Objectives

1. Discuss updates to medical staff standards
2. Briefly discuss the most commonly cited medical staff standards
There are no projected changes to medical staff standards

**Most Often Cited Standards**

MS.01.01.01 – Medical staff bylaws address self-governance and accountability to the governing body.
- Relates to structure, function and activities of the organized medical staff

Most commonly EP 5
- The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

**Most Often Cited Standards**

MS.08.01.03 – Ongoing Professional Practice Evaluation
- Most common issue is lack of effective use of data in decision making
  - Collection of data
  - Evidence of use
- Still issues related to lack of inclusion of non-physician providers
Most Often Cited Standards

MS.08.01.01 – Focused Professional Practice Evaluation
- Continues to be primarily a lack of a process for all initially requested privileges
  - When granting an additional privilege
  - Process for non-physician provider


Most Often Cited Standards

MS.03.01.01 – Organized medical staff oversees the quality of patient care, treatment, and services
- Practicing outside scope of approved privileges
- Determining the qualifications of radiology and nuclear medicine staff
- Specifying the minimal content of histories and physicals


Most Often Cited Standards

MS.06.01.05 – Decision to grant or deny a privilege(s), is an objective, evidence-based process
- Appropriate peer recommendations
- Established criteria to evaluate
  - Practice from orgs where privileged
  - Performance in the hospital
- NPDB queries
- Process to determine if sufficient clinical information to make decision
Questions?

For Standards/NPSG questions:
- 630-792-5900, Option 6 or
- http://www.jointcommission.org/Standards/OnlineQuestionForm/
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The Joint Commission Disclaimer
Statement

These slides are current as of August 12, 2016. The Joint Commission reserves the right to change the content of the information, as appropriate.

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NOTABLE CHANGES IN CR

Not much has changed, but...

- Eliminated (retired) four elements:
  - Practitioner Office Site Quality, Elements A and B
  - Notification to Authorities and Practitioner Appeal Rights, Elements B and C

- Clarified:
  - Organizations must conduct an onsite quality assessment if CMS/state review is older than three years
    - No grace period for the three-year timeframe
Let’s talk about...
STANDARDS RETIREMENT

This is what Standards retirement looks like at NCQA

- What does it mean for 2016 Standards?
- What does it mean for 2017 Standards?

Donna Merrick, Med, BSN, RN
Director, Program Standards and Maintenance

URAC
AccreditNet 2.0 Released

A more powerful web-based database
- Applicant Self-Assessment Tool

Updated program format:
- Focus Area
  - Standards
    - Elements of Performance

Multiple scoring methodology options

New Program Format

In 2017, all URAC Accreditation and Certification programs:
- Move to the new format (Focus Areas)
- Core will be updated to version 4.0
- Modified scoring applied

Major Revisions

Core v4.0

Pharmacy Quality Management® Programs
- Pharmacy Benefit Management (PBM)
- Drug Therapy Management (DTM)

Case Management
Core v4.0: Focus Areas

Risk Management

Consumer Protection and Empowerment

Operations and Infrastructure

Performance Monitoring and Improvement

Credentialing

Practitioner credentialing:
- For PSV, screenshot of issuing source is not required.
- Document as you would for a verbal verification.

Pharmacy credentialing:
- PSV state license (mandatory):
  - Cannot use the verification conducted by NCPDP
- PSV DEA registration or state controlled dangerous substance certificate (mandatory).
**URAC PCMH Certification v3.0**

Three (3) levels:
- Level 1: Qualified
- Level 2: Established
- Level 3: Certified

Practice settings may be in offices, outpatient clinics, or academic-affiliated ambulatory clinics.

Not solely a specialty practice, but rather provides primary care, or a multi-specialty group inclusive of primary care practitioners.

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**URAC PCMH Certification v3.0**

Practice Culture and Patient Centeredness
Electronic Capabilities
Access to Health Care Services
Coordinated Quality Care
Performance Monitoring and Improvement
Reporting Performance Measures to URAC
Health Information Technology (HIT) Designation
  - HIT Designation is optional

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**Clinical Integration**

Clinical Integration Accreditation v1.0
Accountable Care Accreditation v1.0
Future: Accountable Care Organization (ACO) Accreditation
URAC Telehealth Accreditation v1.0

Eligibility – diverse types of organizations engaging in the following types of health care practices:

