Joint Commission Standards for Medical Staff: Introduction

What we will cover...
- Reading the standards
- Priority Focus Areas
- Icons
- Scoring
- Tracers

How to Read the Standards
Each standard contains:
- Brief statement of the standard
- Rationale for the standard explaining its importance and intended effect
- Elements of Performance (EPs) that must be met in order to show compliance
  - activities, mechanisms, and systems necessary to accomplish the intent of the standard
Priority Focus Areas (PFAs)
- Processes, systems, or structures that significantly impact safety and/or the quality of care, treatment, and services provided
- Each EP is assigned to one or more PFA
- 14 PFAs – MS chapter includes:
  - Credentialed practitioners
  - Organizational structure
  - Quality improvement/expertise/activities
  - Information management
  - Patient safety
  - Communication
  - Assessment and care/services

Competence Assessment and MS Credentialing & Privileging Session
- Evaluate process used to collect relevant data for credentialing and privileging decisions
- Evaluate consistent implementation of the credentialing and privileging process
- Evaluate processes for the granting of and appropriate delineation of privileges
- Determine whether practitioners practice within the limited scope of delineated privileges

Competence Assessment/Med Staff Credentialing & Privileging Session, cont.
- Link results of peer review and focused monitoring to the credentialing and privileging process
- Identify vulnerabilities in the credentialing, privileging, and appointment process
- Evaluate OPPE/FPPE processes
Joint Commission Standards for the Medical Staff

Icons
- D: Documentation required
- 3: Direct impact
- ⚠️: Situational decision rules
- 🚨: Immediate threat to health or safety
- A: Category A requirement
- C: Category C requirement
- M: Measurement of Success needed

Measures of Success

“An MOS is a numerical or quantifiable measure, usually related to an audit to determine if an action was effective and sustained, due four months after notification of an acceptable Evidence of Standards Compliance”

How the Standards are Scored

Three-point scale:
- 0 = insufficient compliance
- 1 = partial compliance
- 2 = satisfactory compliance
- N/A = not applicable
Track Record also Scored
Score 0 = Fewer than 6 months
Score 1 = 6 to 11 months
Score 2 = 12 months

Categories “A” EPs
- Usually relate to structural requirements (policies, plans, etc.) that either exist or do not exist
- May be related to a Medicare CoP that must always be fully compliant
- May address an issue that must be fully compliant even though it focuses on performance or outcome (for example, NPSG)
- Score is “2” (Satisfactory) for compliant
- Score is “0” (Insufficient) non-compliant

Category “C” EPs and Scoring
- Frequency-based
- Score is “2” (Satisfactory) for one or no occurrences of noncompliance
- Score is “1” (Partial) for two occurrences of noncompliance
- Score is “0” (Insufficient) for three or more occurrences of noncompliance
Category “C” EPs (all have MOS requirement)

- 04.01.01 EP 9 – MS compliance with residency review committee citations
- 06.01.05 EP 11 – Completed applications acted on as specified in bylaws
- 06.01.07 EP 4 – Timely completion of credentialing & privileging processes

Scoring Category “C” Example MS.06.01.05 EP 11

- Completed applications for privileges are acted on within the time period specified in the bylaws
- Surveyor reviews a sample of 20 credentials files and finds that two are not processed within the required timeframe, each one is counted as a separate occurrence
- Score is “1” for Partial

TJC Scoring – Situational

- May result in Preliminary Denial of Accreditation, Contingent Accreditation, or Accreditation with Follow-up Survey
- MS.06.01.05 EP 1 - All LIPs that provide care possess a current license, certification, or registration, as required by law and regulation
**TJC Scoring – Direct Impact**

- Direct impact on patients if noncompliance is likely to create an immediate risk to patient safety or quality of care, treatment, and services
- Typically system/process issue
- Accreditation decision held in abeyance pending submission of ESC within the established time frame
- Failure to resolve will lead to progressively more adverse accreditation decisions

