How did the Healthcare Facilities Accreditation Program (HFAP) start? What’s its current vision? How many client healthcare facilities do you have?

That’s a bunch of questions. Let me take them one at a time. The Healthcare Facilities Accreditation Program is certainly not a new kid on the block. HFAP was founded in 1943 and began surveying hospitals in 1945. We are, in fact, the oldest, continuous hospital accreditation organization in the United States.

In 1965, when Congress established Medicare and decided that an accredited hospital would be “deemed” to meet the Medicare Conditions of Participation, HFAP was the first accreditation organization to apply for and be granted “deemed” status. We have been a deemed organization continuously since 1965. We meet or exceed the standards required by the Centers for Medicare & Medicaid Services (CMS) to provide accreditation to acute and critical access hospitals, clinical laboratories, ambulatory surgical centers, mental health and physical rehabilitation facilities, and we provide certification in both primary and comprehensive stroke care.

What does that mean for HFAP’s future goals?
HFAP has always been a nimble organization, able to assimilate standards that have demonstrated clinical and quality improvement and do that in a short period of time. Several years ago, the American Osteopathic Information Association (AOIA) was formed to allow business entities of the AOA to act more independently and with fewer restrictions that are placed on membership organizations.

What that means for HFAP is that we have a board that is solely dedicated to our growth and advancement as an accreditation organization. Our governance is now stronger and more focused than ever before.

Could you tell me a bit about your background? How did you come to HFAP?
I came to HFAP as the chief operating officer in October of 2012, and brought with me many years of experience in the accreditation and quality arena. Prior to my appointment with HFAP, I served as chairman of my own consulting company, an organization that provided clients with a range of high-profile services, such as organizational assessment for compliance with current accreditation standards, change-management interventions and leadership development, to emergency preparedness at the local and system level.

Beginning in 1997 and extending to 2009, I worked at The Joint Commission as the vice...
president for accreditation field operations, directing key internal functions as well as the 500-member field surveyor cadre. I have directed quality and medical staff services at large academic medical centers and smaller community hospitals literally all over the world. I spent a number of years in the military as a Navy nurse corps officer.

When I was approached about this position, it took me about two seconds to make up my mind to return to the accreditation arena. The long history of HFAP, the support of the AOA, the opportunity to grow this organization into a recognized and sought after accreditor, and the ability to infuse competition into the accreditation world were some of the reasons I chose to join HFAP. It is a remarkable organization that can easily adapt to the constantly shifting healthcare environment. It is an organization respected, not feared, by the facilities it accredits and one that prides itself in the educational and collegial manner in which we function.

What would you say is HFAP's biggest lure when it comes to getting more hospitals to sign up with it as an accreditation organization?

Well, first of all they have to know about us. We have been the silent accreditor for too long, and many organizations, dissatisfied with the relationship they have with their current accreditor, are finally starting to learn about us. Our evolving recognition is a result of the “word of mouth” reputation passed between senior executives. We have plans in development to go beyond that and create a national awareness based on achievement and recognition.

To your question, our standards are tightly aligned with the Medicare Conditions of Participation, so that our accredited organizations know that if the state or federal government enters their facility for any reason, they can be confident that they are compliant with all required standards. Second, our standards are written in a straightforward, easy-to-understand manner. We strive to be unambiguous. Third, our survey process is nonpunitive, and is designed to be educative and consultative. And finally, there is the financial bottom line. We deliver more value for less cost than any comparable accreditor.

Could you give me a general sense of how the survey process works with HFAP?

We believe that at its core, accreditation is a risk-reduction strategy. If you are compliant with 100% of the standards 100% of the time, the likelihood of bad events occurring is diminished—not eliminated, but diminished. Accreditation is a means to mitigate risk. If you embrace that philosophy, then the more thorough you are in evaluating the standards, the greater benefit you provide to the organization. That is why, unlike any other accreditor, we evaluate every standard on every survey. We don't sample the standards; we review every one for compliance.

How could a healthcare facility, and specifically a healthcare technology management (HTM or clinical engineering) department, best prepare for a survey?

First, and I know this sounds a bit simplistic, read the standards that are applicable to your department. You would be surprised that many responsible professionals believe they know what the standards require, but have never really read the manual and embraced the standards. Second, be sure you understand what the standards are asking of you. If you are unsure, call our Standards Interpretation Department. Also keep in mind that the standard requirement is a minimum baseline. You have to do at minimum what the standard requires. If you have a policy that requires a higher level of performance, you will be held to the higher or more demanding requirement that you set for yourself.

Have HFAP surveys found a common problem or two that most healthcare facilities wrestle with? If so, what are they and how can facilities best address them?

I would say that the most common problems we find are in the area of the Life Safety Code. Facilities are complex, constantly under construction and modification, and the codes are often misinterpreted by

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organizations. Often there are conflicts between various authorities having jurisdiction rendering differing opinions on what constitutes compliance. The best way to address these problems is to start with a facilities staff that is knowledgeable and grounded in the code, develop a strong relationship with the authorities having jurisdiction over your organization, and establish a strong program of self-assessment and inspection to identify potential problems. Work with your accreditation organization to develop a consultative relationship with them and seek their guidance in addressing problems and seeking waivers.

One of the biggest issues for HTM departments is preventive maintenance (PM) policies and practices. That debate flared anew with CMS’ December 2011 memo, which called for hospitals to follow manufacturer recommendations with maintenance schedules. Many HTM departments say they’ve long established and followed their own maintenance practices—safely and effectively. How do you view this debate, and what’s your advice to hospitals wrestling with this issue?

