The 2017 Medical staff Standards Update Panel Featuring TJC, NCQA, URAC, DNV, and HFAP

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Total CE Credits: 1.5

Presenter(s): Louis Goolsby, MD; Veronica C. Locke, MHSA; Donna Merrick, BSN, MEd; Patrick Horine, MHA; and Karen Beem, MS, RN

Moderator: John Pastrano, BBS, CPMSM, CPCS
2017 Medical Staff Standards Update Panel
Featuring TJC, NCQA, URAC, DNV, and HFAP
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CHANGES IN THE SURVEY PROCESS
- The SAFER Matrix
- Antimicrobial Stewardship
- Ligature Risks for Behavioral Health Care Units
- Culture of Safety

The Joint Commission Update
Louis Goolsby, MD
October 24, 2017
SAFER MATRIX

- 20% to 50% of antibiotics prescribed unnecessarily or inappropriately
- Antibiotic resistance related to
  - Two million illnesses each year
  - 23,000 deaths each year

Focus on Reducing Inpatient Suicides

- 1200 to 1500 inpatient suicides each year in the United States
- 70% to 75% by hanging
- Ligature risks are no longer acceptable in areas specified for the treatment of behavioral health care patients with suicide risk
Medical Staff Chapter

- 2015—Six percent of standards and elements of performance scored as insufficient compliance
- 24 Elements of Performance accounted for 77%
- 100 EPs scored in less than 1% of surveys
- 38 EPs never scored in 2015

Medical Staff Standards Summary—2015

<table>
<thead>
<tr>
<th>Standards with highest rate of non-compliance</th>
<th>EPs with highest rate of non-compliance</th>
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<tbody>
<tr>
<td>MS.06.21.03</td>
<td>22.5%</td>
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<tr>
<td>MS.06.21.05</td>
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NCQA Perspective
Major Changes

- Credentialing
  - For HP and MBHO
  - To except or not except?
    - Moved exception language to explanation regarding:
      - State or CMS site review
      - Provider being in a rural area

Major Changes (cont.)

- Delegation
  - Delegation agreement
    - Added language to explanation regarding subdelegation and oversight responsibility
  - Predelegation evaluation
    - Clarified that evaluation must occur within prescribed look-back period (versus an actual timeframe – 6 months)

Major Changes (cont.)

- UM/CR/PN Accreditation Module
  - Replaced UM/CR Certification
    - Only accreditation status
      - 2 or 3 year status (depending on performance percentage)
  - Added PN (Provider Network) as an option for accreditation
Performance Measures

- July-August public comment
- Health Plan Accreditation
- Pharmacy Quality Management®
- Telehealth Accreditation

Telehealth 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
Genetics Precision Medicine

- August-September public comment
- September-October advisory group review and beta testing
- November URAC Board review for approval
- Launch 1Q2018

Core v4.0 Major Revision

- Major revision approved by the April 2017 URAC Board
- Released 2017 (as a stand-alone program)
- First accreditation program to incorporate Core v4.0 will be Case Management
- Schedule posted on the URAC website
Core v4.0
Organized into 4 Focus Areas
➢ Risk Management
➢ Consumer Protection and Empowerment
➢ Operations and Infrastructure
➢ Performance Monitoring and Improvement

Core v4.0: Risk Management
➢ Promotes Enterprise Risk Management (ERM)
➢ Periodic risk assessment of information systems
   » Stored data
   » Data gathering
   » Data transfer

Core v4.0: Consumer Protection and Empowerment
➢ Ethics in healthcare practices are explicit and defined by the organization
➢ Health literacy addresses communication barriers
➢ Culturally and linguistically appropriate services
Core v4.0: Operations and Infrastructure

- Programs adopt and adhere to a code of ethical business conduct
- Every 36 months, P&P reviewed and approved changes effective

Core v4.0: Operations and Infrastructure

- Delegation crosswalk analysis required: SOW x applicable URAC standards x contractor’s P&P
- Leadership accountable for continuous quality improvement and risk management