- Provider-to-Provider Consultation Services
- Provider-to-Consumer Consultation and Treatment Services
- Facility-to-Facility Consultation and Treatment Services

URAC Telehealth Accreditation v1.0

Risk Management
Consumer Protection and Empowerment
Ongoing Credentialing and Maintenance of Practice Privileges
Performance Monitoring and Improvement
Operations and Infrastructure
Telehealth Professional Practice
Telehealth Technology
Consumer Education via Telehealth Media
Care Coordination via Telehealth Media
Measures Reporting

Patrick Horine, MHA
President and CEO

DNV GL - HEALTHCARE
We are growing…

Top Survey Findings – Medical Staff
Anesthesia Services (AS) – (482.52)
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)
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 Findings – Medical Staff

**MS.9 PERFORMANCE DATA**
Practitioner specific performance data is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as determined by the medical staff. Performance data will be collected periodically within the reappointment period or as required as a part of the peer review process. This may include comparative and/or national data if available.

**MS.9 Performance Data**
Areas required to be measured (as applicable) may include:
- SR.1 Blood use (may include AABB transfusion criteria);
- SR.2 Prescribing of medications: Prescribing patterns, trends, errors and appropriateness of prescribing for Drug Use Evaluations;
- SR.3 Surgical Case Review: appropriateness and outcomes for selected high-risk procedures as defined by the medical staff;
- SR.4 Specific department indicators that have been defined by the medical staff;
- SR.5 Anesthesia/Moderate Sedation Adverse Events;
- SR.6 Readmissions/unplanned returns to surgery (as defined);
- SR.7 Appropriateness of care for non-invasive procedures/interventions;
- SR.8 Utilization data;
- SR.9 Significant deviations from established standards of practice; and
- SR.10 Timely and legible completion of patients’ medical records.
**Top Findings – Medical Staff**

**MS.9 PERFORMANCE DATA**
The medical staff must periodically conduct appraisals of its members.
- Lacking of indicators of profile of measures to be evaluated at the time of reappointment
- Inconsistent with mid-level practitioners
- Lacking Objective Information

**Compliance Notes:**
- Selection of Applicable indicators
- Mechanism for on-going measurement and acting on variation
- Creating a standardized process for presenting measures

**Trending…**
- APRNs (PA/NP)
  - Scope of Privileges – Oversight
  - Lack of Objective Data/Information for Review

**Top Standard Level Findings – Medical Staff – Credentialing Aspects**

**MS.12 Clinical Privileges**

SR.1 The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.

SR.4 There shall be a provision in the medical staff bylaws for a mechanism to ensure that all individuals with clinical privileges provide services only within the scope of privileges granted.

1) **MS.12 Clinical Privileges**
- Lack of documented evidence of meeting criteria for special privileges
- Lack of specific training or certification for maintaining specific privileges as defined
- Working outside scope of privileges or scope of practice

**Compliance Notes:**
- Clearly defining criteria for special privileges and distinctly separating these from "core"
- Creating a means for listing any expiration of certification along with licensure and board certification
- Specifying alternative criteria approved by the medical staff to demonstrate competence

**Example…**

**Finding excerpt…** Credentials files for an experienced surgeon and an experienced hospitalist were reviewed. Each requested and was granted clinical privileges to provide moderate sedation.

- There was no objective evidence of the reappointment process including the demonstration of competence in this area or evidence of the organization’s criteria for assessing the competency of these providers to perform procedural moderate sedation.
- Performance data indicated they had not performed moderate sedation procedures during the extended collection period for their last reappointment, excluding experience as evidence of competency.
- The medical staff requires ACLS, which meets rescue capacity competency, but still does not establish competency in contraindications, the selection of drugs or management of the levels of moderate sedation.
- No evidence of continuing education specific to moderate sedation was available for either physician.
- There is no documented evidence of demonstrated competence, such as the successful completion of a moderate sedation test or hospital defined demonstration of competence.
Finding excerpt: Two (2) ED Physician files were reviewed, also based on granted sedation privileges, which is not “core” for the ED physicians. The ED physicians are not required to have ATLS for sedation privileges, but they are required to take and pass the hospital’s sedation exam on initial appointment and every reappointment, neither ED physician had objective evidence of current exams.

– Scope of sedation privileges for ED physicians
– Concerns for use of deep sedation
– Clear criteria and Anesthesia input

Example...

• The general surgeon requested and was granted privileges in pulmonary advanced laparoscopic procedures. During the interview, the staff was not sure that all these listed procedures were actually performed at Samaritan Albany General Hospital.

