The 2014 Joint Commission Medical Staff Standards Update

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The TJC Medical Staff Standards Update 2014
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Objectives
• Review the top ten standards in the medical staff chapter that were scored in 2013
• Review of processes that have been used as solutions to the “top ten”
• Review what’s new as of July 2014
• A look ahead to 2015
MS.01.01.01

- EP 3: Most commonly scored EP, must be scored if one of EPs 12-36 is scored
  - History, Physical and Updates defined at a minimum of what is contained at PC 01.02.03 EPs 4,5

MS.01.01.01

- EP 16: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

MS.01.01.01

- EP 16: Note 2: The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.
MS.01.01.01

- EP 4: The medical staff bylaws, rules and regulations, and policies, the governing body, bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation.

MS.01.01.01

- EP 5: The medical staff complies with the medical staff bylaws, rules, and regulations.

MS.01.01.01

- EP 10: The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy, or amendment thereto.
MS.01.01.01

- EP 21: The process, as determined by the organized medical staff and approved governing body, for selecting and/or electing and removing the medical executive committee members

Associated standards . . .

- **EM 02.02.13 EP 2**  The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.

Associated standards . . .

- **EM 02.02.13 EP 3**  The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. (Usually in the Emergency Operations Plan)
Associated standards . . .

**EM 02.02.13 EP 4** The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).

Associated standards . . .

**EM 02.02.13 EP 5** Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) **AND** at least one of the following:

- A current picture identification card from a health care organization that clearly identifies professional designation
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster
- A current license to practice
Tips for Success

- Take a copy of the bylaws and the standard EPs 12-36 and tab where each of the EP’s is located
- If the details of any of EPs 12-36 are in other areas such as the rules, regs, or policies, keep these handy and updated.
- Keep these updated every time bylaws, etc., are revised

Check your knowledge....

- TRUE or FALSE....
- If your medical staff decides to include the rules and regulations as an article of the bylaws, it is in compliance with the standards to maintain different methods of amending the rules and regulations versus the bylaws.

MS.08.01.03

- EP 3 Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s)
MS.08.01.03

- EP 1: There is a clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice

MS.08.01.03

- EP 2: The type of data to be collected is determined by individual departments and approved by the organized medical staff.

Tips for Success

- Develop a spreadsheet of all of your practitioners and when their OPPE is due.
- Send a list to dept. chairs every month to remind if you don’t have a current OPPE on file.
- Be sure to include allied health practitioners
Tips for Success

- If you are using OPPE that includes activity numbers, it is a good idea to have available the case logs in case the credentials committee has a question about the outcome.

Check your knowledge...

- TRUE or FALSE
- If you are not able to gather data on the allied health practitioners because their activity is billed under the sponsoring physician, your TJC surveyor will be able to accept this and will not score this process as non-compliant.

MS.03.01.01

- EP 16 the medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.
MS.03.01.01

EP 17  For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director’s specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

MS.03.01.01

- EP 7  The organized medical staff monitors the quality of the medical histories and physical examinations.

MS.03.01.01

- EP 2  Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.
Tips for Success

- Keep track of dates of MEC minutes for radiology approvals. Ask radiology director to notify you if service changes.
- Encourage medical staffs to develop audit tool for H and P's and review these regularly and track data and actions taken.
- Check applications carefully for possible omissions or oversights.

Check your knowledge...

- TRUE or FALSE...
- If the histories and physicals are reviewed by the medical records (HIM) department for being complete, the medical staff must also have a mechanism to review the histories and physicals for quality to be compliant with TJC standards.

MS.08.01.01

- EP 1 A period of focused professional practice evaluation is implemented for all initially requested privileges.
  - Usually results from a lack of documentation of the practitioner’s performance in a timely manner.
  - Other reason for scoring is no evidence of process for allied health practitioners.
MS.08.01.01

EP 3 The performance monitoring process is clearly defined and includes each of the following elements:
  – Criteria for performance monitoring
  – Method for establishing a monitoring plan specific to the requested privilege
  – Method for determining the duration of performance monitoring
  – Circumstances requiring an external source

MS.08.01.01

EP 4 Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.