Core v4.0: Performance Monitoring and Improvement

- Quality management program implementation still requires improvement activities; however, formal QI Project requirement limited to:
  - Health Plan
  - Health Plan with Health Insurance Marketplace
  - Dental Plan
Case Management v6.0 Major Revision

- Major revision approved by the July 2017 URAC Board
- Released 2017 with Core v4.0
- Transitions of Care v2.0 will also be released
- Schedule of programs published with Core v4.0 posted on the URAC website

Case Management v6.0

- Three Focus Areas
  - CM-Program
  - CM-Staff
  - CM-Process
Case Management v6.0

- Standards continue to align with the CMSA national standards for case management
- Employ evidence-based clinical guidelines and national standards for practice for CM plans
- Define role of support staff (clinical & admin)
- Access to Professional Case Manager

Thank you!

Patrick Horine, MHA
Chief Executive Officer
What our hospitals have come to appreciate...

- Survey Process
- Integrating a quality management system structure
- Increase efficiency and directed at internal operations
- Improve consistency & Added accountability

Top Survey Findings and Focus Areas
(Related to Medical Staff Credentialing & Privileging)

- **MS.9 Performance Data**
  - CMS CoP §82.22 Periodic Appraisal of Medical Staff members
    - Indicators are not defined or measurable, and not specific/relevant to specialty of privileges granted
    - Indicators are such that in cases only rated "good" or "acceptable" but lack any means to identify patterns, trends or outliers (example: hand written only evaluations)
      - SR.5 Appropriateness of care for non-invasive procedures/interventions;
      - SR.7 Significant deviations from established standards of practice;
      - SR.9 Any variant should be analyzed for statistical signficance

- Improving but still present…APNs (PA/NP)
  - Scope of Privileges – Oversight
  - Lack of Objective Data/Information for Review

- **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.
  - Lack of documented evidence of meeting criteria for special privileges
  - Lack of specific training or certification to maintain specific privileges as defined
  - The privileges are not delineated such as: Tele-neurology Privileges granted stating Tele-neurology without any explanation of what this entails (Consult, assess)
  - Focused attention:
Top Survey Findings and Focus Areas (Related to Medical Staff – Other Areas)

- GB.3 – SR.2 ....The organization must evaluate and select contracted services (including all joint ventures or shared services) and non-contracted services entities/individuals based on their ability to supply products and/or services in accordance with the organization’s requirements.

- (482.12)(e)(5)(1) Governing Body to ensure services provided under contract are provided in a safe and effective manner.

  - Telemedicine
  - ER Group
  - Anesthesia Services
  - Hospitalists

Standards – Revisions/Clarifications

- MS.4 – SR.1 The governing body must consult directly with the individual assigned the responsibility for the organization and conduct of the hospital’s medical staff, or his or her designee. As a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year and include discussion of matters related to the quality of medical care provided to patients of the hospital. For a multi-hospital system using a single governing body, the single multi-hospital system governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system in addition to the other requirements of § 482.12(a).

- MS.17 / SR.1b - MR.7 - H&P – update of patient’s current medical conditions – moves from IG to Standard
  - H&P documentation – interpretive guideline revision

- MS.8 – SR1.a – Primary Source Verification – Acceptable profile reports

- Other clarifications / minor revisions

Of Note...

- Anesthesia oversight – CAHs
- “…in accordance with hospital policy and State law”
  - State Law - What it says or may not say...
  - Reference – Scope of Practice
  - Practice change, policy good….or …. Policy change, practice good
Who is HFAP?

1. HFAP is the oldest Accreditation Organization
2. 1945: Initial Hospital Accreditation Program
3. 1965: Received Medicare "Deeming Authority"
4. Recognized by all states and major payers
5. Not limited to Osteopathic Hospitals!
6. HFAP standards mirror CMS regulations & incorporate CMS Interpretive Guidelines
What’s New?