**TJC Scoring – Direct Impact**

- MS.03.01.01 EP 2 - Practitioners practice only within the scope of their privileges
- MS.03.01.03 EP 3 - A patient's general medical condition is managed and coordinated by MD/DO
- MS.03.02.03 EP 12 - MD or DO on duty at all time (Medicare Deeming only)
- MS.06.01.03 EP 9 - FT/PT/Consulting Radiologist (MD or DO) supervising ionizing radiology services (Medicare Deeming only)

**Tracer Methodology**

- An evaluation method conducted during on-site survey designed to “trace” the care experiences that a patient had while at the hospital
- Purpose is to assess compliance with JC standards
For Each Standard...

Ask yourself or ask your staff:
- Do we do this?
- For "D" EPs, where is it written?
- Are we following our documented processes?
- Where is the evidence that we do this?

Questions

Joint Commission Standards for the Medical Staff: Credentialing, Privileging, and Appointment
What we will cover...

- Standards Related to Credentialing, Recredentialing, Privileging, and Appointment
- CME
- Expedited Credentialing
- Temporary Privileges
- Disaster Privileges

Background for the standards

- Goal = Patient safety and provision of high-quality patient care
- ACGME/ABMS General Competencies
- Appointment and privileging separate standards – different processes

Credentialing

“Credentialing involves the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Verification is sought to minimize the possibility of granting privilege(s) based on the review of fraudulent documents.”
Privileging

“The process whereby the specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual’s credentials and performance.”

Typical Privileging Process

- Developing and approving a procedure list (privilege form)
- Processing application (PSV)
- Evaluating information received
- MS review and making recommendations to the GB for applicant-specific privileges

Typical Privileging Process – Cont.

- Notification of the privileging decision
  - Applicant
  - Relevant personnel
  - External entities as required by law
- Monitoring privileges and quality of care issues
Licensed Independent Practitioners:
- Permitted by law and by the organization to provide care, treatment, and services without direction or supervision
- Operates within the scope of licensure which is consistent with privileges.
- APRNs and PAs who provide a "medical level of care" are credentialed and privileged through the MS function
- Medical level of care = making independent diagnosis and treatment decisions

MS.07.01.01 - Medical staff appointment
- MS develops and uses criteria for membership
- Criteria designed to assure the MS and governing body that patients will receive quality care, treatment, and services
- Appointment does not exceed two years
- Gender/race/creed national origin not considered
- MS recommends, GB approves
(See sample minutes language and Recommendation and Approval Form)

MS.06.01.01 - Determining Organizational Resource Availability
- 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
- Hospital consistently determines the resources needed for each requested privilege
MS.06.01.03 - Credentialing

- Applicants credentialed using a defined process
- Bylaws outline the credentialing process
- Credentialing process based on MS recommendations approved by GB
- Verification of identity (See sample P&P)

MS.06.01.03 – Credentialing – Cont.

- Credentialing process includes requirement for verification of relevant training, current competence, and current licensure (See sample verification letters)
- Verification must be in writing and must come from the primary source, if possible; or from a CVO
- Verify licensure at the time of initial granting, renewal, and revision of privileges, and when the license expires

MS.06.01.05 – Privileging - Objective, evidence-based process

- LIPs providing care have current licensure, certification, or registration (per law)
- Hospital has clearly documented procedure for processing requests for initial grants, renewal, or revision of privileges. MS approves process.
  See Work Sheet for Consideration of New Privilege
MS.06.01.05 – Privileging – Cont.

- Criteria based on MS recommendations and approved by the governing body
  - PSV for current licensure/certification, relevant training
  - Evidence of physical ability to perform the requested privileges
  - Data from professional practice review from the other organization where the applicant currently has privileges, if available
  - On renewal, review of the applicant’s performance within the hospital
  - Recommendations from peers and/or faculty
- Hospital consistently evaluates each criterion for all practitioners with like privileges

MS.06.01.05 – Privileging – Cont.

