The Joint Commission 2024 Medical Staff Update

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Learning Objectives

At the conclusion of this presentation, the participant will be able to:

- Understand the compliant conversion strategies for switching to 3-year credentialing
- Top scored MS standards 2023 and tips for compliance
- Understanding requirements for Bylaws, History and Physicals, OPPE/FPPE
- Standards Reduction Project Updates

Updates to Medical Staff Credentialing and Privileging

MS.06.01.07 EP 9: Privileges are granted for a period not to exceed three years or for the period required by law and regulation if shorter.

CMS IG 482.22(a)(1): The medical staff must periodically conduct appraisals of its members.

The medical staff must at regular intervals appraise the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges. In the absence of a State law that establishes a timeframe for periodic reappraisal, a hospital's medical staff must conduct a periodic appraisal of each practitioner. CMS recommends that an appraisal be conducted at least every 24 months for each practitioner.

Organizations MUST check state law prior to adopting

Credentialing and Privileging Compliance Options

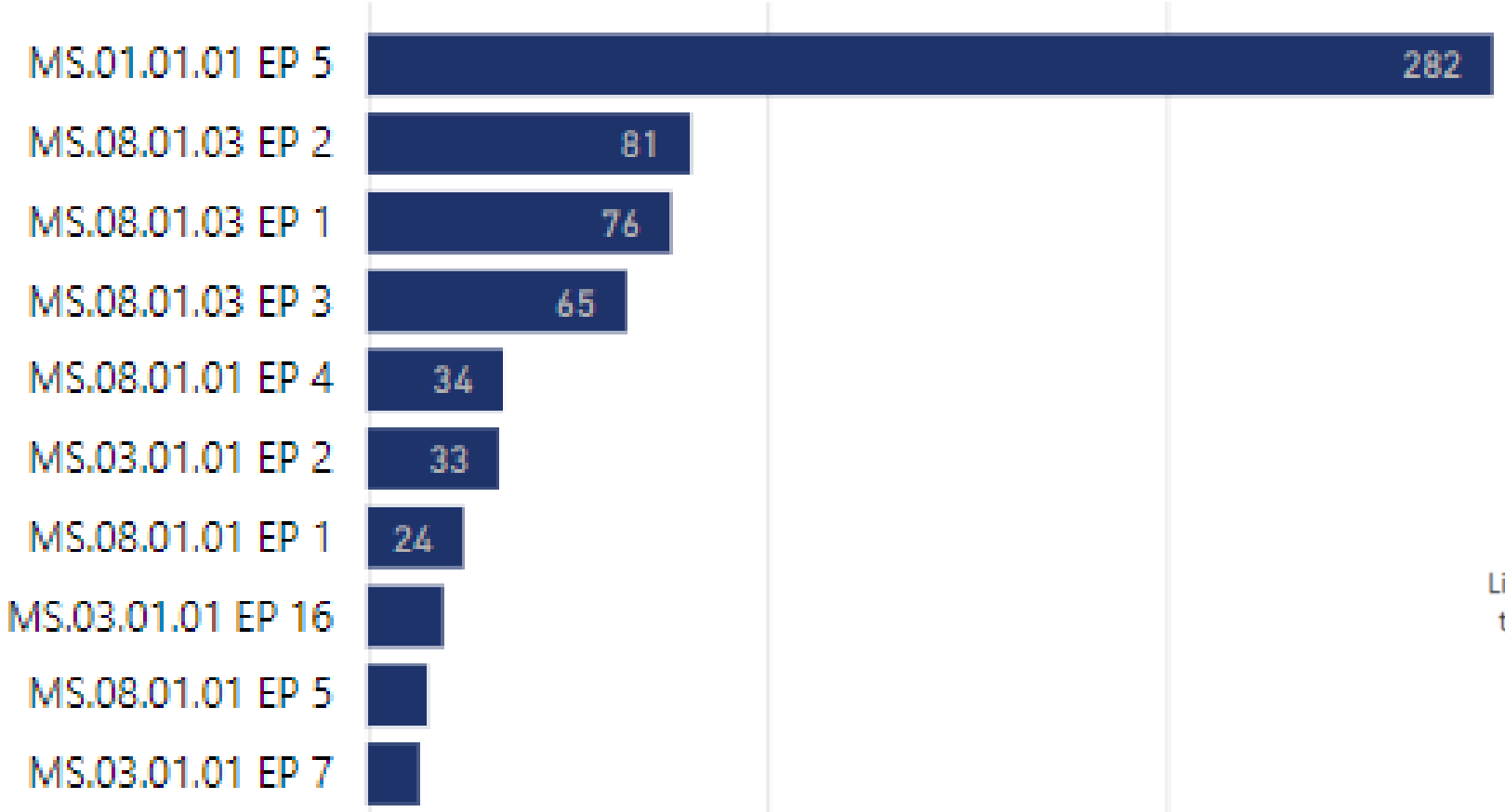
Make an addendum to Medical Staff By laws