Tips for Success

• Establish the FPPE process during the credentialing process.
• Send out an attached copy of the FPPE with the practitioner’s board letter
• Keep a spreadsheet of all currently in FPPE, reminders to reviewers
• Follow through on process and feedback in a timely manner
Check your knowledge…

• TRUE or FALSE…
• If you have a practitioner that begins actively practicing in your organization in November and your TJC survey is in March of the following year, the surveyor will expect to see some data or outcomes regarding the practitioner’s FPPE at the time of survey.

MS.06.01.03

• EP 6 The credentialing process requires the hospital to verify in writing and from a primary source or CVO:
  – Current licensure at time of appointment, reappointment, new privilege request, and license expiration.
  – Relevant training
  – Current competence

MS.06.01.03

• EP 5 The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
  – Current picture hospital ID
  – A valid government issued photo ID
Tips for Success

- Spreadsheet and reminders for license or other certification renewals
- Process of going up the chain of command
- Make sure there is verification of current competence in some way: provide privileges to those who are completing references

Check your knowledge…

- TRUE or FALSE…
- There are four times when primary source verification must be done: at the time of appointment, reappointment, application for new privileges and prior to license expiration.

MS.05.01.03

- EP 3 The organized medical staff participates in the following activity: Accurate, timely, and legible completion of patient’s medical records.
  - How is the medical staff informed of issues, what is the process for outliers?
  - In EHR: may be how scribes are used or if an excessive number of telephone orders?
Associated standards …

- **RC.01.02.01 EP 3** If unable to tell who documented in the medical record: i.e. a history and physical completed in a physician’s office that is clearly written by someone other than the individual who signed it; basically acted as a scribe.

Associated standards . . .

- **RC.01.01.01 EP 8** If there are instances of illegibility that cannot be read by staff members, then it will be scored here. This is because the information is not available to the next provider of care.

Check your knowledge….

- TRUE or FALSE…
  - The Standards Interpretation Group of the Joint Commission has addressed the issue of scribes directly in the standards.
MS.06.01.05

- EP 2  The hospital, with the approval of the medical staff and board, develops criteria that include:
  - Current license and/or certification
  - Documented training
  - Physically able to perform privilege
  - Data from org. where currently performing privilege
  - Peer/faculty recommendation
  - When renewing, check current performance

MS.06.01.05

- EP 3  All of the criteria used are consistently evaluated for all practitioners holding that privilege

MS.06.01.05

- EP 7  National Practitioner Data Bank query at appointment, reappointment, and if requesting a new privilege.
MS.06.01.05

- EP 10 The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

Tips for Success

- Develop solid criteria and use it as a checklist during the credentialing process.
- At the time of reappointment, ensure that you have documentation of the performance of a privilege.
- Pre-populate the privilege forms with the number of times each privilege has been done and outcomes.

Check your knowledge…

- TRUE or FALSE…
- A practitioner can be granted the same privileges every two years at reappointment as long as he or she has never needed a peer review due to a bad outcome.
MS.06.01.07

- EP 9 Privileges are granted for a period not to exceed two years
- EP 5 The hospital's privilege granting/denial criteria are consistently applied for each requesting practitioner

Tips for Success

- Watch how letters are sent out, be sure to not exceed the two year window.
- Be alert during credentialing process, remember FPPE can be different depending on level of experience but the initial criteria should be consistently applied.

MS.06.01.01

- EP 1 There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege
Tips for Success

- Review privilege lists regularly with medical staff
- Keep open lines of communication with directors of departments to get updates if services change

MS.06.01.13

- EP 1 Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.

Tips for Success

- Be sure that temporary privileges are granted for the purposes described in the standard
Check your knowledge…

TRUE or FALSE…
- Temporary privileges can be granted for the convenience of the practitioner even though the service line can be covered in his/her absence.

Medical Staff and Leadership: PI and Quality

- The two should not be mutually exclusive nor functioning in silos.