- Before recommending privileges MS evaluates
  - Challenges to any licensure or registration
  - Voluntary and involuntary relinquishment of any license or registration
  - Voluntary and involuntary termination of medical staff membership
  - Voluntary and involuntary limitation, reduction, or loss of clinical privileges

MS.06.01.05 – Privileging – Cont.

- Before recommending privileges MS evaluates
  - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
  - Documentation as to the applicant’s health status
  - Relevant practitioner-specific data as compared to aggregate data, when available
  - Morbidity and mortality data, when available
MS.06.01.05 – Privileging – Cont.

- Privileging process includes attestation that there are no existing health problems that could affect ability to perform requested privileges
  - Evaluation is documented in credentials file
    - Applicant’s statement that no health problems exist that could affect his or her practice
  - Statement should be confirmed
  - Initial applicant’s health status confirmed by
    - Director of a training program
    - Chief of services
    - Chief of staff at another hospital at which the applicant holds privileges,
    - MD/DO approved by the medical staff
- When in doubt about an applicant’s ability to perform privileges requested, an evaluation by an external and internal source may be required by the medical staff

MS.06.01.05 – Privileging – Cont.

- NPDB on initial grants of privileges, on renewal of privileges, and when new privileges are requested (HCQIA requires every 2 years)
- The hospital must have a process to determine whether it has adequate clinical performance information to make its decision regarding the granting, limiting, or denial of privileges

MS.06.01.05 – Privileging – Cont.

- Peer recommendations include current information in writing regarding
  - Medical/clinical knowledge
  - Technical and clinical skills
  - Clinical judgment
  - Interpersonal skills
  - Communication skills
  - Professionalism
MS.07.01.03 – Peer Recommendations

- Include requirements of MS.06.01.05
- Obtained and evaluated for all new applicants for privileges
- Used on renewing privileges if there are insufficient practitioner-specific data available
- Practitioner in same professional discipline with personal knowledge of the applicant’s ability to practice

See Sample Peer Recommendation letter

MS.06.01.05 – Privileging – Cont.

- Completed privilege applications are acted on within the specified time period specified in the bylaws
- When changes in clinical privileges are made, information regarding the practitioner’s scope of privileges is updated

See Credentials File Audit for MS.06.01.03 through MS.06.01.07 Requirements

MS.06.01.07- Analysis and Use of Information Received

- Review and analysis of information process is clearly defined
- Privileging criteria based on MS and GB approval/GB final authority
- Criteria are consistently applied for each requesting practitioner
- No use of gender, race, creed, and national origin
- Hospital completes processes in a timely manner (See sample application flow chart)
MS.06.01.07 - Analysis and Use of Information Received – Cont.

- Privileges don’t exceed two years
- Criteria utilized to make decisions on medical staff membership and clinical privileges must be directly related to the quality of healthcare, treatment, and services
- If privileging criteria are used that are unrelated to quality of care, treatment, and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment, and services is evaluated

MS.06.01.09 - Privilege decision notification

- Practitioners are notified of the decision to grant, deny, revise, or revoke privileges and this is done within the time frame specified in the medical staff bylaws
- If denied, the applicant is informed of the reason
- The decision is distributed and made available to all appropriate internal persons and external persons or entities as delineated by the organization and per law (See sample policy)
- The MS approves the process used to distribute information regarding the decision to grant, deny, revise or revoke privileges
- Hospital makes the practitioner aware of available due process/fair hearing and appeal

MS.12.01.01 - CME

- OMS prioritizes hospital-sponsored educational activities
  - Related to the type and nature of care, treatment, and services offered by the hospital
  - Based on the findings of performance improvement activities
- All LIP participation in CE documented
- Participation considered at reappointment and renewal or revision of privileges
**EXPEDITED CREDENTIALING PROCESS**

**MS.06.01.11 – Expedited Board Process**
- Board may delegate to a committee consisting of at least 2 governing body members
- Medical staff develops and uses criteria for an expedited process
- Applicant is ineligible if submits an incomplete application or MEC makes a final recommendation that is adverse or has limitations

