the highest level of safety and quality currently available.

- **Helping you organize and strengthen your improvement efforts**
  Joint Commission standards include state-of-the-art performance improvement concepts that provide a framework for continuous improvement using standards as a means to achieve and maintain excellent operational systems.
• **Improving liability insurance coverage**
  By enhancing risk management efforts, accreditation may improve access to or reduce the cost of liability insurance coverage. A list of liability insurers that recognize Joint Commission accreditation can be found on our website at: http://www.jointcommission.org/BusinessCommunity/liability_insurers.htm.

• **Enhancing staff recruitment and education**
  The accreditation process is designed to be educational, not punitive. Our surveyors are trained to help you improve your internal procedures and day-to-day operations in a consultative manner. Prospective employees also look for accreditation as a sign of excellence in an organization.

**What Types of Facilities are Eligible for Critical Access Hospital Accreditation?**

A facility that meets the following criteria may be designated by the Centers for Medicare & Medicaid Services (CMS) as a critical access hospital (CAH):

- Is located in a State that has established with CMS a Medicare rural hospital flexibility program; *and*
- Has been designated by the State as a critical access hospital; *and*
- Is currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989 to November 29, 1999; or is a health clinic or health center that was downsized from a hospital; *and*
- Is located in a rural area or is treated as rural; *and*
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); *and*
- Maintains no more than 25 inpatient beds; *and*
- Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; *and*
- Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services 7 days per week.

A CAH may also be granted "swing-bed" approval to provide post-hospital skilled nursing facility-level care in its inpatient beds.

In the case of hospice care, a hospice may contract with a CAH to provide the Medicare hospice hospital benefit. Reimbursement from Medicare is made to the hospice. The CAH may dedicate beds to the hospice, but the beds must be counted toward the 25-bed maximum. However, the hospice patient is not included in the calculation of the 96-hour annual average length of stay. The hospice patient can be admitted to the CAH for any care involved in their treatment plan or for respite care. The CAH negotiates reimbursement through an agreement with the hospice.
In addition to the 25 inpatient CAH beds, a CAH may also operate a psychiatric and/or a rehabilitation distinct part unit of up to 10 beds each. These units must comply with the Hospital Conditions of Participation.

**Standards, Goals and Survey Process**

**The Standards Manual**
The Joint Commission’s *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)* is the place to begin when preparing for accreditation. Even if you do not pursue accreditation right away, this manual is an excellent tool to help your organization become organized and established. The CAMCAH contains functional standards that are organized around the way care is provided. It is provided free of charge upon receipt of your accreditation deposit or can be provided earlier, call (630) 792-5717 for more information.

Joint Commission standards address patient-focused performance measures and are organized around functions and processes.

**Patient-Focused Functions**
The patient-focused section includes chapters on Infection Control, Medication Management, Provision of Care, and Rights and Responsibilities.

**Infection Prevention and Control**
These standards are designed to help CAHs in developing and maintaining practices that cover a wide range of situations.

**Medication Management**
These standards address a well-planned and implemented medication management system, including selection and procurement, storage, ordering, preparation and dispensing, administration and monitoring.

**Provision of Care, Treatment, and Services**
This chapter addresses assessment of patient needs, care planning, and providing and coordinating care.

**Rights and Responsibilities of the Individual**
Standards address the following processes:
- Informing patients of their rights
- Helping patients understand and exercise their rights
- Respecting patients’ values, beliefs, and preferences
- Informing patients of their responsibilities regarding their care, treatment and services

**Organization Functions**
This section of the CAMCAH includes chapters on Environment of Care, Emergency Management, Human Resources, Information Management, Leadership, Life Safety, Medical Staff, Nursing, Performance Improvement, and Record of Care.
Management of the Environment of Care
These standards promote a safe, functional and supportive environment within the CAH so that quality and safety are preserved. The environment of care is made up of the building or space, including how it is arranged and special features that protect patients, visitors and staff. It also encompasses the equipment used to support patients and the people, including employees, patients and visitors.

Emergency Management
These standards are organized to allow critical access hospitals to plan to respond to the effects of potential emergencies that range from disruptive to disastrous.

Human Resources
The standards and elements of performance address the critical access hospital’s responsibility to establish and verify staff qualifications, orient staff, and provide training that staff needs to support the care, treatment and services that the CAH provides.

Management of Information
These standards address how well the critical access hospital obtains, manages and uses information to provide, coordinate and integrate services.

Leadership
These standards are divided into four different areas to address all organizational areas so that they come together to shape and drive the CAH’s operations:
- Leadership Structure
- Leadership Relationships
- Critical Access Hospital Culture and System Performance
- Operations

Life Safety
This chapter includes all the Joint Commission requirements regarding Life Safety Code compliance, which specifies construction and operational conditions to minimize fire hazards and provide safe systems in case of emergency.

Medical Staff
These standards provide structure for self-governing medical staff, licensed independent practitioners and other medical staff personnel.

Nursing
This chapter addresses nursing direction, establishing guidelines for delivery of care and providing treatment, nursing care and services.

Performance Improvement
These standards focus the critical access hospital on measuring the performance of processes that support care and then using data to make improvements.