Continue 2-year cycle and renew at 3 years

National Practitioner Data Bank Queries

- NPDB querying requirements under the Health Care Quality Improvement Act of 1986 and NPDB Regulations under 45 CFR 60.17.
- Under this requirement, all hospitals must request information (query) from the NPDB:
  - Every 2 years for licensed practitioners who are on its medical staff (courtesy or otherwise) or has clinical privileges at the hospital.

2023 Scoring Update



Statistics for Selected Standards

Surveys	Average RFIs Per Survey	Number of RFIs
463	1.39	642

SAFER Matrix Scoring

Likelihood to Harm	Limited	Pattern	Widespread	
Immediate Threat to Health or Safety -			0.0%	
High	4.2%	1.6%	1.6%	**7.3%**
Moderate	44.7%	20.1%	10.6%	**75.4%**
Low	13.4%	3.4%	0.5%	**17.3%**
	62.3%	**25.1%**	**12.6%**	

Scope

Hospital deemed full surveys 1/1/2023-12/31-2023

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MS.01.01.01 EP 5	The medical staff complies with the medical staff bylaws, rules and regulations, and policies.
MS.08.01.03 EP 2	OPPE PROCESS: The type of data to be collected is determined by individual departments and approved by the organized medical staff.
MS.08.01.03 EP 1	OPPE PROCESS: There is a clearly defined process in place that facilitates the evaluation of each physician's or other licensed practitioner’s professional practice.
MS.08.01.03 EP 3	OPPE PROCESS: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).
MS.08.01.01 EP 4	FPPE is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.
MS.03.01.01 EP 2	Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.
MS.08.01.01 EP 1	A period of focused professional practice evaluation is implemented for all initially requested privileges.
MS.03.01.01 EP16	The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.
MS.08.01.01 EP5	The triggers that indicate the need for performance monitoring are clearly defined.
MS.03.01.01 EP7	The organized medical staff monitors the quality of medical histories and physical examinations.

MS.01.01.01 EP 5

The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

Trends

- Not following specific requirements in by-laws
- Incomplete H&P based on organization requirements

Solutions

- Medical staff not aware of requirements in bylaws
- Monitoring of H&P; including in time out process or prior to moving patients to OR's

MS.08.01.03 EP 2

OPPE: clearly defined process in place that facilitates the evaluation of each physician's or other licensed practitioner's professional practice.

Trends

- Specific TYPES of qualitative data not determined
- No process in place for allied health/APP credentialed through medical staff

Solutions

- Development of monitoring items determined by chair of each service/department
- Include all staff credentialed though MS process

MS.08.01.03 EP 1

OPPE: There is a clearly defined process in place that facilitates the evaluation of each physician's or other licensed practitioner's professional practice.

Trends

- No defined frequency for review or responsibility
- No evidence that PA or APP included
- Process is not consistently followed

Solutions

- The process should define the methodology for obtaining the data used for OPPE (chart review, direct observation, monitoring of diagnostics/treatments)
- Ensure clear process for ALL providers (MD, mid-level providers)
- Clear responsibility (Department chair, medical staff officer, member of credentialing committee)

MS.08.01.03 EP 3

OPPE: Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

Trends

- No OPPE data available for PA/APP
- OPPE data not available for current credentialing cycle
- Performance data only- no issues=no data

Solutions

- Ensure process includes review of current OPPE data
- Ongoing OPPE data collection
- Ensure provider-specific

MS.08.01.01 EP 4

FPPE is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.

