2015 Medical Staff Standards Update Panel featuring TJC, NCQA, URAC, DNV, CIHQ and HFAP

Session Code: TU02

Time: 8:00 a.m. – 9:30 a.m.

Total CE Credits: 1.5

Presenter: Karen Beem, MS, RN, Richard Curtis, RN, MS, HACP, Sandra Greenawalt, RN, BSN, MCHA, CCM, CCP, CPHQ, Patrick Horine, MHA, Frank Stelling, MEd, MPH, Ronald Wyatt, MD, MHA, and Traci Burgkwist, RCP, HACP
2015 Medical Staff and Credentialing Standards Panel Discussion Featuring:

- National Committee for Quality Assurance – Frank Stelling, MEd, MPH
- Healthcare Facilities Accreditation Program – Karen Beem, MS, RN
- The Joint Commission – Ronald Wyatt, MD, MHA
- Utilization Review Accreditation Commission – Sandi Greenawalt, RN, BSN, MCHA, CCP, CPHQ
- Det Norske Veritas Healthcare, Inc – Patrick Horine, MHA
- Center for Improvement in Healthcare Quality - Traci Burgkwist, RCP, HACP

Moderator – John Pastrano, BBA, CPMSM, CPCS

Objectives

- Top 3 Things You Should Know
- Facilitated Question & Answer Panel Discussion

Introductions

THE PANEL

- National Committee for Quality Assurance – Frank Stelling, MEd, MPH
- Healthcare Facilities Accreditation Program – Karen Beem, MS, RN
- The Joint Commission – Ronald Wyatt, MD, MHA
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Types of Practitioners
Licensed independent practitioners (physicians and non-physicians) who provide care for members AND:
• Have an independent relationship with the organization (Directs members to see the practitioner).
• See members outside of an inpatient hospital setting or ambulatory free-standing facilities
• Are hospital-based AND see members as a result of independent relationship with organization
• Are oral surgeons

Use of an agent
• Entity that contracts with an approved source to provide requested credentialing information
• This contractual relationship must entitle the agent to provide verification of specific credentials on behalf of the primary source
Non-discrimination

Policies and procedures must address the following:
• Non-discrimination based on gender, race/ethnicity, age, sexual orientation or types of patients seen (e.g. Medicaid)
• Process for preventing discrimination
• Process for monitoring discrimination

Verification of Board Certification (Initial and Recred) – New Requirement for 2014

• Whether certification meets education and training requirements or not
• Must be verified if practitioner states that he or she is board certified
• Sources
  • ABMS or ABMS Agent
  • AMA Masterfile
  • AOA Profile Report or Physician Masterfile
  • Confirmation from specialty board
  • Confirmation from non-ABMS or non-AOA specialty board (w/proof of primary verification)
  • Confirmation from state licensing agency (w/proof of primary verification)

Questions?

Frank Stelling, MEd, MPH
stelling@ncqa.org
History of HFAP

• The Healthcare Facilities Accreditation Program (HFAP) was founded as a division of the American Osteopathic Association (AOA).

• The AOA / HFAP has accredited hospitals since 1945. Initially, the purpose was to evaluate training sites of the Osteopathic Residency Programs.

• HFAP has accredited hospitals and other healthcare facilities since the inception of Medicare in 1965.

Who We Are

• The Healthcare Facilities Accreditation Program (HFAP) was the first Accreditation Organization (AO) to achieve this CMS recognition.

• HFAP accredits both:
  • Deemed Status
  • Non-deemed Status
Who Does HFAP Accredit?

HFAP Accredits BOTH:

- Osteopathic Hospitals
- Allopathic Hospitals

Acute Care Hospitals include:
- Physical Rehabilitation, Specialty, and LTCHs (Long Term Care Hospitals)

HFAP Accreditation Programs

- Critical Access Hospitals
- Ambulatory Surgical Centers
- Ambulatory Care / Office Based Surgery / Physical Therapy Centers
- Behavioral Health Facilities
- Clinical Laboratories

HFAP Certification Programs

Stroke Certification:
- Comprehensive Stroke Centers
- Primary Stroke Centers
- Stroke Ready Centers

Lithotripsy Certification
Diabetes Certification
Heart Failure Certification
Wound Care Certification
Joint Replacement Certification
How Does HFAP Align With CMS?

