The TJC Medical Staff Standards Update 2015
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Joint Commission Resources
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Objectives
- Review the top scored standards in the medical staff chapter and their related CoPs that were in 2014
- Review of processes that have been used as solutions to the top scored standards
- Review standards/CoPs from other chapters that impact medical staff
- Review what was new as of July 2014
- Review what was new as of September 2014
- Review what’s new in 2015
TJC and CMS

- Continue to become more closely aligned following most recent granting of deeming authority in 2015
- CMS CoPs (Conditions of Participation) and TJC Standards do not have a one to one relationship
- A CoP can have multiple standards associated with it
- A Standard/EP can have more than one CoP associated with it
- Scoring depends on the context and circumstances of the finding

Top Scored Standards
**MS.01.01.01**

- **EP 3:** Most commonly scored EP, must be scored if one of EPs 12-36 is scored
- **EP 16:** Most commonly scored EP of EPs 12-36
  - History, Physical and Updates defined at a minimum of what is contained at PC 01.02.03 EPs 4,5
  - H & P (482.22 (c)(5)(i))
  - Update (482.22 (c)(5)(ii))

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**MS.01.01.01**

- **EP 16:** The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

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**MS.01.01.01**

- **EP 16: Note 2:** The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.
**MS.01.01.01**

- **EP 4**: The medical staff bylaws, rules and regulations, and policies, the governing body, bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation.

  (482.22 (c))

- **EP 5**: The medical staff complies with the medical staff bylaws, rules, and regulations

  - If deficiencies are present in histories, physicals or updates…it will be scored here

  (482.22 (a)(1))
  (482.22 (c))

**Associated standards . . .**

- **EM 02.02.13 EP 2** The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.
**EM 02.02.13 EP 3** The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. (Usually in the Emergency Operations Plan)

**EM 02.02.13 EP 4** The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).

**EM 02.02.13 EP 5** Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) AND at least one of the following:
A current picture identification card from a health care organization that clearly identifies professional designation
Primary source verification of licensure
Identification 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 organization or group
Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster
A current license to practice

Tips for Success
- Take a copy of the bylaws and the standard EPs 12-36 and tab where each of the EP’s is located
- If the details of any of EPs 12-36 are in other areas such as the rules, regs, or policies, keep these handy and updated
- Keep these updated every time bylaws, etc., are revised

MS.08.01.03
- EP 3 Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s)

(482.22 (a)(1))
EP 1: There is a clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice.

EP 2: The type of data to be collected is determined by individual departments and approved by the organized medical staff.

Tips for Success:
- Develop a spreadsheet of all of your practitioners and when their OPPE is due.
- Send a list to dept. chairs every month to remind if you don’t have a current OPPE on file.
- Be sure to include allied health practitioners.
Tips for Success

- If you are using OPPE that includes activity numbers, it is a good idea to have available the case logs in case the credentials committee has a question about the outcome.

MS.03.01.01

EP 16 For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.
- Can now be done by the Radiology Medical Director

(482.26 (c)(2))

MS.03.01.01

EP 17 For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director’s specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.
- Can now be done by the Radiology Medical Director

(482.53 (a)(2))
• **EP 7** The organized medical staff monitors the quality of the medical histories and physical examinations.

• **EP 2** Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

  (482.52 (a)(3))
  (482.12 (c)(2))
  (482.12 (a)(1))…

**Tips for Success**

• Encourage medical staffs to develop audit tool for H and P’s and review these regularly and track data and actions taken

• Check applications carefully for possible omissions or oversights
**MS.08.01.01**

- **EP 1** A period of focused professional practice evaluation is implemented for all initially requested privileges
  - Usually results from a lack of documentation of the practitioner’s performance in a timely manner
  - Other reason for scoring is no evidence of process for allied health practitioners

  (482.22 (a)(1))