Record of Care, Treatment, and Services
Comprehensive sets of requirements for medical record contents are provided and standards address policies and procedures that structure the compilations, authentication, retention and release of records.
The Joint Commission Patient-Centered Accreditation Process

The purpose of a Joint Commission accreditation survey is to assess the extent of an organization’s compliance with applicable Joint Commission standards, National Patient Safety Goals, and Accreditation Participation Requirements. Another important aspect of the Joint Commission survey process is the on-site education as surveyors offer suggestions for approaches and strategies that may help the organization better meet the intent of the standards and, more importantly, improve performance. While integrating evaluation of standards compliance and educating an organization, the Joint Commission accreditation process also emphasizes quality patient care.

Although surveys for critical access hospitals are triennial (conducted every three years) the accreditation process does not end when the on-site survey is completed. In the three years between on-site surveys, The Joint Commission requires ongoing self-assessment and improvement. Continuous survey compliance means less focus on the ‘ramp up’ for survey every three years. Instead, organizations can and should continually study and improve their systems and operations, eliminating the need for intense survey preparation. Continuous compliance with the Joint Commission standards directly contributes to the maintenance of safe, high quality patient care and improved organizational performance.

Tracer Methodology

Tracer Methodology utilizes the patient care experience to assess standards compliance. At the beginning of the on-site survey, the surveyor(s) will select patients from the organization’s files. The surveyor(s) will ‘trace’ the patient’s experience, looking at services provided by various care providers and departments within the organization, as well as ‘hand-offs’ between them. This type of review is designed to uncover systems issues, looking at both the individual components of an organization and how the components interact to provide safe, high-quality patient care. For a sample of a survey agenda, go to page 22.

There are two types of tracers used in the Tracer Methodology:

- The Individual Care Tracer follows the actual care experiences of individuals who have received care, treatment and services within or from that organization.
- The Individual-based System Tracer traces the experience of individuals through a specific system related to the provision of care, treatment and services. The system tracer focuses on high-risk processes across an organization.

The number of patients followed under the Tracer Methodology will depend on the size and complexity of the organization, and the length of the on-site survey.

Priority Focus Process

The Priority Focus Process focuses on an organization’s “challenge areas” during the on-site survey. Prior to the initial survey, information is gathered from several data sources which include:

- Data from the completed Application for Accreditation; and
- Complaints about the organization (if any) received by the Joint Commission’s Office of Quality Monitoring.
The data is then converted into useful information that focuses survey activities, increases consistency in the accreditation process and customizes the on-site survey to make it specific to your organization.

**Evidence of Standards Compliance**

At the end of the on-site survey, the report left with the organization will identify if there are any standards that were scored as partial or non-compliant, also known as **Requirements for Improvement (RFIs)**.

RFIs are identified by a scoring system which measures an organization’s **Elements of Performance (EPs)**. Elements of Performance are the portion of the standard that are scored by the surveyor on site. EPs are scored on a three-point scale of “0=insufficient compliance,” “1=partial compliance,” and “2=satisfactory compliance.” EPs with a score of 0 or 1 may result in RFIs for the organization.

If there are no RFIs, the organization is accredited. If there are RFIs, the organization will not receive accreditation status until they are resolved. For those standards scored as non-compliant, the organization will need to submit **Evidence of Standards Compliance** (ESC) to show that the organization is now meeting those standards and elements of performance. ESCs must be submitted within 45 and/or 60 days following the survey. For some ESCs, organizations will need to identify **Measures of Success (MOS)**. These are quantifiable, data-driven measurements that can show compliance with a standard or set of standards and can be used to validate resolution of problem areas. Once the ESCs are approved by The Joint Commission, the organization is officially accredited. See page 17 for a description of the accreditation status decisions.

**Performance Measurement Requirements**

Critical Access Hospitals (CAHs) are exempt from the requirement to transmit data via a performance measurement system to The Joint Commission, but they are required to select and use six performance measures relevant to the services they provide and the patients they serve. If they wish, CAHs may voluntarily collect data on core (i.e. nationally standardized) measure sets that might be appropriate to their patient population. During the on-site survey, CAHs will share their measurement data—whether core or non-core—results and conclusions with surveyors. For more information, contact Frank Zibrat, Associate Director, ORYX Implementation, at fzibrat@jointcommission.org or (630) 792-5992.

**Random Unannounced ESC Validation Survey**

All organizations new to the accreditation process that become accredited after their initial survey will be included in a 5% pool of organizations undergoing an unannounced validation survey. This survey will validate information in the organizations’ Evidence of Standards Compliance and evaluate how effectively corrective actions are sustained over time. There is no charge to organizations for this survey.

**National Patient Safety Goals**

National Patient Safety Goals and their requirements are a series of specific actions that organizations are expected to take in order to prevent medical errors such as miscommunication among caregivers or medication errors. A panel of national safety experts has determined that taking these simple, proven steps will reduce errors. The Joint Commission issues a set of National Patient Safety Goals each year, drawn in part from the
Joint Commission’s extensive sentinel event database. Aggregate data on achievement of the Goals is made public each year.

Much like Joint Commission standards, organizations that provide care relevant to a National Patient Safety Goal are evaluated for compliance with the specific implementation expectations associated with those Goals. Organizations are permitted to design alternative approaches to meeting Goal requirements and to request Joint Commission consideration and approval of such alternatives. The Joint Commission also provides guidance on how to achieve effective compliance with each Goal’s requirements.