• HFAP mirror CMS regulations
• HFAP standards are cross-walked to the Medicare CoPs
• Approximately 80% of HFAP hospital standards reflect Medicare regulations

HFAP Standards Reflect

• CMS Code of Federal Regulations (CFR)
• CMS Final Rule – May 2014
• Current Interpretative Guidelines
• Current Survey & Certification Memos

Sample HFAP Standard
What’s New?

New Medical Staff Requirements:

1. Governing Body Periodically Consults with the Medical Staff (01.01.10)
   • Minimum of 2/ year

2. Unified and Integrated Medical Staff For Multiple-Hospital Systems
   • Joint Decision: Governing Body & Medical Staff by Vote
   • See standards 01.00.33; 03.00.10 through 03.00.15

What’s Changed?

03.00.01 Eligibility and Process for Appointment to MS
Consistent with State law:
A. The Governing Body determines types / categories:
   1) Physicians, and if it chooses,
   2) Non-physician Practitioners (NPP)
B. The Governing Body has authority to appoint non-physician practitioners to the medical staff

How is this Interpreted?

• All practitioners who require privileges in order to furnish care to hospital patients must be evaluated under medical staff privileging process
• All practitioners granted privileges must function under the bylaws, rules and regulations of the medical staff
• Privileges granted must be consistent with State Scope of Practice laws
Who is Eligible for Privileges?

Consistent with State law, may grant privileges:

- NP, PA, CRNA, CNM
- Clinical Psychologists
- Clinical Social Workers
- Anesthesiologist’s Assistants
- Registered Dietitian / Nutrition Professional
- OT, PT, SLP
- Pharmacists

Non-physician Practitioners

1) Old terms: Allied Health Practitioners
   - Mid-levels
   - Physician Extenders

2) Credentialing and Privileging requirements for NPP are same as for Medical Staff –
   - Submit Application / Request Privileges q 2 years
   - OPPE / FPPE
   - Chapter 2: Retired

What are the Trends?

Consistent with State Laws and Scopes of Practice:

1) Privileges to Write Orders*
   - Respiratory Therapy Services
   - Therapeutic Diet Orders & Supplements
   - Pharmacy

*At recommendation of the medical staff per medical staff credentialing and privileging process
What are the Trends?

2) Orders for Outpatient Services per medical staff policy approved by Governing Body

   a) Flexibility to determine practitioners eligible to write orders:
      • Practitioners on the medical staff with privileges
      • Practitioners NOT on the medical staff
      • Out-of-State Practitioners

What are the Trends?

2) Orders for Outpatient Services – Policy (cont’d)

   a) Flexibility to Restrict Orders for Outpatient Services to members of the medical staff
      • Chemotherapy
      • Nuclear Medicine
      • Others

   See Standard 31.00.11

Top 10 Deficiencies

Medical Staff
2014 HFAP Top Deficiencies

Standard 03.01.11
• The Governing Body approves Bylaws every 3 years

Standards 03.01.07 and 03.01.08
• The Bylaws include:
  • H&P Requirements
  • Updates to H&P Prior to Surgery

2014 HFAP Top Deficiencies

Standard 03.04.04 Utilization Review Plan (CoP)
• Elements & Implementation of UR Plan

Standard 10.01.08 Discharge Summary
• Completed within 7 days of discharge

Standard 03.00.01 Eligibility & Appointment
• Inconsistent credentialing for non-physician practitioners

Questions

Telephone:
• Karen Beem  312-202-8069
• Donna Tiberi  312-202-8073

Please submit questions to:

info@hfap.org
Joint Commission Credentialing and Privileging

- Process involving a series of activities designed to collect, verify, and evaluate data relevant to a practitioner’s professional performance
- Serves as a foundation for objective, evidence-based decisions regarding appointment to the medical staff, and recommendations to grant or deny initial and renewed privileges

The Goal of OPPE and FPPE

Align competency expectations to those used by ACGME training programs

**OPPE**
- Require organizations to review performance data for all practitioners with privileges on an ongoing basis rather than the two-year reappointment process and thus allow them to take the appropriate steps to improve performance on a more timely basis