Trends

- Lack of implementing FPPE for initial privileges

Solutions

- Implementation of workflow checkpoints with audit tool used as part of sign off.

MS.03.01.01 EP 2

Licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

Trends

- APP's privileges to perform specialized procedures not allowed by By-Laws
- Staff performing procedures in which they were not privileged for

Solutions

- Second check process for when APP are credentialed and privileged and attached to specialty providers
- Processes put in place to randomly audit procedures list by providers and compare to privilege list

MS.08.01.01 EP 1

A period of focused professional practice evaluation is implemented for all initially requested privileges.

Trends

- No specific data description used for FPPE
- Lack of FPPE initiation after receiving initial privileges

Solutions

- Utilization of key metrics related to specialty tied to quality but trackable in EHR
- Evidence (documentation) process was followed

MS.08.01.01 EP5

The triggers that indicate the need for performance monitoring are clearly defined.

Trends

- Lack of clearly defined triggers
- No action taken when triggers met

Solutions

- Clearly defined triggers
- Clearly defined process when met

MS.03.01.01 EP 7

The organized medical staff monitors the quality of medical histories and physical examinations.

Trends

- Identified during medical staff tracer once H&P issues were identified during patient tracer activity

Solutions

- Included in OPPE process
- Incorporated into other chart auditing functions (i.e. core measures)

By-Laws Review

Bylaws Review Tool

	The bylaws must contain Elements of Performance 12 through 37 of MS.01.01.01
What?	Standardized tool for survey
Who?	Anyone Field Representative and organization
Where?	Located in the Survey Activity Guide as well as extranet site under “continuous compliance”
When?	Use prior to Medical Staff Session, if not used at the organization in the past
Why?	Standardized review of the Bylaws

Medical Staff Bylaws Review Tool

Medical Staff Bylaws Review MS.01.01.01					
EP	**Description**	**Expectation**	**Yes**	**No**	**Notes**
12	The structure of the medical staff	Self-explanatory			
13	Qualifications for appointment to the medical staff	Self-explanatory			
14	Process for privileging and re-privileging physicians and other licensed practitioners,	Only basic steps required, but includes all categories of privileges including temp, tele-med (as applicable)			
15	Duties and privileges related to each category of the med staff	Such as for active, courtesy, etc. *Duties and prerogatives, not clinical privileges*			
16	Req. for completing/documenting H&P by physician or other qualified licensed practitioner—Including time frames (30 days before 24 hours after, and requirement for update)	*Consistent* with CoP and PC.01.02.03 EP 4 & 5.			.
17	Description of those members of the medical staff eligible to vote	Self-explanatory			
18	Process by which org MS selects or elects and removes MS officers	Self-explanatory Only basic steps required *			
19	List of all the officer positions for the medical staff	Self-explanatory			
20 and 22	The MEC's function, size, and composition; authority delegated to MEC to act on MS behalf; how such is delegated or removed	Self-explanatory			
21	Process for selecting or electing and removing MEC members	Self-explanatory Only basic steps required *			
23	That the MEC acts on behalf of MS between meetings as defined by MS	Self-explanatory			
24	Process for adopting and amending the medical staff bylaws	Self-explanatory Only basic steps required *			
25	Process for adopting/amending the MS rules and regulations, and policies	Self-explanatory Only basic steps required *			