**Situation to be evaluated case-by-case and usually lead to ineligibility**
- Current or previously successful challenge to licensure or registration
- Involuntary termination of MS membership
- Involuntary limitation, reduction, denial, or loss of clinical privileges
- Unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment
See sample policy and procedure
**TEMPORARY PRIVILEGES**

**MS.06.01.13 - Temporary Privileges**

Under *certain circumstances* TP can be granted for a limited period of time:

- Fulfill an important patient care, treatment, or service need
- Applicant with complete application raising no concerns awaiting review and approval of the MEC and governing body

**MS.06.01.13 - Temporary Privileges**

- Limited to 120 days for new applicants
- Specific limitation of days for important patient care need not addressed – time limited and spelled out in Bylaws
- Recommended by MS President or designee
- Granted by CEO or designee

See sample form and bylaws language
Temp Priv for Patient Care Need - Verify:
- Current licensure
- Current competence
- NPDB also required per HCQIA

Temporary Privileges - New Applicant

**Verify:**
- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- Other criteria required by medical staff bylaws
- NPDB

**“Must have’s”**
- Complete application
- No successful challenges to licensure or registration
- No involuntary termination of MS appointment
- No involuntary limitation, reduction, denial, or loss of clinical privileges

**DISASTER PRIVILEGES**
EM.02.02.07 Disaster Privileges

- May be granted:
  - When the emergency operations plan has been activated AND
  - Hospital is unable to meet the immediate patient needs
- MS bylaws identify individuals responsible for granting disaster privileges to volunteer LIPs

Before functioning as a volunteer LIP, the hospital obtains valid government-issued photo ID and at least one of the following:
- A current picture ID card from HC organization that clearly identifies professional designation
- A current license to practice
- PSV of licensure
- ID 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 hospital or group
- ID indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by LIP currently privileged by the hospital or a staff member with personal knowledge of the volunteer practitioner’s ability to act as LIP during a disaster

See sample policy and procedure

TJC - EM.02.02.13

- During a disaster, the medical staff oversees the performance of each volunteer LIP
- Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner’s arrival if granted disaster privileges should continue
TJC - EM.02.02.13

- PSV of licensure when situation under control or W/I 72 hours or must document
  - Reason(s) why it could not be performed within 72 hours of the practitioner’s arrival
  - Evidence of demonstrated ability to continue to provide adequate care/treatment/services
  - Evidence of attempt to perform PSV ASAP
- If PSV of licensure can’t be completed W/I 72 hours, do ASAP
- PSV of licensure is not required if the volunteer has not provided care, treatment, or services under the disaster privileges

Questions

Joint Commission Standards for Medical Staff: Part II
What we will cover...

- Medical Staff Structure/Accountability
- Medical Staff Leadership/MEC
- Bylaws
- Oversight of Patient Care
- OPPE/FPPE/PI
- MS Involvement in Patient-Focused Areas and Therapeutic Services
- LIP Health
- Graduate Medical Education

MEDICAL STAFF STRUCTURE

MS.01.01.01: Medical Staff Structure

- MS bylaws include definition of MS's structure
- In most cases, there should be a single MS for the hospital
  - Exception:
    - Single governing body with multiple inpatient care sites serving geographically different patient populations
    - Patient population consists of individuals who chose the hospital as their primary source of inpatient care
MS.01.01.01: Medical Staff Structure

- If departmentalized, these are documented in bylaws along with qualifications, roles and responsibilities of the chairmen.
- Bylaws define the officers and clinical leaders of the medical staff and how they are elected/selected and removed.