An example of the National Patient Safety Goals content and structure (requirement and implementation expectations) is illustrated with Requirement 1 – Use of at least two patient identifiers when providing care, treatment or services.

**Requirement** – Use at least two patient identifiers when providing care, treatment or services.

**Rationale for Requirement** -- Wrong-patient errors occur in virtually all aspects of diagnosis and treatment. The intent for this goal is two-fold; first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual.

**Implementation Expectations for Requirement 1:**

1. Prior to any specimen collection, medication administration, transfusion, or treatment, the organization actively involves the patient, and as needed the family, in the identification and matching process. When active patient involvement is not possible or the patient’s reliability is in question, the organization will designate the caregiver responsible for identity verification. 
   Note: The involvement of a single caregiver is acceptable as long as the other components of patient identification are satisfied.

2. Two patient identifiers are used when administering medications, blood, or blood components.

3. Two patient identifiers are used when collecting blood samples and other specimens for clinical testing.

4. Two patient identifiers are used when providing other treatments or procedures.

5. The patient’s room number or physical location is not used as an identifier.

6. Containers used for blood and other specimens are labeled in the presence of the patient.

The National Patient Safety Goals and frequently asked questions (FAQs) about the National Patient Safety Goals can be found on the Joint Commission website by clicking on critical access hospitals at http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals. The FAQs include detailed answers about implementing the goals.
Our Standards Represent a National Consensus
The Joint Commission’s critical access hospital standards and accreditation processes are the result of careful analysis of the rapidly changing health care field. Every effort is made to provide reasonable guidelines that every critical access hospital should strive to meet.

Our Surveyors: Critical Access Hospital Professionals
Joint Commission critical access hospital surveyors are salaried professionals experienced in the critical access hospital arena, who understand the day-to-day issues that confront you and have the hands-on expertise to help you resolve them. A Joint Commission critical access hospital on-site survey is conducted by a masters-prepared nurse or administrator, the majority of who are also currently practicing in the critical access hospital field.

The Joint Commission ensures surveyor consistency by providing 2-3 weeks of initial training and a minimum of 10 days of continuing education annually to keep surveyors up-to-date on advances in quality-related performance evaluation. All surveyors must also pass a rigorous Certification Exam. The Joint Commission evaluates its surveyors’ performance continually throughout the year, in part to ensure that your on-site survey is an educational process, not just an inspection.

Preparing and Applying for Accreditation

Accreditation Preparation
The accreditation process begins when you submit your application. It is best to submit your application when you are confident your organization can demonstrate compliance with the accreditation requirements and applicable elements of performance by the time of your on-site survey date. See “How to Request Accreditation” on page 14.

After The Joint Commission accepts an organization’s Application for Accreditation and receives the application deposit fee, both parties begin preparing for the on-site survey. An organization should begin by reviewing the accreditation requirements and conducting a self-assessment to see where improvements are needed, and then taking measures to put new policies or processes in place as needed. Many organizations find it helpful to conduct one or two “mock surveys” by using the self-assessment grid next to each element of performance in the Standards Manual. Use the “Ready to Go” list on page 28 and the “Accreditation Readiness Checklist” on pages 29-30 for further assistance.

To help organizations prepare for accreditation, The Joint Commission also offers the Survey Activity Guide on your “Joint Commission Connect®” extranet site where the application is located. In addition, Joint Commission Resources, an affiliate company, offers educational programs, numerous publications and periodicals to aid in your preparation.

The Joint Commission organizes a surveyor, or team of surveyors, to match an organization’s needs and unique characteristics. On-site surveys for traditional critical access hospital accreditation are typically conducted by one surveyor for two days and a life safety code specialist for two days. The length of the survey is determined by the organization’s average daily census over the preceding three years. The on-site survey follows a Tracer Methodology, which follows a sample of patients through their experiences of care in the organization, to evaluate individual components of care and systems of care. The survey follows actual patient records through the facility and includes interviews with key personnel,
observation of the organization’s administrative and clinical activity, assessment of the physical facilities and equipment and review of documentation. The accreditation survey activity list and the document list are included on pages 23-27.

For initial accreditation surveys, your account executive is available as a resource during the application and pre-survey process.

**Informing the Public Regarding Your On-Site Survey**
The Joint Commission requires all organizations seeking accreditation to continuously inform the public about their ability to report any complaints or concerns about safety or quality of care to The Joint Commission. The public includes, but is not limited to, patients and their families, patient advocates and advocacy groups, members of the community for who services are provided, and staff members. Any individual who learns that a Joint Commission survey is taking place may request a Public Information Interview during an on-site survey; however, there is no longer a formal process to notify the public in advance of the survey.

The Joint Commission will continue to conduct all special types of surveys – for-cause, special, random unannounced – as warranted. When The Joint Commission learns of a serious event at an organization that has significantly impacted the delivery of safe and high quality care, it will continue to authorize a for-cause unannounced survey.

**Survey Scheduling**

**Initial Surveys**
The Joint Commission schedules initial surveys systematically and efficiently. The date for the initial survey, that is, an organization’s first full accreditation survey, will be unannounced, and should be scheduled within twelve months from the time The Joint Commission receives the organization’s Application for Accreditation. To encourage continuous standards compliance, future reaccreditation surveys are also unannounced.