Medical Staff Bylaws Review MS.01.01.01					
EP	**Description**	**Expectation**	**Yes**	**No**	**Notes**
26	Process for credentialing/re-credentialing physicians and other licensed practitioners,	Only basic steps required;			
27	Process for appointment/re-appt to membership on the med staff	Only basic steps required *			
28	Indications for automatic suspension of MS membership or clinical privileges	Self-explanatory			
29	Indications for summary suspension of MS membership or clinical privileges	Self-explanatory			
30	Indications for termination or suspension of MS membership and/or termination, suspension, or reduction of privileges	Self-explanatory			
31	Process for automatic suspension of MS membership or clinical privileges	Self-explanatory Only basic steps required *			
32	Process for summary suspension of MS membership or clinical privileges	Self-explanatory Only basic steps required *			
33	Process for recommending termination or suspension of MS membership and/or termination, suspension or reduction of clinical privileges	Self-explanatory Only basic steps required *			
34	The fair hearing and appeal process	Process for scheduling and conducting hearings/appeals. Only basic steps required *.			
35	Composition of the fair hearing committee	Self-explanatory			
36	**If departments of MS exist**, the qualifications, roles and responsibilities of department chair				
	a) Qualifications	Board certification or comparable competence			
	b) Roles and responsibilities	Clinically related activities of the department			

Medical Staff Bylaws Review Tool

Medical Staff Bylaws Review MS.01.01.01					
EP	**Description**	**Expectation**	**Yes**	**No**	**Notes**
		Administrative activities of dept, unless provided by hospital			
		Continuing surveillance of prof perf of all in dept with privileges			
		Recommending to the med staff the criteria for departmental clinical privileges			
		Recommending clinical privileges for			

Medical Staff Bylaws Review MS.01.01.01					
EP	**Description**	**Expectation**	**Yes**	**No**	**Notes**
		• MS.05.01.01 • MS.05.01.03			
		Orientation and continuing education of persons in dept or svc			
		Recommending space and resources needed by the dept or service			
		Applies to deemed status hospitals			Applies whether

*Only basic steps must be included in the Bylaws. Details may be in the Rules and Regulations or policies, as applicable.

EP 1-11 may be in the bylaws, but they are not required to be. While discussion of Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation and their use may be contained in the Bylaws, they are not a required part of the Bylaws of the Medical Staff.

		number of qualified and competent persons			
		Determination of qualifications and competence of dept or service non-LIP			
		Continuous assessment and quality improvement See also: • MS.03.01.01 EP 7 • MS.05.01.01 • MS.05.01.03			
		Maintenance of quality control programs, as appropriate See also: • MS.03.01.01 EP 7			

*Only basic steps must be included in the Bylaws. Details may be in the Rules and Regulations or policies, as applicable.

EP 1-11 may be in the bylaws, but they are not required to be. While discussion of Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation and their use may be contained in the Bylaws, they are not a required part of the Bylaws of the Medical Staff.

Additional Medical Staff Bylaws Standards						
STD	**EP**	**Description**	**Expectation**	**Met**	**Not Met**	**Comments**
EM.12.02.03	5 ~~2~~	The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners.	This information may be in the Bylaws, MS rules/regs or policies and procedures.			
MS.02.01.01		The medical staff executive committee makes recommendations, as defined in	**In order to be compliant with this standard, the MEC has to have the authority and responsibilities as defined in**			

Medical Staff Bylaws Review Tool

Additional Medical Staff Bylaws Standards						
STD	**EP**	**Description**	**Expectation**	**Met**	**Not Met**	**Comments**
		the bylaws directly to the governing body on, at least, all of the following	**the bylaws to do these things**. See also MS.01.01.01 EP 20).			
	8	Medical staff membership	Self-explanatory. See explanation above.			
	9	The organized medical staff's structure	Self-explanatory. See explanation above.			
	10	The process used to review credentials and delineate privileges	Self-explanatory. See explanation above.			
	11	The delineation of privileges for each practitioner privileged through the medical staff process	Self-explanatory. See explanation above.			
	12	The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups	Self-explanatory. See explanation above.			
MS.06.01.03	4	The credentialing process is outlined in the medical staff bylaws	Self-explanatory. Only basic steps required			.
MS.06.01.05	11	Completed applications for privileges are acted on within the time period specified by the medical staff. (Effective 9/17/20 this does NOT have to be in the bylaws).	In order to be able to comply with this standard, the time period for acting upon the application for privileges must be specified by the medical staff.			
MS.06.01.13	1	Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.	In order to be able to comply with this standard, the time period for which temporary privileges can be granted must be defined in the bylaws. Temporary privileges cannot exceed 120 days for new privileges (see EP 6).			
MS.10.01.01	5	The fair hearing process developed by the medical staff must, with the governing body, provide a mechanism to appeal adverse decisions as provided in the medical staff bylaws.	Self-explanatory. (see also MS.01.01.01 EP 34)			
Additional information to ask about:						
MS.03.01.01	16 17	Medical staff approves qualifications for radiology staff who use equipment	***Only for Deemed surveys.*** Examples of compliance may include, but not limited to:			