Chapter 3: Medical Staff

➢ 2017: No New Standards

➢ 2018: First 6 months
  ➢ No new standards
  ➢ Retiring a few

Top Cited Deficiencies

1. Medical Staff Bylaws
2. History & Physical
3. Informed Consent
4. OPPE / FPPE
5. Surgical Privileges Roster

Medical Staff Bylaws

➢ Bylaws Must Address:

1. History & Physical expectations
2. Update the History & Physical
3. OPPE and FPPE Processes
I. History and Physical Expectations:
   A. Completed no more than 30 days prior to admission – and –
   B. Prior to Surgery / procedure with anesthesia

II. Expectations to Update the History & Physical
   A. If H&P is less than 30 days, complete examination
      1. Within 24 hours of admission – but –
      2. Prior to surgery / procedure with anesthesia
   B. Documentation Expectations
      1. “Examination was conducted”
      2. “No Changes” – or –
      3. Address any changes in patient’s condition

Medical Record Compliance
A. Record Review:
   • Inpatient, Outpatient Surgery, GI, OB, etc.
B. Deficiency:
   1. No History & Physical
   2. History & Physical greater than 30 days
   3. No Update to the History & Physical
Informed Consent

- **HFAP Requirement:**
  - Informed consents will be written in simple sentences (4th grade comprehension level) and in the primary language of the patient.
  - **Deficiency:** Consents written at higher reading level, e.g., medical terminology

Bylaws: OPPE / FPPE

- **Medical Staff Bylaws Address**
  - **A. Ongoing Professional Practice Evaluation (OPPE)**
  - **B. Focused Professional Practice Evaluation (FPPE)**
    1. Initial appointments
    2. Requests for new / additional privileges
    3. Poor performance / Quality-related issues

OPPE

- **A. Operationalize – What is the evidence?**
  1. Selection of clinical & administrative indicators
  2. OPPE Data Collected 3 / year
  3. Reports distributed to the practitioners

- **B. OPPE for all practitioners granted privileges**
  - Physicians, Nurse Practitioners, Physician Assistants, CRNA, CNM, OT, PT, SLP, Dietitians, and etc.

- **C. OPPE data reviewed at time of reappointment**
FPPE

A. Operationalize – What is the evidence the FPPE has been assigned to practitioners?

Indications:
1. Initial applicants
2. Requests for new / additional privileges
3. Identification of quality issues / low-performance

Non-physician practitioners

A. No longer use term “Allied Health Practitioners”

B. New term “Non-physician Practitioners” (NPP)
   1. Nurse Practitioners / Physician Assistants
   2. CNM and CRNAs
   3. OT, PT, SLP
   4. Qualified Registered Dietitians / Nutritionists
   5. Etc., per State law
   6. Does NOT include Respiratory Therapists

Non-physician practitioners

A. Privileges consistent with State Scope of Practice

B. Requests for Privileges per Medical Staff process
   1. Application
   2. Re-application every 2 years
   3. Function under the Medical Staff Bylaws / Policies
   4. * FPPE / OPPE – Frequently Cited
Infrequently Cited

1. Applications:
   a. Incomplete application sent to Board
   b. Lack of Medical Staff recommendation to Board
   c. Lack of evidence the quality data (OPPE) was considered with decision to re-appoint
   d. Lack of evidence the Board approved privileges –* Practicing without privileges = Condition of Participation!

Infrequently Cited

2. Surgical Privileges Roster:
   a. Surgery / Nursing Units:
      1) Do not have current list of privileges
      2) Do not have access to list of privileges
   b. Inappropriate Privileges
      1) Newborn NP should not have Propofol privileges
      2) Procedure is not performed at this location

Infrequently Cited

3. Policy approval every 3 years by Medical Staff:
   a. Strategy:
      1. Inventory all policies requiring Med Staff approval
      2. Schedule review over 3 years
   b. Priority: Policies for Board Approval
      1. Medical Staff Bylaws, Rules & Regulations
      2. Utilization Review Plan
      3. Completion: Target 12-months prior to survey
Calculate: Survey Window

1. Survey Window Opens 6 months prior to accreditation expiration date.
   a. Determine: Accreditation Expiration Date
   b. Subtract: Six Months

2. Survey anytime once the window opens

3. If revise Bylaws, send to Account Manager

HFAP Website – Ask questions

Contact Information

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Questions for our Panel