You Ask, Hugh Responds

**Question 1.** I think many of us feel like we are constantly treading water, trying to ensure we are Joint Commission compliant, but also spending most of our time putting out daily fires in the Medical Staff Office, trying to meet the demand for immediate turnover of credentialing applications, keeping up with reappointments, ensuring F/OPPE are completed timely, coordinating the numerous physician social events, and myriad other demands on our time. What do you recommend as the best way to ensure continuous survey readiness in all aspects of the Medical Staff chapter of Joint Commission? Do you have any tips/tools/audit forms you can share that will help confirm we are doing well or that will help identify opportunities for improvement? Also, for those undergoing survey this year, any idea what surveyors are currently focused on?

**Hugh Responds:** Ensuring continuous survey readiness might not be the most important aspect of your job. It has generally been shown that those medical staff professionals who perform their jobs well do not need to worry about survey readiness. Having said that it is also important for MSPs, VPMAs, and others in administration to make informed decisions concerning their preferred accrediting organization. Today hospitals have many choices, DNV, HFAP, CIHQ, TJC, analyze these options and help your organization choose wisely. ([https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Accrediting-Organization-Contacts-for-Prospective-Clients-.pdf))

The standards and survey procedures of each organization differ, and the total cost of preparation, compliance and attendant survey fees also varies. Hospitals should make periodic determinations concerning which accreditor they invite to their facilities and which set of standards will encourage the most positive outcome for patients.

Don’t sweat the small stuff and nearly all survey findings are small stuff. Receipt of an occasional recommendation from an accreditation agency is not the end of the world and should not give rise to great concern. Review the recommendation(s) and respond. Due to differences among surveyors and their focus it is likely that all hospitals might periodically receive a deserved or undeserved citation.

There are dozens of tools available for use in determining compliance with relevant standards. However the best source is the actual standards themselves. Know these as well as possible and do not hesitate to “Google” any subject in need of further clarification. Hospitals often spend considerable resources attending conferences, buying books, securing consultation, and otherwise attempting to improve knowledge and compliance. It is far better to first assure that the organization is completely knowledgeable about the actual standard. Do not over comply unless this will improve patient care, do not implement policies and procedures that are not necessary, over compliance is often viewed as the best mechanism to assure survey readiness. As Einstein once said “All things should be as simple as possible but not more so.”

Depending upon your preferred accreditation organization it is likely that institutional efforts to prevent patient suicide (especially in the ED) are major focal points of current surveys. On the medical staff side continue to be diligent concerning F and OPPE. Legacy issues such as primary source verification, granting clinical privileges, medical staff bylaws, rarely give rise to serious recommendations.
**Question 2.** What are your recommendations for how to address inappropriate behavior/sexual harassment by physicians?

**Hugh responds:** Great leadership is essential for effectively preventing or responding to allegations such as those referenced in this question. Without such leadership by physician leaders and executives well drafted policies and procedures will make little difference.

Make sure your leaders are dedicated, educated, trained and well supported. (To determine this you must figure out how to ask them if they believe they are well prepared.)

Have a reasonable policy and procedure that addresses each of the following:

a. Prohibits unprofessional or illegal behavior (This section should be specific and provide examples of proscribed actions or inactions.)
b. Required that each person subject to the policy be orientated to it and agrees to abide by it.
c. Calls for an effective reporting process that permits and encourages filing of reports alleging the proscribed behavior.
d. Establishes an investigational process that would be used to determine validity of received reports.
e. Outlines a corrective action process that includes progressive notification, and corrective action.
f. Authorizes short-term reappointments that allow the MEC to make crystal clear that certain behavior must stop.
g. Requires that there be a high level review of the issue of employee and applicable non employed physician behavior and the effectiveness of the organizations response to reports of potentially inappropriate behavior.

An excellent reference is available on the net.  
[Medical Staff Code of Professional Behavior - Stanford Health Care](http://example.com)

**Question 3.** For all the training and education I have received, it has always been my understanding that you could not use partners or associates in practice for references when applying for medical staff privileges. The CAQH application even states that professional references cannot be partners in your practice. Do you happen to have any additional information on that or know where I can find something?

**Hugh Responds:** Not quite a myth but should be! References are unquestionably one of the most important sources of information concerning an applicant’s current clinical competence and professionalism. Many decades ago a reference was simply a letter from another physician attesting to applicants abilities. Many a conference faculty has joked that some references were worded as follows: “When you get to know this applicant as we know this applicant you will appreciate this applicant as we appreciate him.” We have also occasionally seen references that are incomplete or misleading, such as check marks between “Satisfactory and Unsatisfactory”. Intentional or unintentional, one will never know.

There is not to my knowledge any peer reviewed research concerning the issue of references of physicians desiring medical staff appointment. We simply do not know if partners shade the truth.
Nor do we know, with certainty, how best to construct our reference questionnaires. Not that it is all a guess, history has shown the following:

We need references in order to make good decisions.

We know that physicians are occasionally prone to shade the negative for fear of litigation or that the applicant will be forced to stay in town as opposed to moving away.

We suspect that people completing references do not particularly enjoy the task and that an increasing number of facilities are merely confirming “She was here with no problems, in good standing.”

We know that some past rules were poorly conceived, for example, you must have a podiatrist complete a reference at reappointment for the single podiatrist who has practiced exclusively with a group of Orthopedists at your hospital. So we needlessly contacted a podiatrist who had no clue about current competence since residency 22 years ago.

We know that reference questionnaires are better at soliciting information than personal letters.

We know that for new applicants you must have at least one professional reference. Statistically speaking we know that out of any group of physicians only one will be truly “average”. Half will be above average and half below average. Some of the below average will need improvement and some should not be appointed. We suspect that some individuals completing reference questionnaires will try to “fence sit” by checking the middle of 5 possibilities (poor, fair, average, satisfactory, excellent) when they suspect the practitioner is fair or poor. Consider revising your questionnaires to eliminate the possibility of fence sitting. (below average, above average, don’t know/won’t say.)

The following is also true. A professional reference could be completed by one of your department chairs or the VPMA after a careful review of collected information and conversations with the applicant and perhaps colleagues in past practice. Many decades ago there may have been some logic to the prohibition against partners giving references, today that logic is falling apart. Medicine today is often practiced by teams. Teams of radiologists, pathologists, anesthesiologists, and hospitalists. Primary care as well as most other specialists often practice as part of a group. If a member of such an arrangement leaves the group and applies to new medical staff it is logical that the physicians in the prior group would “know” a great deal about the physician’s competence and character. It is also possible that they might not report negative opinions to “downstream” organizations for fear of litigation or friendship. It is also best practice today to acquire recommendations from individuals who work with or rely upon the practitioner but may not be in the same specialty.

For example: If an Emergency physicians applies consider obtaining references from a hospitalist, nursing director of the ED, and a general surgeon these references would bolster the recommendation from another ED doctor.

Bearing the above in mind you should not rely solely upon recommendations from former associates or partners. Likewise do not rely upon recommendations from family members. Obtaining one or more of such references is perfectly OK however other non-conflicted individuals must augment these.