Additional Medical Staff Bylaws Standards						
STD	**EP**	**Description**	**Expectation**	**Met**	**Not Met**	**Comments**
		and administer procedures (EP 16) and nuclear medicine staff (EP 17).	Evidence may be found in MEC minutes, Radiology Dept. minutes, job descriptions or competency forms, etc., approved by the medical director. **Note**: Re-approval is only required if there has been a substantive change			

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History and Physical Requirements

The basics

- Must be completed after registration and prior to a surgery or within 24 hours after admission.
  - If completed prior to registration must be within 30 days and updated prior to procedure or within 24 hours after admission

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Patient assessment in Lieu of a History and Physical for certain outpatient procedures

PC.01.02.03 EP 7 – timing

- For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is completed and documented after registration but prior to surgery or a procedure requiring anesthesia services when the patient is receiving specific outpatient surgical or procedural services.

MS.03.01.01 EP 6 – content

- The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services.

MS.01.01.01 EP 38 – Bylaws requirement

- For hospitals that use Joint Commission accreditation for deemed status purposes: When the medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific outpatient surgical or procedural services, the medical staff bylaws specify that an assessment of the patient is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services.

MS.03.01.01 EP 19 – policy development

- For hospitals that use Joint Commission accreditation for deemed status purposes: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following:
  - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
  - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
  - Applicable state and local health and safety laws

FPPE / OPPE Requirements

Focused Professional Practice Evaluation

FPPE

- Became effective January 2008
- The goal of FPPE is for the hospital and medical staff to get a comfort level with the practitioner's performance of new privileges within the context of the hospital's policies and procedures, staffing, available equipment, the physical facility and financial support.
- All applicants for new privileges must have a period of focused review. There is no exemption for board certification, documented experience, or reputation.
- It is acceptable to group activities where the knowledge, and skills are so similar that if the practitioner performed a mix of the activities, they could be deemed competent in the entire group.

FPPE Requirements

The process must be defined

The process must be consistently implemented as defined

All new privileges (new applicants and new privileges for existing applicants) must be reviewed in accordance with the defined process

There are no exceptions for any applicant or privilege

Qualitative data is required, quantitative data may be necessary as well

Data types

- **Qualitative**
  - Description of procedures performed
  - Periodic Chart Review
    - appropriateness of tests ordered / procedures performed
  - Types of patient complaints
  - Peer recommendations
  - Discussion with other individuals involved in the care of patient(s), IE: consultants, surgical assistants, nursing, administration, etc.
- **Quantitative**
  - Length of stay trends
  - Post-procedure infection rates
  - Periodic Chart Review
    - Dating/timing/signing entries
    - T.O./V.O. authenticated within defined time frame
  - Number of H & P / updates completed within 24 hours after inpatient admission/registration
  - Compliance with medical staff rules, regulations, policies, etc.

Ongoing Professional Practice Evaluation

OPPE

OPPE has been in effect since January 1, 2007.

Overarching goal is that organizations maintain a comfort level with:

- the performance of practitioners on an ongoing basis, identify performance issue on an ongoing basis,
- take steps to improve performance when issues are identified
- collection of data will result in a more evidence-based re-privileging process at the two-year renewal point.