**Timeliness of Application and Deposit Fee**
The Joint Commission requires an organization to submit a new application for Accreditation if the organization does not accept a scheduled survey within one year. This assures that the organization’s information is current. If an organization’s initial survey is not conducted within six months of submitting its application, the organization forfeits its application deposit. The organization must then reapply and submit a new deposit to begin the accreditation process again.

**How to Request Critical Access Hospital Accreditation**
Critical access hospital organizations that wish to be accredited by The Joint Commission can receive an application for Accreditation by either:

- calling (630) 792-5717
- e-mailing jconway@jointcommission.org,
- or writing to:
  **Critical Access Hospital Accreditation Program**
The Joint Commission
One Renaissance Blvd
Oakbrook Terrace, IL 60181
The Application for Accreditation
The Application for Accreditation is in an electronic format that can be completed by using a provided password and login name to access the Joint Commission Connect™ website, located at www.jointcommission.org. The Application is valid for one year from the date submitted, which means you can submit your application and still have time to finish your preparations for the on-site survey.

It is best to submit your application at the point where you are confident your organization will be able to demonstrate compliance with the accreditation requirements by the time of your preferred survey date.

Your organization will be given password-protected access to the secure Joint Commission extranet site “Joint Commission Connect™” where you will find a Survey Activity Guide, a sample survey agenda, as well as a guide to the limited number of documents you will need to gather for the surveyor. You will also be assigned an account executive who will:

- Answer your questions about survey preparation, and help you through each step of the accreditation process;
- Analyze your Application for Accreditation and contact you if there are any questions or items requiring clarification;
- Update changes to your demographic information, including address, contact name(s), services, etc.;
- Assist you with other Joint Commission contacts and questions.

The Joint Commission schedules on-site surveys based on information provided in your Application for Accreditation. With the information provided, The Joint Commission determines the number of days required for a survey, the composition of the survey team and the services to be reviewed.

Handling Changes During the Application Process
Your organization must notify The Joint Commission (not more than 30 calendar days after changes) if it undergoes a change that modifies the information reported in the Application for Accreditation. These types of changes may require an extension survey; check with your assigned account executive. Information that must be reported includes organization name changes as well as:

- A change in ownership and/or significant changes in management, clinical staff, or operating policies and procedures;
- A significant increase or decrease in the volume of services;
- Opening or closing any unit or service, or providing a more intensive level of service;
- Offering significant services at a new location or in a significantly altered building/physical plant; or
- Merger, consolidation, or acquisition of an unaccredited site or service.

The Joint Commission may schedule an additional survey at a later date if its survey team arrives at the organization and discovers that a change was not reported. The Joint Commission may also review any unreported services addressed by its standards. In either event, there may be additional fees assessed. The Joint Commission will make the final
accreditation decision for the organization only after reviewing all services provided by the organization for which The Joint Commission has standards.

**Application Fee**
For initial surveys, a nonrefundable, nontransferable survey deposit of $1,700 must be submitted at the time of the application. The Joint Commission applies the deposit to the organization’s open invoices until the deposit is exhausted. To pay the survey deposit by credit card, call (630) 792-5662. Checks should be made payable to The Joint Commission and mailed to The Joint Commission, PO Box 92775, Chicago, IL 60675-2775. Please include your Joint Commission ID number on your check.

**Fees and Annual Billing**
The Joint Commission currently uses an annual billing model, also called *subscription billing*. This billing model spreads the costs accreditation over a three year period. The accreditation fee is based on an on-site survey fee due after the on-site survey, plus an annual fee every year of the accreditation cycle. Annual fees will vary depending upon the size and complexity of an organization, as determined by the information submitted in the electronic application. Approximately 60% of the accreditation fees will be paid in the first year, with 20% each due the second and third year.

The annual fees, which are non-refundable, will be due from accredited organizations each January upon receipt of an invoice. Organizations seeking accreditation for the first time will have their first annual fee pro-rated, based upon when the organization’s application is processed.

The Joint Commission is committed to “cost transparency” to help organizations plan and budget for their future investment in achieving accreditation. Call our pricing unit directly for a customized quote at (630) 792-5115 or via email at or pricingunit@jointcommission.org.

**Cost of Critical Access Hospital Accreditation**
For 2011, the annual fee is $2,590 and the on-site survey fees are:

- $2,500 Per surveyor, first day
- $1,310 Per surveyor, second and subsequent days
- $2,500 Life Safety Code Specialist, first day
- $1,310 Life Safety Code Specialist, second day

The on-site survey fee is paid at the beginning of the year in which the on-site survey will be conducted, along with the annual fee, and covers survey-related direct costs. For more information about pricing, contact the Joint Commission’s Pricing Unit at (630) 792-5115.

**Accreditation Options**

**Critical Access Hospital Accreditation**
The Joint Commission’s premier accreditation product has earned industry recognition as the “gold standard” for quality and safety.
Early Survey Option for Critical Access Hospital Accreditation

Some organizations requesting a traditional critical access hospital survey may not be quite ready for full evaluation. These organizations may prefer the Early Survey Option. The Early Survey Option allows a critical access hospital new to Joint Commission accreditation to enter the accreditation process in two stages. For a new organization, this makes it possible to set up the business operations on a foundation of compliance with administrative and organizational standards before the first patients are served.

