Changing the system
How one healthcare organization aligned eight hospitals under HFAP

After reading this article, you will be able to:
► Discuss the historical context of HFAP
► Describe the mix of accreditation programs used by Kettering Health Network prior to converting to HFAP
► Identify differences in accrediting body standards that were taken into account during Kettering’s research
► Describe the options for accreditation at the time of Kettering’s conversion to HFAP

The Healthcare Facilities Accreditation Program (HFAP) is often called “the quiet accreditor.” One of the small group of organizations granted deeming authority by CMS to accredit hospitals, HFAP has been a part of the healthcare accreditation landscape for over 60 years. But, much like its nickname indicates, the organization rarely makes a big splash in the headlines.

So how does an eight-hospital system decide to move its organization under HFAP’s accreditation process?

“We should start at the beginning,” says Christina L. Turner, MBA, MS, RN, NEA-BC, CPHQ, chief quality officer for Kettering Health Network in Dayton, Ohio. “Over the course of the last 12 years we have grown from two hospitals to eight. As we’ve added them, each hospital has come with different approaches to accreditation and different accrediting bodies.”

Until recently, accreditation has been handled individually by each hospital. As the processes already in place worked adequately, there was not an immediate need for change.

But about two years ago, one of Kettering’s board members called attention to a particularly discouraging survey one hospital had undergone.

“This was not because the hospital wasn’t prepared as far as that accrediting body’s standards were concerned, but because that individual hospital struggled somewhat with the CMS Conditions of Participation [CoP] validation survey,” says Turner.

After this particular survey, the board member suggested a more standard approach to accreditation across the system.

“We are an organization that subscribes to the Baldrige framework for management processes,” says Turner. “One of the key concepts is you take best practices to drive improvement efforts. You learn from those efforts, pilot small tests of change, standardize...
what works, and spread those improvements across the organization. This allows us to expedite our improvements and standardize what works well.

One area to which Kettering had not yet applied that process was accreditation.

“We pulled together an interdisciplinary group with representatives from all of our hospitals. Included in this group were the individuals who were campus leaders for accreditation,” says Turner.

The group, chartered by Turner and comprising several nurses, a few physicians, and various accreditation professionals, fell under the purview of quality.

“We came together and talked about the different pros and cons of each accreditation organization,” says Turner. They created a decision grid, which looked at such concepts as:

- Survey cycles
- Cost
- Available resources
- Educational opportunity
- Alignment with CMS CoPs

The group explored the three approved accrediting bodies at the time, The Joint Commission, HFAP, and Det Norske Veritas, Inc. (DNV), and weighed the advantages and disadvantages—their philosophies, their survey processes, and more.

Note: As of April, the Accreditation Association for Ambulatory Health Care has launched an accreditation organization for hospitals.

“One of the drivers we looked at was cost,” says Turner. “We saw this as an opportunity to look at where we had each hospital with its own process and create a centralized function and knowledge sharing across the system. In a time where reimbursement is changing and the public is asking us to be more accountable for the money we spend, sharing resources, expediting improvement, and standardizing our approach were all of huge importance.”

Alignment with the CoPs

The next focus area for the group was how each hospital aligned with the CoPs.

“One of the biggest surprises came when we started looking at the standards and how they were measured, and how far off from the CoPs they were, or how many extra or additional things that were not related to patient safety, quality initiatives, or the CoPs that were included in the standards,” says Turner. “When you start looking at value-added work, there seemed to be a lot of things that weren’t related to those areas.”

The number of accreditation body-specific standards that couldn’t be tied back to those additional areas was surprising, she says.
“Those are the things when you look at preparing for survey that take extra time,” says Turner. “It’s hard to explain to staff why they are important. The purpose of accreditation is to demonstrate that the organization has met the requirements to provide safe care. When you get criteria that aren’t tied to that, it becomes bureaucratic."

**The surprise move**

At the time, Kettering consisted of six Joint Commission–accredited facilities and two HFAP-accredited facilities. Several had been exploring moving to DNV and had begun the research process, but none had yet made the jump.

“It would seem like the preconceived notion of people who knew we were embarking on this process was that we would move to The Joint Commission,” says Turner. “The majority of our facilities were already Joint Commission accredited and the biggest two hospitals among the eight were with The Joint Commission. It would have been easier to move two hospitals to The Joint Commission."

Or so one might think.

But the Kettering system did something unexpected: It resolved to shift all eight hospitals under the HFAP umbrella.

“The biggest factor overall was alignment to the CoPs,” says Turner.

When looking at the standards as they existed in 2009, she says, The Joint Commission’s standards were derived from the CoPs (i.e., they could be connected back to the CoPs), but the accreditor also had standards that were not directly tied back in this fashion. HFAP’s standards were laid out in the same format as the CoPs and were simpler to trace back to the source.