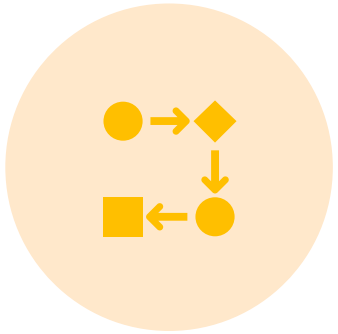
OPPE Requirements

The process must be clearly defined:

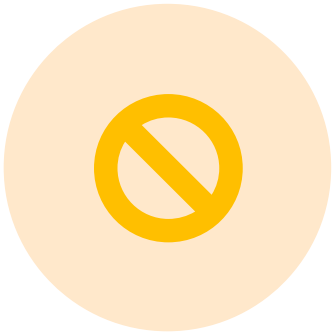
- Responsibility for data review:
  - Department chair, department as a whole, etc as defined by the organization
  - Credentialing committee
  - Medical Executive Committee
  - Special committee of the organized medical staff
- Frequency of data review
- The process to use the data for decision-making
- The decision process resulting from the review

OPPE Outcomes

Determining that the practitioner is performing within desired expectations, no further action is warranted



Determining that a performance issues exists and requires a focused evaluation – see MS.08.01.01 EP 5.



Revoking the privilege because it is no longer required

Suspending the privilege, which suspends the data collection, and notifying the practitioner that if they wish to reactivate it they must request a reactivation

Frequently asked questions…

Low-volume Practitioners

When practitioner activity at the 'local' level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may **NOT** be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data's relevance, timeliness, and accuracy.

Examples where supplemental data could be used may include, but are not limited to:

- activity is limited to periodic on-call coverage for other physicians or groups
- occasional consultations for a clinical specialty

Consistent with the "Medical Staff" chapter, the medical staff must develop policies and procedures which ensure oversight of local data and the use of supplemental data.

https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000001500/

The Joint Commission Refines Requirements for Hospital Credentialing, Privileging, and Evaluation of Practitioners

Use of Supplemental Data from Other Hospitals Allowed

Table 1. Considerations for Data Sharing Related to Credentialing and Privileging

Examples of Required Items That May Be Shared Between CMS–Certified Organizations	Examples of Items That May Not Be Shared Between CMS–Certified Organizations: PSV Mandatory
General information related to application for privileges that does **not** require verification via primary source	PSV:* • Current licensure/certifications • National Practitioner Data Bank query • OIG Exclusion List
Verification of relevant training (may be shared as long as there is evidence that the information was obtained through PSV or a CVO)	
Physical ability to perform requested privileges	
Peer and/or faculty recommendation	

Table 2. Considerations for Data Sharing Related to FPPE and OPPE

Focused Professional Practice Evaluation (FPPE)	Ongoing Professional Practice Evaluation (OPPE)
FPPE data may be obtained from a CMS–certified organization. However, any information received can be used only as supplemental information, not in lieu of collecting organization-specific data.	OPPE data may be obtained from a CMS–certified organization. However, any information received can be used only as supplemental information, not in lieu of collecting organization-specific data.

CMS, US Centers for Medicare & Medicaid Services.

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THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