MEDICAL STAFF ACCOUNTABILITY

MS Accountability – LD Standards

- MS accountable to the governing body.
- Governing body affords MS the opportunity to participate in governance:
  - Representation at GB meetings (attendance and voice) by one or more of its members selected by MS.
  - MS members eligible for full membership on GB unless prohibited by law.
MS.02.01.01 - MEC

- MS must have an executive committee
- Acts on behalf of the OMS between MS meetings
- The MS, as a committee of the whole, may serve as the MEC
- MS defines the makeup and structure of the MEC (conforms to MS bylaws)

MS.02.01.01 - MEC Composition

- All MS members (any discipline or specialty) are allowed to participate
- Majority are licensed MD/DO actively practicing in the hospital
- Hospital CEO (designee) attends on an ex-officio basis, with or without a vote
- Can be composed of elected or appointed department directors or it may be a body of elected members
MS.02.01.01 – MEC Makes Recommendations Regarding

- MS structure
- Medical staff membership, membership termination, privileges
- Process used to review credentials and delineate privileges
- Committee's review of and actions on reports of MS committees, departments, and other assigned activity groups
- Requests evaluations of practitioners privileged through the MS process when there is doubt about an applicant's ability to perform the privileges requested

MEDICAL STAFF BYLAWS

Bylaws – MS 01.01.01

- OMS develops, adopts and amends bylaws - process for adoption and amendment cannot be delegated
- Proposed changes are submitted to the governing body for action and don't become effective until approved
- No unilateral amendment (01.01.03)
- MS bylaws/rules & regulations, and policies; governing body bylaws; and hospital policies are compatible with each other and compliant with law and regulation

See sample crosswalk form for documenting MS and Board bylaws elements
Bylaws – MS 01.01.01
- The MS complies with the bylaws, rules and regulations, and policies
- MS enforces the bylaws, rules and regulations, and policies by
  • Taking action or
  • Recommending action to the GB
- The GB upholds the MS bylaws, rules and regulations, and policies that have been approved by the GB

Bylaws – MS 01.01.01
- Every requirement from EPs 12 through 36 are contained in MS bylaws (See Chart for Review of Bylaws for Compliance with TJC Standards Required Documentation)
- Bylaws include timeframe for processing applications (MS 06.01.03)

Bylaws – MS 01.01.01
- MS bylaws include at least the basic steps needed to implement requirements for processes necessary for EPs 12 – 36
- Details associated with requirements of EPs 12 - 36, can be included in bylaws, rules and regulations, or policies
- OMS adopts associated details, determines where they are located, and whether adoption can be delegated
- Can't delegate adoption of associated details that are in MS bylaws
MS 01.01.01 Bylaws Revisions

- OMS can adopt and amend bylaws, rules, regs, and policies, and to recommend them directly to the GB
- Must first communicate the proposal to the MEC
- If the MEC proposes to adopt or amend a rule, reg, or policy it first communicate the proposal to the MS
- Applies only when the OMS delegates authority to the MEC
- OMS has a process to manage conflict between the MS and MEC on proposals to adopt/amend a rule, reg, or policy
- If there is a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the MEC, if delegated authority, can provisionally adopt and the governing body provisionally approve the urgent amendment without prior notification of the MS.

MEDICAL STAFF
OVERSIGHT OF PATIENT CARE/PRACTITIONERS

LD 01.05.01

- MS leaders must oversee the quality of the care provided by those who have been granted privileges
- An MD or DO (or DDS/DPM if allowed by state regulations) is responsible for the MS's organization and conduct
**MS.03.01.01 - Oversight**
- MS oversees the quality of patient care, treatment, and services provided by those privileged through the MS process.
- LIP MS members are responsible for and perform oversight activities.
- MS uses specific methods to provide leadership in activities that relate to patient safety.
- MS participates in the oversight of the analysis and improvement of patient satisfaction processes.
- Practitioners practice only within the scope of their privileges.

**MS.03.01.03 - Management and Coordination of Patient Care**
- Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services.
- Patient's general medical condition is managed and coordinated by MD/DO.
- Definition of "physician" is from CMS:
  - MD, DO
  - DMS, DMD, DPM, OD, DC
  - only with respect to functions legally authorized to perform by the State.