**FPPE**
- Require organizations to establish a process to evaluate the specific competence of all practitioners who do not have documented evidence of competency performing the privileges at the organization (e.g., new appointees, new privileges for current staff)
- Process to evaluate a current privileged practitioner’s ability to provide safe, high quality patient care.
How to Handle “Low Volume” Practitioners

MS.08.01.03 Ongoing Professional Practice Evaluation

- Zero performance of a privilege should be evaluated to determine possible reasons
  - the practitioner no longer performing the privilege, e.g., no open cholecystectomies because they are now done laparoscopically
  - the practitioner taking patients needing the privilege to other organizations or settings such as ambulatory surgery
  - the privilege typically a low volume procedure that has yet to be done

MS.08.01.03 Ongoing Professional Practice Evaluation

- EP 3: Information resulting from the evaluation needs to be used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed.
- Based on analysis, several possible actions might occur, including but not limited to:
  - Continuing the privilege as no performance issues exist
  - Revoking the privilege because it is no longer required by the practitioner
  - Determining that the collected data or evidence of zero performance or low volume should trigger a focused review (MS.08.01.01EP 5)
  - Suspending the privilege, which suspends the data collection, and notifying the practitioner that if they wish to reactivate it they must request a reactivation
  - Determining that the privilege should be continued because the organization’s mission is to be able to provide the privilege to its patients

OPPE & FPPE Documents Reviewed by Surveyors

- Policy and procedures, including definition of terms, OPPE, FPPE initial, FPPE as a result of OPPE.
- Ongoing Professional Practice Evaluation:
  - How is the information displayed? Most organizations are creating physician profiles, using both volume, generic and department specific indicators
  - Who is responsible? Usually the department chair or section chief
  - When is the review documented? Every six months? Eight months? (must be more often than 12 months)
  - What is documented? That the review occurred and that the practitioner is performing well or that an investigation is needed
  - Is the data shared with the ULP?
Questions?

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About URAC

Mission: To promote continuous improvement in the quality and efficiency of healthcare management through the processes of accreditation, education, and measurement.

Structure: Independent 3rd party representing healthcare quality, non-profit, governed by diverse healthcare stakeholders
Providers  Regulators  Expert Advisory
MCOs  Labor  Panel’s (volunteer)
Purchasers  Consumers

Sandi Greenawalt, RN, BSN, MCHA, CC
CCP, CPHQ
URAC
URAC Standards are THE Industry Standards

URAC Corporate Member Organizations

The URAC Board also maintains a large representative from consumer groups, public organizations and other industry experts.

URAC Product Suites

A Full Range of Accreditation and Certification Programs

Health Plan
- Health Plan
- Health Network
- Credentialing
- Enrollment
- Claims Processing
- Health Provider Credentialing
- Dental Network
- Dental Health Plan

Healthcare Management
- Health Utilization Management
- Case Management
- Call Center
- Workforce
- Compensation
- Health Utilization Management
- Independent Review
- Disease Management
- Comprehensive Wellness

Health IT & Information
- Health IT Website
- HIPAA Privacy
- HIPAA Security
- Consumer Education & Support
- Health Content

Provider
- Health Utilization Management
- HIPAA Privacy
- HIPAA Security
- Consumer Education & Support
- Health Content

Pharmacy Quality Management
- Pharmacy Core
- Specialty Pharmacy
- Pharmacy Benefit Management
- Mail Service Pharmacy
- Workers Compensation
- Drug Therapy Management
- Community Pharmacy

URAC Accreditation

The “Seal of Approval”

Quality Standards set by independent group of diverse stakeholders in healthcare

Accreditation Program to support the Quality Standards

Independent group of surveyors audit the organization to make sure it meets the Standards.
The Value of Accreditation

Value to Consumers and Employers
- Assures that consumers will receive due process
  - e.g. patient appeals process
- Guarantees that confidential information will be appropriately and securely handled
- Provides employers a measure of comparison to select health care vendors
- Reduces burden of oversight of health care vendors’ operations

Value to Policymakers
- Standards keep pace with healthcare advancements more readily than if undertaken by legislation/regulation.
- Affords a cost-effective oversight of MCO compliance with state regulations
- Ensures that consumer protections are incorporated into managed care operations
- Provides transparency and accountability through nationally-recognized and publicly available standards

Value to Health Care Providers
- Promotes appropriate clinical oversight of clinical processes
- Assures same specialty peer-to-peer decision-making for physicians engaged in dispute resolution
- Incorporates provider protections and ensures a timely credentialing process
- Gives providers a voice throughout the healthcare system

Value to Health Insurers
- Allows multi-state MCO’s to meet different states’ requirements through a single accreditation process
- Differentiates among health insurers, giving accredited companies a marketing advantage
- Encourages operational efficiencies that improve results and reduce costs.
- Provides evidence that the insurer is keeping current with quality benchmarks and best practices

Questions?