The Early Survey Option is different than a normal, full survey in that it consists of two on-site visits.

First Survey

The first survey can be conducted as early as two months before the organization begins operations, provided the organization meets the following criteria:

- it is licensed or has a provisional license;
- the building in which patient care services will be provided is identified, constructed, and equipped to support such services;
- it has identified its chief executive officer or administrator, its director of clinical or medical affairs, and its nurse executive, if applicable; and
- it has identified the date it will begin operations.

The Joint Commission requires written evidence of these criteria within 30 days before conducting the first survey. The first survey is a limited survey, addressing physical plant, policies and procedures, plans, and related structural considerations for patient care. Following this initial survey, assuming that the organization can demonstrate compliance with the abbreviated set of standards, the organization receives Preliminary Accreditation.

Second Survey

The second survey under the Early Survey Policy is an announced full accreditation survey. *(Note: The second survey will be unannounced for organizations seeking to meet CMS deemed status requirements.)* The Joint Commission conducts this survey at the following times:

- Approximately six months after the first survey
  or
- At a time frame selected by the organization within four months of the acceptance of its first ESC for organizations seeking to meet CMS deemed status requirements

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

- Preliminary Accreditation
- Accredited
- Accreditation with Follow-up Survey
- Contingent Accreditation
- Preliminary Denial of Accreditation
- Denial of Accreditation
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 for Preliminary Accreditation is 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. Submission of an acceptable ESC may be required based on the survey findings of the second survey.

Accreditation Decisions

Survey Results and Accreditation Decision
Shortly after the survey, an organization’s report of survey findings is posted on the organization’s secure site on their Joint Commission extranet site. The report includes any requested Requirements for Improvement (RFI).

The final accreditation decision, which is valid for three years, is based on the organization’s compliance with Joint Commission standards and will be awarded a decision in one of these categories of accreditation:

Preliminary Accreditation
The organization demonstrates compliance with selected standards in surveys conducted under the Early Survey Policy.

Accredited
The organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all Requirements for Improvement (RFIs) in an Evidence of Standards Compliance (ESC) within 45 or 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.

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.

Contingent Accreditation
The organization fails to successfully address all requirements of the Accreditation with Follow-up Survey decision and/or does not have a required license or similar issue at the time or survey. In most cases, a follow-up survey in 30 days will be required.

Preliminary Denial of Accreditation
There is justification to deny accreditation to the organization as evidenced by the following:
- An Immediate Threat to Health or Safety for patients or the public, and/or
- Failure to resolve the requirements of Accreditation with Follow-up Survey after two opportunities (in most cases), and/or
- Failure to resolve the requirements of Contingent Accreditation, and/or
- Significant noncompliance with Joint Commission standards
The decision is subject to review and appeal prior to the determination to deny accreditation.
Denial of Accreditation
The organization has been denied accreditation. All review an appeal opportunities have been exhausted.

Accreditation Effective Dates
For organizations that undergo their first Joint Commission survey (initial organizations) and receive one or more Requirements for Improvement (RFIs) as a result of the survey, their accreditation effective date will be on the date on which the organization submits its evidence of standards compliance (ESC), if the ESC is determined to be acceptable. In other cases, the following effective dates apply:

- For initial organizations that do not receive any RFIs, the effective date of accreditation will be the day after the last day of the organization's survey.
- For initial organizations that receive either a conditional accreditation or a preliminary denial of accreditation decision, the effective date will be the date of the Accreditation Committee meeting at which the decision was made.

Extension Survey
Accreditation is not automatically transferred or continued if significant changes occur within an organization. An extension survey is a survey of limited scope conducted to assure that a previously demonstrated level of compliance is being maintained under changed circumstances. There are many circumstances that may lead to an extension survey, including:

- An organization's addition or significant expansion of services or programs;
- A change in organizational structure or operations due to a merger or acquisition;
- The addition of a more intensive level of patient care;
- A new location or significantly altered existing location; or
- When an accredited organization due for resurvey requests to extend the accreditation date.

See Handling Changes on page 15 for further information.
Promoting Your Accreditation

Once you are accredited by The Joint Commission, publicize your achievement by notifying the public, the local media, third-party payers and patient referral sources. The Joint Commission offers a free publicity kit at http://www.jointcommission.org/AccreditationPrograms/PublicityKit/. It includes:

- Suggestions for celebrating your accreditation;
- Guidelines for publicizing your Joint Commission accreditation;
- Frequently asked questions;
- Sample news releases and information;
- Fact sheets; and
- “Gold Seal of Approval™” artwork that can be downloaded.

Following your survey, information about your accreditation status will be posted on Quality Check® at www.qualitycheck.org, which is also available on the Joint Commission web page. Quality Check® allows anyone to search for health care organizations within a city or state, or by type of setting, and will highlight your Joint Commission accreditation status.