**MS.08.01.01**

- **EP 3** The performance monitoring process is clearly defined and includes each of the following elements:
  - Criteria for performance monitoring
  - Method for establishing a monitoring plan specific to the requested privilege
  - Method for determining the duration of performance monitoring
  - Circumstances requiring an external source

**MS.08.01.01**

- **EP 4** Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.
Tips for Success

- Establish the FPPE process during the credentialing process.
- Send out an attached copy of the FPPE with the practitioner’s board letter
- Keep a spreadsheet of all currently in FPPE, reminders to reviewers
- Follow through on process and feedback in a timely manner

MS.06.01.03

- EP 6 The credentialing process requires the hospital to verify in writing and from a primary source or CVO:
  - Current licensure at time of appointment, reappointment, new privilege request, and license expiration.
  - Relevant training
  - Current competence

  (482.22 (a)(2))…

- EP 5 The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
  - Current picture hospital ID
  - A valid government issued photo ID
Tips for Success

- Spreadsheet and reminders for license or other certification renewals
- Process of going up the chain of command
- Make sure there is verification of current competence in some way: provide privileges to those who are completing references

MS.05.01.03

- **EP 3** The organized medical staff participates in the following activity: Accurate, timely, and legible completion of patient’s medical records.
  - How is the medical staff informed of issues, what is the process for outliers?
  - In EHR: may be how scribes are used or if an excessive number of telephone orders?

  \[(482.24(c)(1))\]

Associated standards …

- **RC.01.02.01 EP 3** If unable to tell who documented in the medical record: i.e. a history and physical completed in a physician’s office that is clearly written by someone other than the individual who signed it; basically acted as a scribe

  \[(482.24)\]
  \[(482.26)\]
Associated standards . . .

- **RC.01.01.01 EP 8** If there are instances of illegibility that cannot be read by staff members, then it will be scored here. This is because the information is not available to the next provider of care.

  (482.24)

Associated Standards...

- **RC.01.01.01 EP 11 and EP 19**
  - Dating and timing of medical records

  (482.24)
  (482.53)

MS.06.01.05

- **EP 2** The hospital, with the approval of the medical staff and board, develops criteria that include:
  - Current license and/or certification
  - Documented training
  - Physically able to perform privilege
  - Data from org. where currently performing privilege
  - Peer/faculty recommendation
  - When renewing, check current performance
**EP 3** All of the criteria used are consistently evaluated for all practitioners holding that privilege.

(482.22 (a)(1))
(482.54 (c)(4)(i))

**EP 7** National Practitioner Data Bank query at appointment, reappointment, and if requesting a new privilege.
- Continuous query demonstrates compliance

(482.22 (a)(1))
(482.12 (a)(6))

**EP 10** The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

(482.22 (a)(1))
Tips for Success

- Develop solid criteria and use it as a checklist during the credentialing process.
- At the time of reappointment, ensure that you have documentation of the performance of a privilege.
- Pre-populate the privilege forms with the number of times each privilege has been done and outcomes.

MS.06.01.07

- **EP 9** Privileges are granted for a period not to exceed two years (482.22 (a)(1))
- **EP 5** The hospital's privilege granting/denial criteria are consistently applied for each requesting practitioner (482.51 (a)(4))

Tips for Success

- Watch how letters are sent out, be sure to not exceed the two year window.
- Be alert during credentialing process, remember FPPE can be different depending on level of experience but the initial criteria should be consistently applied.
There is a 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.

Tips for Success

- Review privilege lists regularly with medical staff
- Keep open lines of communication with directors of departments to get updates if services change

Other CMS CoPs and their Corresponding TJC Standards
(482.13 (b)(1)-(4))

Medical staff support patients’ rights to:

- Participate in the development/implementation of plan of care
  - PC.01.03.01
- Make informed decisions regarding care
  - RI.01.02.01
  - Be informed of health status
  - Be able to request or refuse treatment
- Formulate advance directives/have staff comply
  - RI.01.05.01
- Have a family member/representative and physician of choice notified promptly of hospital admission
  - RI.01.02.01

(482.13 (b)(1)-(4))