“They used the exact same language as CMS,” says Turner. “There was no room for interpretation or finessing the standard back to the CoP it related to.”

The team was also impressed with how HFAP explained what it was looking for, laying out evidence of compliance in a road map for the survey itself.

“It’s very easy for us to have our accreditation team go through the organization, through the standards, and tell exactly the best practice to get us to compliance and where we are not meeting the standard and why,” says Turner.

Turner and her team also identified HFAP’s nod to the National Quality Forum’s recommendations.

“It makes it very easy when you’re trying to connect the dots, explaining why it is important to us and our patients,” she says.

**Bringing in the accreditors**

Kettering’s decision was nearly final when it reached out to HFAP directly. The system sat down with leaders from the accrediting body and discussed where it was in its decision process.

One of the trickiest parts of changing accrediting bodies—whether DNV to Joint Commission, Joint Commission to HFAP, or any other combination of moves—is timing the transfer.

“We wanted to make sure we didn’t have any more overlapping time than we had to,” says Turner. “We tried to time it so that we would know what our accreditation status was and if we were terminating with The Joint Commission we could serve the proper 90-day notice and not pay for the next survey.”

Kettering did not, however, reach out to The Joint Commission until it had all of its plans in place.

“We’d talked to other organizations who had moved away from The Joint Commission and we had a lot of feedback from them to delay that notification as long as possible. The feedback was that early notification could create a lot of additional and unnecessary work,” notes Turner.

---

“It’s not punitive, and because it connects back to the CoPs, it’s not an interpretation, it’s exactly what you need to comply. It’s been a really positive experience.”

—Christina L. Turner, MBA, MS, RN, NEA-BC, CPHQ
Organizations must have a plan in place to address any deficiencies in their last survey, and Kettering didn’t want to have to manage a correction with The Joint Commission while simultaneously transitioning to HFAP. That being said, however, Turner notes that The Joint Commission’s reaction to Kettering’s decision was gracious and involved none of the problems other organizations had mentioned.

“Maybe it was urban myth, but once they knew we were leaving we didn’t have any of the problems other organizations had talked about,” says Turner. “We did have a phone call with them, and they wanted to know if there was anything they could do to change our minds, and what they could do better, as well as what it might take for us to come back.”

Prior to the phone call with Joint Commission representatives, though, the organization was concerned about drawing undue attention to itself and the switch.

“We struggled with that. We wanted to be very transparent and have very open conversations with our staff and leadership, but we were concerned that information would get back to The Joint Commission and out in the community and open us up to an increased level of scrutiny,” says Turner.

**Resistance, or lack thereof**

It was interesting, says Turner, that the mandate to investigate a move to one accrediting body for the network didn’t spur a lot of resistance.

“We kept everyone involved all along the way,” she says. “We let them know what the comparisons were telling us, where we had risks.”

Of course there must have been grumblings somewhere in the organization, but there was no public outcry or active resistance to the move.

“I’m sure there were people who were upset. Most people don’t like change,” says Turner. “But I think we did a really good job of demonstrating why we made this decision.”

One challenge Turner did find in advocating the transition was HFAP’s lack of public notoriety.

“HFAP has been around a long time, but by and large we’ve found lots of places aren’t aware of who they are or that they’ve been around so long,” she says.

The Joint Commission and DNV have a higher level of visibility for a variety of reasons, Turner notes.

“It was something I wasn’t prepared for,” she says. “We were aware of them, but it’s been surprising how few people are familiar with HFAP.”

Another matter of confusion is HFAP’s connection to the American Osteopathic Association (AOA). “Those who were somewhat familiar with HFAP still associated them with osteopathic hospitals,” says Turner.

While HFAP falls under the AOA as a business, it is not an osteopathic-specific accreditor or survey process. The vast majority of its physician surveyors are, in fact, MDs rather than DOs.

Since making the transition, Kettering has seen one particular improvement that has left leadership very pleased: a better understanding among staff regarding the CoPs.

“We had had other hospitals go through successful surveys with other accrediting bodies who weren’t able to speak well to the CoPs during a CMS survey,” says Turner. “They could speak to the standards, but weren’t able to trace it back.” A particular hospital would perform impressively during the accreditation survey, but during its CMS validation survey, that same facility would struggle.

This has improved since bringing all facilities under HFAP. In addition, Kettering has seen the benefits it hoped to see. The knowledge gained from each survey was evident because changes from previous survey recommendations were incorporated across the system.

“I have to tell you, having gone through different surveys—they’re never fun. You are descended upon by surveyors and they look in every nook and cranny. But [the HFAP process] is truly an educative process,” says Turner. “It’s not punitive, and because it connects back to the CoPs, it’s not an interpretation, it’s exactly what you need to comply. It’s been a really positive experience.”