Information for Resurveys

In the three years between on-site surveys, The Joint Commission requires ongoing self-assessment and continuous improvement activities. As the accreditation process does not end when the on-site survey is completed, neither do the need for updates and changes to policies and procedures. Below are updates to specific procedures for the accreditation process. Accredited organizations undergoing future surveys are encouraged to read this section to prepare for future changes, as well as continually study and improve their systems and operations as continuous compliance with the Joint Commission standards contributes directly to quality patient care.

Unannounced Surveys

Since January 2006, organizations that have already completed their initial survey are surveyed on an unannounced basis. The Joint Commission implemented unannounced surveys:

- To enhance the credibility of the accreditation process by ensuring that surveyors observe organization performance under normal circumstances;
- To reduce the unnecessary costs that health care organizations incur to prepare for survey;
- To address public concerns that The Joint Commission receive an accurate reflection of
the quality and safety of care; and

- To help health care organizations focus on providing safe, high quality care at all times, not just when preparing for survey.

Organizations undergoing an unannounced survey should be aware of the following:

- Joint Commission surveys are unannounced and occur 18 to 36 months after the previous full survey.
- On the morning of an organization’s unannounced survey, the following information will be posted by 7:30 am (local time) to your Joint Commission extranet site, “Joint Commission Connect®”:
  o Letter of introduction from The Joint Commission
  o Survey agenda
  o Biography and picture of surveyor(s) assigned
  o Output data from Priority Focus Process for your organization.
- The organization will be invoiced immediately after the survey;
- Accredited organizations will be able to identify up to 10 days each year in which an unannounced survey should be avoided. These 10 days should not include federal holidays but may include regional events in which it may be difficult to conduct a survey during a given period. The Joint Commission will make every effort to accommodate the organization regarding avoiding these 10 days. However, The 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 are such that a survey can be reasonably accomplished.
- The organization is required to fulfill an Accreditation Participation Requirement (APR), which requires organizations seeking accreditation to continuously inform the public about their organization’s ability to report any complaints or concerns about safety to The Joint Commission; and
- The organization will not receive any communication from the surveyor prior to the survey.

For more information regarding unannounced surveys, refer to the Survey Activity Guide on the Joint Commission extranet site “Joint Commission Connect®,” and see Page 28 for a “Ready-To-Go List.”

**Priority Focus Process**
Information for the **Priority Focus Process** will also be gathered from previous Requirements for Improvement from past surveys.

**Evidence of Standards Compliance**
For organizations not undergoing their initial survey, once the Evidence of Standards Compliance is approved by The Joint Commission, the accreditation decision is retroactive to the day after the last day of the survey.
Updated Application for Re-accreditation
All organizations undergoing a resurvey are notified they are required to update their original application information. Staff member(s) with knowledge of your organization's services, sites, and patient volume will need to update the original Application for Accreditation (if changes are necessary.)
As a Hospital, you will need the following information and documents available for the surveyor to review during the Preliminary Planning Session and Surveyor Planning Session, which occurs on the first day of survey.

*Note: The 12-month reference in the following items is not applicable to initial surveys.*

- Performance Improvement Data from the past 12 months
- Documentation of performance improvement projects being conducted, including the reasons for conducting the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
- Infection Control surveillance data from the past 12 months
- Analysis from a High Risk Process
- Environment of Care data including the Statement of Condition (SOC) from the last survey, as applicable
- Environment of Care, Plans for Improvement – access to an internet connection for surveyor acceptance
- Environment of Care Management Plans and annual evaluations
- Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey
- Emergency Operations Plan (EOP), Hazard Vulnerability Analysis, and Annual evaluation of the EOP
- Infection Control Plan
- An organization chart
- A map of the organization, if available
- List of all sites that are eligible for survey
- List of sites where deep or moderate sedation is in use
- List of departments/units/areas/programs/services within the organization, if applicable
- List of patients that includes: name, location, age, diagnosis and length of stay.
- Lists of scheduled surgeries and special procedures, e.g. cardiac catheterization, endoscopy lab, Electroconvulsive Therapy, Caesarian Sections, including location of procedure and time
- List of unapproved abbreviations
- Name of key contact person who can assist surveyors in planning tracer selection
- Measures of Success (MOS) data identified in the Plan of Action from the PPR.
- ORYX data
- Organ donation and procurement conversion rates (Hospital)
- Medical Record Delinquency data
- Organization marketing materials

The following documents may be requested if or when the survey team identifies an issue of concern related to the topic:

- List of all contracted services to include the nature and scope of services provided
Agreement with outside blood supplier
Written policy regarding the organization’s grievance process
Governing Body minutes to verify compliance with budget requirements
Credentials files to verify appropriate clinical service leadership/oversight for Anesthesia, Respiratory or Emergency services
Medical Staff Bylaws and Rules and Regulations
Medical Executive Committee meeting minutes

Please note that this is not intended to be a comprehensive list of documentation that may be requested during the survey. Surveyors may need to see additional documents throughout the survey to further explore or validate observations or discussions with staff.

Survey Planning and Readiness Notes:

1. Please review the Hospital Survey Activity List which has been developed to assist you in preparing for your survey. The list includes the potential survey activities that can occur on a Hospital survey, suggested duration, and suggested timing for these activities. This information is provided so that your organization may begin to identify the participants that need to be involved in the survey. This activity list includes a column for your organization to use for recording participant names, possible meeting locations, or any other notes.