- There is coordination of the care, treatment, and services among the practitioners involved in a patient's care, treatment, and services.
- MD/DO manages and coordinates the care of any Medicare patient's psychiatric problem that is not specifically within the scope of practice of DMS, DMD, DPM, OD, DC, clinical psychologist (deemed status).
MS.03.01.03 - Consultations

- OMS, through designated mechanism, determines circumstances requiring consultation or management by MD, DO, or other LIP
- Obtained as required

See sample Clinical Consultation Form

MS.03.01.03 - Management and Coordination of Patient Care

- The hospital educates all LIPs on assessing and managing pain
- MD/DO on duty or on call at all times (deemed status)

FOCUSED AND ONGOING PROFESSIONAL PRACTICE EVALUATION
MS.08.01.01 - FPPE
- All initially requested privileges
- OMS defines criteria to use when issues affecting the provision of safe, high quality patient care are identified
- Triggers defined
  - single incidents or clinical practice trend
- FPPE process consistently implemented
- Measures employed to resolve performance issues clearly defined and consistently implemented

MS.08.01.01 - FPPE
- Monitoring process is clearly defined and includes:
  - Criteria for conducting performance monitoring and type of monitoring to be conducted
  - How performance monitoring plan and duration of plan specific to the requested privilege is determined
  - Circumstances requiring monitoring by an external source
- Monitoring decision based on the evaluation of current competency, practice behavior, and ability to perform the requested privilege

MS.08.01.03 - OPPE
- Clearly defined process
- Facilitates evaluation of each practitioner's professional practice
- Type of data to be collected
  - determined by departments (if they exist)
  - approved by the MS
- MS uses info to decide whether to continue, limit, or revoke existing privileges – review prior to or at time of renewal
Potential Aspects of OPPE/FPPE:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient

See sample P&P and forms

MS.09.01.01 - Concerns

Hospital has a clearly defined process for collecting, investigating, and addressing clinical practice

- Based on OMS recommendations
- Approved by governing body

Reported concerns uniformly investigated and addressed, as defined by the hospital and applicable law
MS.05.01.03 – MS Participates in PI

- If issues that are relevant to an individual’s performance are identified, MS determines how to integrate into the OPPE process
- Staff and governing body are advised of findings, conclusions, recommendations, and actions to improve performance
- Educating patients/families
- Coordination of care, treatment, and services with the others caring for the patient
- Medical records completion (accurate, timely, and legible)

MS.05.05.01 – PI

- Data regarding sentinel events and patient safety are included as part of the PI process
- Hospital attempts to obtain autopsies in cases of unusual deaths and medical, legal, educational interest, and informs the attending physician or clinical psychologist of autopsies that it intends to perform (deemed status)

MS.05.05.01 – PI

- OMS leadership in measuring, assessing, and improving processes that primarily depend on the activities of LIPs and other practitioners credentialed and privileged through the medical staff process
- MS actively involved in measuring, assessing, and improving:
  - Appropriate use of medications
  - Ordering and administration of blood and blood components
  - Operative and other procedures
  - Appropriateness of clinical practice patterns
  - Significant deviations from established patterns of clinical practice
  - How criteria for autopsies are used
  - Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process
  - Medical assessments (H&Ps) and treatments ordered or provided
MS.03.01.01 – H&P Exams

- MS.01.01.01 - Bylaws include requirements for completing and documenting H&P. H&P completed and documented by a physician (CMS definition), an oral/maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy (deeming only).
- MS can allow individuals other than LIPs to perform part or all of a patient's H&P under supervision of, or through delegation by, a physician who is responsible for the H&P, if allowed by state law and medical staff policy.
- OMS defines when an H&P must be validated and countersigned by a responsible, privileged LIP.
- OMS defines minimal content of H&P for both IP services and non-IP procedures - can differ depending on the patient care setting or intensity of care, treatment, or services being provided.
- MS monitors quality of H&P exams.
- H&Ps are performed by practitioners privileged to do so.
PC.03.05.09 (Deemed Status)