• The ED had requested the special privilege for ultrasound listed on the privilege form. However, the organization has documented requirements for granting those privileges. The organization had not secured any evidence that the physician had the training or experience to do these privileges.

• The hospital had requested several special procedure privileges on initial appointment to the medical staff. The hospital had established a minimum number of procedures to be performed prior to being granted the privilege. The privileges were granted even though the physician had not met the minimum requirement and there was no additional documentation for the exception.

DNV GL – Healthcare

Upcoming Revisions – Rev 12
Upcoming in Revision 12 – Medical Staff

MS.2 ELIGIBILITY
- ...in accordance with State law,
- categories of practitioners are eligible candidates for appointment
- may also include other categories of non-physician practitioners determined as eligible for appointment by the Governing body.
- examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment

Practitioners:
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialists
- CRNA
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Anesthesiology Assistant

Upcoming in Revision 12 – Medical Staff

MS.8 APPOINTMENT
Appointment – Credentialing and Privileging
- Practitioners
  - In accordance with State Law and Scope of Practice

MS.7 MEDICAL STAFF BYLAWS
- Inclusion of the requirements and guidelines specifically for unified and integrated medical staff

MS.3 ACCOUNTABILITY
The medical staff shall be organized in a manner approved by and accountable to the governing body and shall be responsible for the quality of the medical care provided to patients.
- Professionals – Review to also include other practitioners

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CMS Proposed Rule – Antimicrobial Stewardship

The Centers for Medicare & Medicaid Services (CMS) has proposed requirements that hospitals and CAHs must meet to participate in Medicare and Medicaid. (June 16, 2016)

The CMS proposed Condition of Participation would:

Require a Hospital-wide Antibiotic Stewardship Program (ASP)


Consider: Antibiotic Privileges

As the Antibiotic Stewardship Program is designed, consider:

1. Who may prescribe Antibiotics?
   - Core privilege for Physicians, NP, & PA, regardless of department?
   - Physicians with ICU Privileges? ED Privileges?
   - Will clinical privileges for prescribing antibiotics be required?

2. Will Privileges for Ordering Antibiotics be limited, e.g., for Vancomycin?
   - Only Infectious Disease Physicians to order certain defined antibiotics?
   - Will an Infectious Disease Consult be required?

3. Will patient care benefit from written Antibiotic Protocols?
   - Diagnostic testing, antibiotic selection, initial doses, and STOP dates
   - Medical Staff to review protocols annually
OPPE Considerations

Performance Measure: Antibiotic Stewardship
A. Compliance with protocols and the Prescribing of Antibiotics
B. Compliance with diagnostic testing associated with antibiotic use
C. Rate of healthcare-acquired infections (HAI)

Deficiency #1: Bylaws

The Medical Staff Bylaws must include a requirement:
1. The medical history and physical be completed and documented for each patient no more than 30 days before or 24 hours after admission but prior to surgery / procedure requiring anesthesia. §482.22(c)(5)(i)
2. An updated examination of the patient, including any changes in patient’s condition, be completed and documented within 24 hours after admission but prior to surgery / procedure requiring anesthesia. §482.22(c)(5)(i)

Deficiency #2: Medical Records

All records must document the following, as appropriate:
1. A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission, but prior to surgery/ procedure requiring anesthesia services. §482.24(c)(4)(i)(A)
2. An updated examination of the patient, including any changes in the patient’s condition, when the medical history and physical examination are completed within 30 days before admission. §482.24(c)(4)(i)(B)
HFAP welcomes new management

Better together

The oldest accreditation organization in the US with programs for:
- Acute Care Hospitals
- Critical Access Hospitals
- Ambulatory Surgery Centers
- Clinical Laboratory
- Behavioral health
+ Certification programs

The newest accreditation organization in the US with programs for:
- Acute Care Hospitals
- Critical Access Hospitals
+ Affiliation with AAAHC
- Ambulatory surgery centers
- Office-based surgery settings
- Primary care settings

Better together

- Enriched educational resources for accredited organizations
- Accreditation of an HFAP-accredited organization will not expire, it will roll into the deemed status of AAHHS or AAAHC
- No extension surveys are needed
- No initial Medicare certification survey is needed for existing HFAP customers
Thank you!

The next session in this room will be Part 2 of the panel which will be an open question and answer session with our panelists.