Medical Staff and Leadership: PI and Quality Survey Expectations

- In order to show compliance with MS 05.01.01 the surveyors should be able to discern from meeting minutes and discussion with physicians that there is significant medical staff involvement in performance improvement.
Medical Staff and Leadership: PI and Quality Survey Expectations

- From a leadership perspective, the organization's administration, in partnership with the medical staff, should be able to show how an organization-wide patient safety program has been implemented as delineated in LD.04.04.05. This will be assessed through the review of minutes and the leadership session.

Survey Process Changes

2014

Key Elements of the Survey Process

1. Methodology for assessing standards compliance: individual tracer methodology and system tracer methodology
2. User friendly process with participation encouraged by all
3. Focus is on systems, not on individual
4. Onsite activity influenced by ICM Profile and Client Value Assessment Tool (NEW!)
   (Used to have Priority Focus Areas and Clinical Service Groups)
NEW!! - Report Changes

- Statement of Conditions
  - The number of open PFIs will be referenced in preliminary report on site; the final report ten days later will have all open PFIs listed with completion dates.
  - All PFIs should be related to Life Safety chapter

NEW!! – Report Changes

- Statement of Conditions
  - If open PFIs are not resolved within 6 months post the completion date, the standards interpretation group engineers will get a notice and will call the organization to follow up and determine if the delay is warranted.
  - The possibility of an onsite revisit exists if deemed necessary.

NEW!! – Report Changes

- There will be a new section on the report called: “Opportunities for Improvement”
  This section will consist of any “C” category element of performance with only one observation.
  There is no requirement to submit an ESC for any findings in this section.
- Standard MS.03.01.03 The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

  EP 13. For hospitals that use Joint Commission accreditation for deemed status purposes: Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital.

- MS.06.01.05 The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

  EP 15. For hospitals that use Joint Commission accreditation for deemed status purposes: The surgical service maintains a current roster listing each practitioner’s surgical privileges.

  • Note: The roster may be in paper or electronic format
NEW! – July 2014

- **PC.03.01.01 EP 10** For hospitals that use Joint Commission for deemed status purposes:
  - In accordance with the hospital’s policy and state scope-of-practice laws, anesthesia is administered only by:
    - An anesthesiologist’s assistant supervised by an anesthesiologist who is immediately available if needed.

On The Horizon….

What’s coming next….  
- Proposed new standards that completed field review stage of evaluation.
- Once the field review comments were compiled, TJC opted to delay implementation for one year for review and revision
- Likely to be very similar to original format since based on American Board of Radiology requirements
For hospitals that provide computed tomography (CT) services: At the time of granting initial privileges, the hospital verifies and documents that a radiologist who interprets CT exams is board certified in radiology or diagnostic radiology by the American Board of Radiology, American Osteopathic Board of Radiology, or an equivalent source. If the radiologist is not board-certified, then the hospital verifies and documents that he or she has achieved the following qualifications and experience:

- Completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) diagnostic radiology residency
- Performance and interpretation of 500 CT examinations in the past 36 months

For hospitals that provide computed tomography (CT) services: Upon renewal of privileges, the hospital verifies and documents that a radiologist who interprets CT examinations has the following experience:

- The radiologist meets the Maintenance of Certification (MOC) requirements of their certifying body.
- A radiologist reading CT examinations across multiple organ systems has read 135 exams in the past 24 months.
- A radiologist reading organ system-specific CT examinations (for example, abdominal, musculoskeletal, head), has read a minimum of 40 organ system specific CT examinations in the past 24 months. In addition, he or she must have also read a total of 135 cross-sectional imaging studies for MRI, CT, PET/CT and ultrasound in the past 24 months.

For hospitals that provide computed tomography (CT) services: Upon renewal of privileges, the hospital verifies and documents the ongoing education of a radiologist who interprets CT examinations. Ongoing education must include As Low As Reasonably Achievable (ALARA), Image Gently, Image Wisely, and one of the following:

- Meeting the Maintenance of Certification (MOC) requirements of their certifying body
- Completing 100 hours of relevant continuing medical education (CME) in the past 24 months; this must include 50 hours of Category 1 CME
- Completing 10 hours CME in the past 24 months specific to the imaging modality or organ system
Questions?