- Physicians, clinical psychologist, or other LIPs ordering restraints or seclusion have "working knowledge" of restraint and seclusion policies
- Policies and procedures regarding restraint or seclusion include training requirements for these practitioners

PC.02.01.01 (Deemed Status)

- Blood transfusions and IV medications are administered in accordance with policies and procedures that have been approved medical staff and in accordance with state law

IC.01.03.01 EP 4

- On at least an annual basis and when significant changes occur, the hospital reviews and identifies its infection risks with input from the medical staff...
LD.01.02.01 EP4 (Deemed Status)

- The CEO, MS, and nurse executive ensure that the hospital-wide PI and training programs address problems identified by the individual responsible for IC
- Leaders make sure that corrective action plans are successfully implemented

LD 04.01.05 (Deemed Status)

- A qualified MD or DO directs:
  - Anesthesia
  - Nuclear medicine
  - Respiratory care
- Emergency services directed and supervised by a qualified MS member

MS.03.01.01 (Deemed Status)

- OMS determines the qualifications of the radiology staff who use equipment and administer procedures
- OMS approves the nuclear services director’s specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff
MS.03.01.01 (Deemed Status)

- If emergency services are provided by the hospital, MS develops P&P for appraisal of emergencies, initial treatment, and referral of patients at off-campus locations that do not provide emergency care.
- If emergency services are not provided at the hospital, MS develops P&P for appraisal of emergencies, initial treatment of patients, and necessary referrals.

MS.06.01.03 (Deemed Status)

- For Psych hospital: IP services directed by LIP who meets training and experience requirements for examination by the American Board of Psychiatry and Neurology or American Osteopathic Board of Neurology and Psychiatry.
- A full-time, part-time, or consulting MD or DO radiologist qualified by education and experience in radiology supervises ionizing radiology services.

PC.02.02.03 EP 22 (Deemed Status)

- A current therapeutic diet manual approved by the dietitian and MS is available to all medical, nursing, and food service staff.
PC.03.01.08 (Deemed Status)

- The laboratory has a written policy specifying which tissue specimens require only a macroscopic examination, and those that require both a macroscopic and microscopic examination.
- The policy must be approved by the medical staff and a pathologist.

MS.11.01.01 – LIP Health

- MS develops and implements a process to identify and manage matters of individual health for LIPs.
- Separate from disciplinary procedure.
MS.11.01.01 – LIP Health Process Includes

- Education of LIP and organization staff regarding recognizing illness and impairment issues specific to LIP
- Self-referral by an LIP and referral by others while maintaining the confidentiality of the informant.
- Referral of the LIP to appropriate professional internal or external resources
- Maintaining confidentiality of the LIP who is seeking referral or who is being referred for assistance (must comply with reporting requirements of regulations)

MS.11.01.01 – LIP Health Process Includes

- Evaluation of the credibility of a complaint, allegation, or concern
- Process for monitoring the LIP and the safety of patients until the LIP completes rehabilitation and during any required period afterward
- Reporting to medical staff leadership any occasions in which an LIP is providing treatment in an unsafe manner
- Appropriate actions to be taken when an LIP fails to complete a required rehabilitation program
04.01.01 - GME

- OMS defines process for supervision by LIP with appropriate privileges
- OMS and hospital staff are given written descriptions of the roles, responsibilities, and patient care activities of GME participants
- Description of how GME supervisor(s) and directors decide about the GME participant's progressive involvement and independence in specific patient care activities

04.01.01 - GME

- OMS R&Rs and policies delineate who may write patient care orders, the circumstances under which they may do so and when countersignature by supervising LIP is required
- MS shows compliance with residency review committee citations

04.01.01 – GME COMMUNICATION

- Mechanism for communication between the GME committee and the OMS/governing body
- Mechanism for hospital to communicate information to the GMEC about participant's quality of care, treatment, and services and educational needs
- Info about the quality of care, treatment, and services and educational needs is communicated from the GMEC to hospital governing body