2. If your hospital has other programs being surveyed at the same time as your hospital, please consider including the following in your survey readiness plans:

   - Arrangements to have as much of the documentation from each program-specific information and document list as possible available at the hospital site for the Surveyor Arrival and Preliminary Planning Session.
   - Arrangements to have a representative from each program being surveyed available in-person or by phone for the Opening Conference and Orientation to the Organization session.

   Please plan to collaborate with your surveyor(s) to confirm the best day and time for specific survey activities to take place.

   Contact your Account Executive with any questions related to this information.
## Hospital Accreditation Survey Activity List

<table>
<thead>
<tr>
<th>Survey Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Suggested Scheduling of Activity</th>
<th>Organization Participants (Refer to Survey Activity Guide for more info.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyor Arrival and Preliminary Planning</td>
<td>30 – 60 minutes</td>
<td>1st day, upon arrival</td>
<td></td>
</tr>
<tr>
<td>Opening Conference and Orientation to the Organization</td>
<td>30 – 60 minutes</td>
<td>1st day, as early as possible</td>
<td></td>
</tr>
<tr>
<td>Surveyor Planning Initial</td>
<td>30-60 minutes</td>
<td>1st day, as early as possible</td>
<td></td>
</tr>
<tr>
<td>Individual Tracer</td>
<td>60-120 minutes</td>
<td>Individual Tracer activity occurs each day throughout the survey; the number of individuals that surveyors trace varies by organization. If travel is required to perform tracer activity (e.g., to an outpatient setting), it will be planned into this time.</td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>Issue Resolution</td>
<td>30 minutes</td>
<td>End of each day except last; can be scheduled at other times as necessary</td>
<td></td>
</tr>
<tr>
<td>Team Meeting/Surveyor Planning</td>
<td>30 minutes</td>
<td>Mid-day and/or end of each day except first and last</td>
<td></td>
</tr>
<tr>
<td>Daily Briefing</td>
<td>30-45 minutes</td>
<td>Start of each survey day except the first day; can be scheduled at other times as necessary</td>
<td></td>
</tr>
<tr>
<td>Competence Assessment</td>
<td>30-60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>Medical Staff Credentialing &amp; Privileging</td>
<td>60 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>Environment of Care</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>Emergency Management</td>
<td>60-90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>System Tracer – Data Management</td>
<td>60 -90 minutes</td>
<td>After some individual tracer activity has occurred; at a time negotiated with the organization. If this is the only system tracer taking place during survey, the topics of Infection Control and Medication Management will be</td>
<td></td>
</tr>
</tbody>
</table>
### Hospital Accreditation Survey Activity List

<table>
<thead>
<tr>
<th>Survey Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Suggested Scheduling of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization Participants</strong></td>
<td></td>
<td>(Refer to Survey Activity Guide for more info.)</td>
</tr>
</tbody>
</table>

**Leadership**
- **Suggested Duration:** 60 minutes
- **Suggested Scheduling of Activity:** Towards the middle or end of survey at a time negotiated with the organization

**Report Preparation**
- **Suggested Duration:** 60-120 minutes
- **Suggested Scheduling of Activity:** Last day of survey

**CEO Exit Briefing**
- **Suggested Duration:** 15-30 minutes
- **Suggested Scheduling of Activity:** Last day of survey

**Organization Exit Conference**
- **Suggested Duration:** 30-45 minutes
- **Suggested Scheduling of Activity:** Last day, final activity of survey

**Note:** The following activities may be incorporated into the survey agenda as noted under the Suggested Scheduling of Activity column.

- **System Tracer – Infection Control**
  - **Suggested Duration:** 60 minutes
  - **Suggested Scheduling of Activity:** Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred; at a time negotiated with the organization.

- **System Tracer – Medication Management**
  - **Suggested Duration:** 60 minutes
  - **Suggested Scheduling of Activity:** Occurs on surveys greater than three days in duration. After some individual tracer activity has occurred; at a time negotiated with the organization.

- **Interim Exit – w/ early departing surveyors & Org.**
  - **Suggested Duration:** 30 minutes
  - **Suggested Scheduling of Activity:** At the end of any day another program surveyor or Life Safety Code Specialist is departing from the survey in advance of the team.

**Life Safety Code® Survey Activity**

- **Life Safety Code Specialist Arrival and Preliminary Planning Session**
  - **Suggested Duration:** 30 minutes
  - **Suggested Scheduling of Activity:** LSCS survey 1st day, early

- **Facility Orientation/ Maintenance Document Review**
  - **Suggested Duration:** 60-90 minutes
  - **Suggested Scheduling of Activity:** At a time negotiated with the organization

- **Life Safety Code® Building Assessment**
  - **Suggested Duration:** 2 - 5 hours per day
  - **Suggested Scheduling of Activity:** At a time negotiated with the organization

- **Lunch**
  - **Suggested Duration:** 30 minutes
  - **Suggested Scheduling of Activity:** At a time negotiated with the organization

- **Facility Maintenance / Document Review (Critical Access Hospital ONLY)**
  - **Suggested Duration:** 60-90 minutes
  - **Suggested Scheduling of Activity:** At a time negotiated with the organization