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Top Condition Level Findings – Medical Staff

Anesthesia Services (AS) – (482.52) 8 citations
Anesthesia services. If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.
- Direction v. Administration
- State Law

Medical staff (MS) – (482.22) 3 citations
The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

Top Standard Level Findings – Medical Staff

SS.8 OPERATIVE REPORT SR.1 482.51(b)(6) 95 citations
An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

AS.3 POLICIES AND PROCEDURES SR.2 482.52(b)(1) 62 citations
A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.

AS.3 POLICIES AND PROCEDURES SR.2d 482.52(b)(3) 51 citations
A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services.

MS.9 PERFORMANCE DATA 482.22(i)(1) 51 citations
The medical staff must periodically conduct appraisals of its members.
**Follow up on Burden II...**

Composition of the Medical Staff (including non-physician members)
- State Law and Medical Staff Bylaws

Governing Body Participation
- Participation in other respective committees

Unified/Integrated Medical Staff
- How these are handled...

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**Making accreditation work FOR the hospital**

<table>
<thead>
<tr>
<th>NIAHO® feature</th>
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<tbody>
<tr>
<td>Stable standards, infrequent change</td>
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<tr>
<td>Annual surveys</td>
</tr>
<tr>
<td>Gradual introduction of ISO 9001 (no additional staff)</td>
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<tr>
<td>Focus on sequence/interactions of all hospital processes</td>
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<td>Demeanor of the survey team</td>
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<td>No ‘tipping’ point (survey findings)</td>
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**Changing the culture...**

- ISO is about Consistency, Customer, (patient) focus & Continual Improvement not **PERFECTION**
- DNV-GL is looking for compliance to the standards; it is not inspection oriented
- Survey findings are not necessarily a bad thing
  - Once issues have been identified they can be improved
- The actions you take should impact your patients’ care and experience in a positive way
- Develop your system in a way that works for you, your staff, your medical staff and your patient’s, **NOT** just to please a survey team.
Questions?

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Traci Burgkwist, RCP, HACP
CIHQ

Center for Improvement in Healthcare Quality

The nation’s newest accredits approved by CMS to deem acute care hospitals!
About CIHQ

- Formed in 1999
- Headquartered in Round Rock, TX
- Member-based organization comprised of over 300 hospitals across the United States
- Originally a small consulting firm helping hospitals with accreditation and certification compliance
- Virtual company – small storefront!

Three Divisions... One Organization

Our Standards

- Based on the Medicare Conditions of Participation at 42 CFR
  - Requirements are based on the interpretive guidance provided to CMS State enforcement agencies in the State Operations Manual (SOM)
- Additional standards that address key patient safety and quality of care concerns
Key Medical Staff Stuff

Medical staff standards meet the minimum requirements by CMS.
- Minimal language requirements for bylaws

CIHQ does not:
- Dictate to the medical staff how to govern itself or the relationship between the MEC and the organized staff (No MS.01.01.01)
- Have specific FPPE requirements
- Have specific OPPE requirements

Key Medical Staff Stuff

CIHQ does have standards above that of CMS that address:
- Temporary Privileges
- Resources to Support Privileges
- Physician Health
- Fair Hearing
- Graduate Medical Education Programs

CIHQ Accreditation Program

Top Three Hospital Findings...
- Primary Source Verification of Licensure at Time of Initial Appointment and Time of Renewal
- Demonstration that Criteria is Met When Granting or Re-Granting Privileges
- Compliance with Regulations Regarding the Integration of a Medical Staff within a Health System
Want More Information?

Visit www.cihq.org

Call 866-324-5080

Email Richard Curtis, Chief Executive Officer at rcurtis@cihq.org

THANKS!

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2015 Medical Staff and Credentialing Standards

Question and Answer Session

National Committee for Quality Assurance – Frank Stelling, MEd, MPH
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