Standards Reduction Project

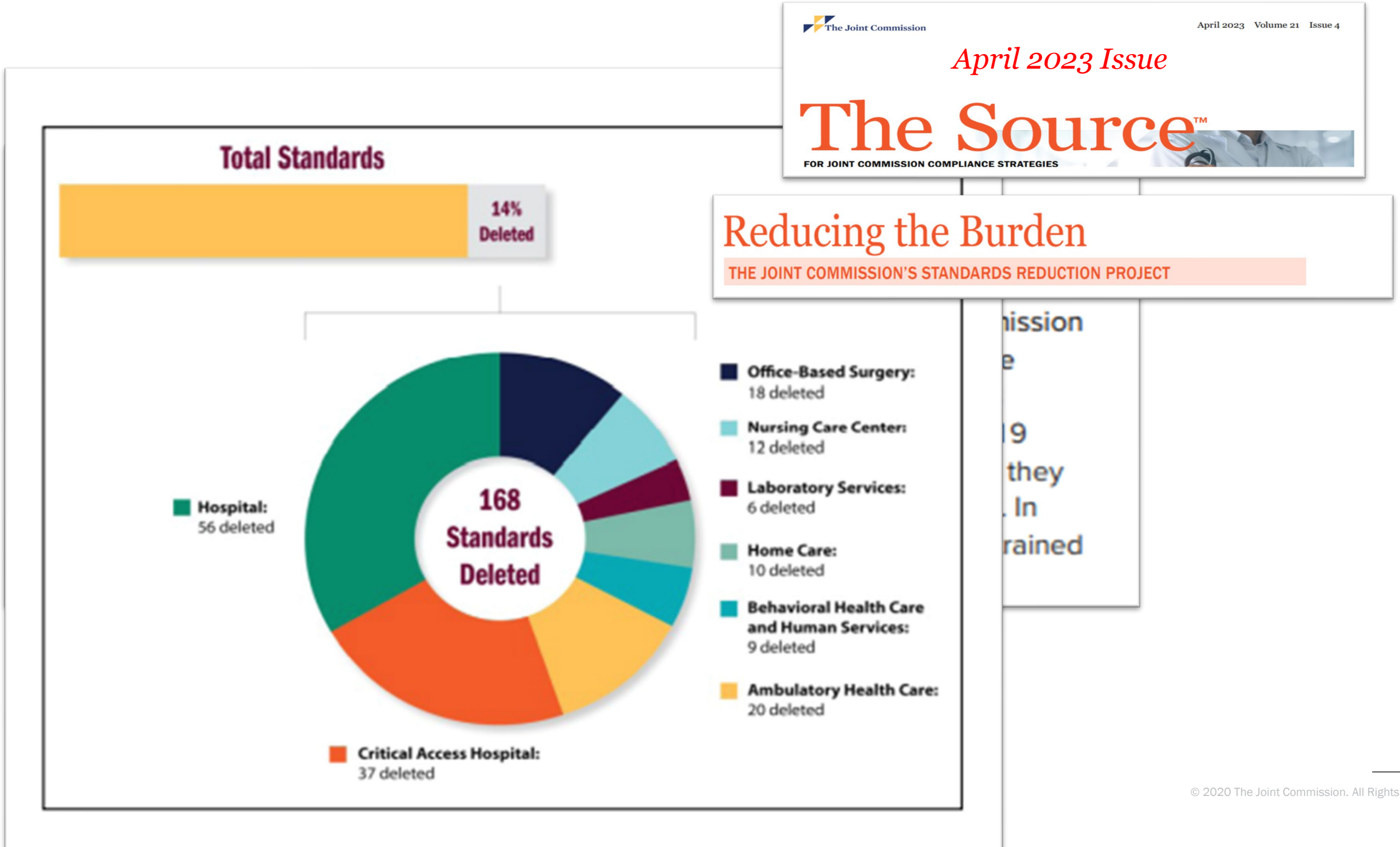
Standards Mega-Review:

- **Scope:**
  - Review requirements that go beyond CMS or other state and federal agency regulations
- **Goal:**
  - Decrease the number of low-value requirements, increase focus on meaningful value-added requirements, while reducing the burden on HCOs
- **Focused on requirements that:**
  - ✓Do not support a CMS CfC or state regulation
  - ✓Have been in effect for more than three years
  - ✓Have been scored five times or less –between 2017 and 2019

Standards Mega-Review:

- **Review process:**

  - ✓Are HCOs already compliant?
  - ✓Has the topic has been adopted into standard practice?
  - ✓Is the requirement redundant to another existing requirement?
  - ✓Is it difficult to assess compliance with the EP objectively and consistently



Standards Mega-Review:

The Joint Commission

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Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Joint Commission Requirement

APPROVED: The Joint Commission Continues to Reduce Requirements

Requirements Reduced in Most Accreditation Programs

Last year, The Joint Commission reviewed all its hospital accreditation requirements, identified those above and beyond the US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs), and reduced those requirements for hospitals, as well as related requirements across accreditation programs (*see* the November 2022 and January 2023 issues of *Perspectives* for more information about this project). The second phase of this project reviewed requirements in The Joint Commission's other accreditation programs

Questions