- **Environment of Care & Emergency Management (Critical Access Hospital ONLY)**
  - **Suggested Duration:** 60-90 minutes
  - **Suggested Scheduling of Activity:** At a time negotiated with the organization
<table>
<thead>
<tr>
<th>Survey Activity Name</th>
<th>Suggested Duration of Activity</th>
<th>Suggested Scheduling of Activity</th>
<th>Organization Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Tracer / Issue resolution</td>
<td>30 minutes</td>
<td>At a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td><em>(Critical Access Hospital ONLY)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Preparation</td>
<td>60 minutes</td>
<td>Towards the end of last day of survey</td>
<td></td>
</tr>
<tr>
<td>Interim Exit</td>
<td>30 minutes</td>
<td>Last activity on last day of survey</td>
<td></td>
</tr>
<tr>
<td><strong>California Hospital—Unique Survey Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDPH – System Tracer – Medical Staff Functions/Regulatory Review</td>
<td>60 minutes</td>
<td>At a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>IMQ – System Tracer – Medical Staff Leadership</td>
<td>60 minutes</td>
<td>At a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>CDPH – System Tracer – Dietetic Service and Food Service Visit</td>
<td>60 minutes</td>
<td>At a time negotiated with the organization</td>
<td></td>
</tr>
<tr>
<td>CDPH – System Tracer – Pharmaceutical Services and Clinical Unit Inspection</td>
<td>60 minutes</td>
<td>At a time negotiated with the organization</td>
<td></td>
</tr>
</tbody>
</table>
### Suggested “Ready to Go” List

It would facilitate the survey process if the following items could be readily available to the surveyor on the first day of the survey:

- Performance improvement data;
- Infection control surveillance data;
- Environment of Care data including the:
  - Statement of Conditions (SOC) and Plans for Improvement
  - Management Plans and annual evaluations, if applicable
  - Environment of Care multidisciplinary team meeting minutes for the 12 months prior to survey; if applicable
- An organization chart;
- List of departments/units/areas/programs/services within the organization, if applicable
- Any reports or lists of patients (e.g., MDS patient roster) that will help in identifying individuals to trace;
- Name of key contact person who can assist surveyors in planning tracer selection
- Priority Focus Process (PFP) data; if applicable
- A map of the organization, if available.
Critical Access Hospital Accreditation Readiness Checklist

**Preparing for Accreditation**

_____ Obtain a current copy of the *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)*; call 630-792-5717 for details.

_____ Organize an interdisciplinary accreditation readiness team. Conduct a self-assessment to see where improvements need to be made.

_____ Distribute the CAMCAH to organization staff with responsibility for ensuring standards compliance. Review the standards and elements of performance. If you have questions on how standards are applied, you can call or e-mail our Standards Help Desk at 630-792-5900 or access the standards inquiry form on the Joint Commission website.

_____ Access current standards information and expectations on the Joint Commission website under “What’s New” at [www.jointcommission.org](http://www.jointcommission.org).

_____ Use the expertise of The Joint Commission’s affiliate to help prepare for accreditation. Joint Commission Resources (JCR) offers seminars, custom education, and numerous publications. Go to [www.jcrinc.com](http://www.jcrinc.com) for up to date information on available resources.

_____ Implement standards compliance into daily operations prior to the date of your on-site survey. Note specifically the following requirements which can be found in the current edition of the CAMCAH:

   _____ Demonstrate compliance with the National Patient Safety Goals.
   _____ Conduct a proactive risk analysis of at least one high-risk process as per standard PI.3.20
   _____ Conduct a Hazard Vulnerability Analysis (HVA) as per standard EC.4.10
   _____ Complete the Statement of Conditions (SOC)
   _____ Demonstrate compliance with the Staffing Effectiveness requirements
   _____ Conduct an Annual Evaluation of Environment of Care plans
   _____ Demonstrate compliance with the Public Information policy

**Applying for Accreditation**

_____ Request an *Application for Accreditation* by calling 630-792-5717

_____ Receive a password for accessing the application on your secure Joint Commission extranet site on Joint Commission Connect™.

_____ Submit the *Application for Accreditation* electronically
Mail the initial application deposit to The Joint Commission at PO Box 92775, Chicago, IL 60675, or pay by credit card by calling 630-792-5662.

Obtain the name of your assigned account executive who will help you throughout the accreditation process.

Review information on your Joint Commission extranet site including the Survey Activity Guide, which details on-site activities.

Receive password to access the JCR website (new applicants should receive this within 4-6 weeks of receipt of their application deposit). Review issues of Perspectives, which is the Joint Commission’s official newsletter accessible on the Joint Commission Resources web site, www.jcrinc.com. Any revisions or additions to policies, standards, survey process, etc. are published in this official newsletter, often up to a year in advance of taking effect.

Receive a customized on-site survey using the Tracer Methodology. After the survey, you will receive your final report, clearly outlining your organization’s performance. If you have any Requests for Improvement, you’ll need to present Evidence of Standards Compliance (ESC), generally within 45 and/or 60 days, to demonstrate the corrective measures that you have implemented. Once the ESC is accepted, your organization is accredited and your status is posted on the Joint Commission web site at www.qualitycheck.org.

Publicize your accreditation. A publicity kit is available on The Joint Commission Connect website that will show you many ways to publicize your accreditation status to the public you serve.