HFAP recognizes that healthcare organizations have for a long time established medical equipment PM practices and frequencies that are based on a historical-evidence strategy. This strategy may or may not be consistent with the manufacturer’s recommendations, but is based on utilization, application, and predictive use.

CMS stated in the Dec. 2, 2011 Survey & Certification Letter 12-07-Hospital that hospitals may adjust their maintenance, inspection, and testing frequencies on equipment considered noncritical to patient health and safety and which has a maintenance history to the organization—provided such schedules are based on an assessment of the risk to patient health and safety. The CMS memo specifically states alternative equipment maintenance methods are not permitted, although later statements from CMS do allow alternative test equipment.

Through accreditation activities, HFAP is dedicated to partner with healthcare organizations to mitigate the risk of potential injury and illness to patients through inadequately maintained medical equipment. Our position as an accredited organization is to not only assess healthcare organizations for compliance with applicable standards, but to also work with and influence the position of CMS and other standard-writing groups when their standards are archaic, unreasonable, or out of date. Be assured that HFAP has already taken action, along with other accreditation organizations and professional membership groups, to discuss and influence CMS’s position on equipment PM methods and strategies. As a result of these activities, CMS has decided to re-examine S&C letter 12-07-Hospital, to determine if historical-evidence strategies are indeed an acceptable approach to equipment PMs.

In the meantime, HFAP is committed and obligated to survey healthcare organizations to be in compliance with not only HFAP standards, but also the CMS Conditions of Participation and standards. Until such time CMS issues a new memo approving alternative approaches to equipment maintenance, HFAP will require healthcare organizations to be in full compliance with the provisions of S&C Letter 12-07-Hospital. If cited, healthcare organizations may apply for a waiver to allow them to use maintenance methods and frequencies that are less than the manufacturer’s recommendation.

Do you see the PM debate speaking to a bigger issue?

Well, I think it does lead to a bigger issue and one that we have struggled with for years. While we are an accreditation organization responsible for the evaluation of our organizations, we are also an advocate for those same organizations. We are in constant communication with CMS to support the adoption of policies and practices that benefit the public, that raise the quality bar at our organizations, and that provide a safe, error-free environment. One might think that the two roles are incongruous but they are not. They are really quite complementary.
Unfortunately, the experience we have through our accredited organizations does not always carry the weight we would wish when trying to influence policy at CMS. Organizations need to know that we are constantly advocating for common sense and a practical approach to policy and regulation.

**The delivery of healthcare has become increasingly intertwined with information technology and computer networks. How has that changed the accreditation process for hospitals and other healthcare facilities, and what other changes can be expected?**

I think the promise of technology, and with the advent of the electronic medical record, that we all thought that by this time we would have systems that seamlessly interfaced and provided and uninterrupted flow of data and information. We all know that hasn’t happened and probably won’t in the foreseeable future. But the way we collect and manage information in hospitals has changed dramatically. For starters, hospitals are acutely concerned about privacy issues and so are we as an accreditor. During a survey, we will explore how data of all types—not just patient or clinically focused data—is collected, shared, stored, and secured. During the survey, we may need dedicated staff members to help us navigate your electronic health record if you have one. We will ask about and evaluate telemedicine services that may have been established in your organization. We will also want to know how the loss or interruption of power impacts your ability to render care.

**Do HFAP surveys look at the “meaningful use” of electronic health records in any way?**

“Meaningful use” is a term created by the federal government that links certain specified activities to financial incentives. Meaningful use criteria in the American Recovery and Reinvestment Act (ARRA) give healthcare providers financial incentives to improve patient care, reduce costs, and create the infrastructure and processes to realize the full value of integrated health records. Neither CMS nor any other hospital accreditor has constructed standards that address criteria contained in the ARRA.

**What about the security of medical devices and systems in the cyberworld? Is that examined in surveys?**

As I said a bit earlier, cybersecurity is rapidly approaching physical security. Medical devices keep getting “smarter” and the amount of protected data they might store continues to grow. We look at these issues and specifically the plans, programs, and oversight that the organization exercises in this area.

**What's the biggest change you’ve seen in your career in terms of how hospitals are organized and operated?**

I have long maintained that when you have seen one hospital, you’ve seen one hospital. In this era of alignment strategies, mergers and acquisitions, employed physicians, and ever-evolving reimbursement schemes, every hospital has its unique challenges. I believe that if a hospital can’t deliver higher quality care for a lower cost, it won’t exist in five years. I further believe that the role of an accreditor is to help them achieve those goals. Accreditation standards must serve as impetus to elevate the quality and safety bar, but do so in a manner that takes into account the uniqueness of every hospital.

**What's the biggest challenge that hospitals and other healthcare facilities face over the next decade?**

You certainly can’t discount the impact that the Affordable Care Act will have on hospitals. That’s a work in progress that will evolve over time. And you have to take into account that hospitals have traditionally been incented to fill beds to generate revenue, but I believe that is about to change. Accountable Care Organizations (ACOs) are evolving, but with inconsistent adoption and support. And perhaps the biggest trend is for hospitals to move from provider-facing organizations to consumer-facing organizations. Sum that all up, and you have a murky picture of what the future holds. My belief is that hospitals that are not nimble and able to execute efficiently will face a very uncertain future.