Medical staff support patient rights to:

- Informed Consent: RC.02.01.01, RI.01.03.01, RI.01.03.03, RI.01.03.05
- Personal privacy
  - RI.01.01.01
- Care in a safe setting
  - EC.02.06.01
- Confidentiality of clinical records
  - IM.02.01.01, IM.02.01.03
- Freedom from:
  - all forms of abuse/harassment/punishment
    - RI.01.06.03
  - restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff
    - PC.03.05.01

Autopsies

- The medical staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest.
  - MS.05.01.01 EP 9
- The mechanism for documenting permission to perform an autopsy must be defined.
  - RI.01.05.01 EP 21
- There must be a system for notifying the medical staff, and specifically the attending practitioner, when an autopsy is being performed.
  - 482.22(d)
Telemedicine

- Usually a contracted service
- May be a bylaws provision (not required)
- Watch how the contract is written, be sure to include written performance expectations
  - These can include verification of ID and OPPE for the individual as long as it can be specific to your site

Telemedicine

- MS.13.01.01

Telemedicine Options

- Regardless of option chosen: must maintain a file.
  - EP 1 Full Credentialing
    - This is traditional process
    - Changed in response to cumbersome nature of performing this process

(482.22(a)(3))
Telemedicine

- MS.13.01.01 (con’t)
- Telemedicine Options
  - EP 2 Use the information from distant TJC site to put practitioners through their process
  - EP 3 Use the decision from the TJC distant site
    • Must have in contract
    • Must have access to and ability to provide quality data

(482.22(a)(3))

Telemedicine

- MS.13.01.03

- Telemedicine
  - EP 1 What can be done through this medium
  - EP 2 Quality should be industry standard

Anesthesia and Sedation
Anesthesia and Sedation

- **PC.03.01.01** Plans sedation: who can do: whether moderate or deep (482.52)
- **LD.04.01.05** (482.52, 482.53 (a)(1), 482.57 (a)(1))
  - **EP 7**: Qualified doctor of medicine or osteopathy directs anesthesia, emergency services, nuclear medicine, and respiratory therapy
  - **EP 9**: For hospitals that use Joint Commission accreditation for deemed status purposes: The anesthesia service is responsible for all anesthesia administered in the hospital.
  - *For TJC purposes: this includes sedation*

- **PC.03.01.03** Performs pre-anesthesia assessments, includes immediately prior to procedure (482.52 (b)(1))
- **PC.03.01.05** Monitors patient during procedure (482.52 (b)(2))
- **PC.03.01.07** Post-anesthesia assessment (482.51 (b)(4))
  - Seven Required Elements (482.52 (b)(3))

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A post-anesthesia evaluation includes:
- Respiratory function, including respiratory rate, airway patency, and oxygen saturation
- Cardiovascular function, including pulse rate and blood pressure
- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Post-operative hydration
Medical Staff and Leadership: PI and Quality

- The two should not be mutually exclusive nor functioning in silos.

Medical Staff and Leadership: PI and Quality Survey Expectations

- In order to show compliance with MS 05.01.01 the surveyors should be able to discern from meeting minutes and discussion with physicians that there is significant medical staff involvement in performance improvement.

  (482.62 (b)(2))

Medical Staff and Leadership: PI and Quality Survey Expectations

- From a leadership perspective, the organization’s administration, in partnership with the medical staff, should be able to show how an organization-wide patient safety program has been implemented as delineated in LD.04.04.05. This will be assessed through the review of minutes and the leadership session.

  (482.21)
The medical staff, along with CEO and DNS, must:

- Ensure that the hospital-wide quality assurance program and training programs address problems identified by the infection control officer or officers; and
- Be responsible for the implementation of successful corrective action plans in affected problem areas.

(482.42(b))

Questions?

OPPE/FPPE
Allied Health Practitioners
What is the definition of an allied health practitioner for purposes of OPPE/FPPE?

- Per CMS: An individual who provides a medical level of care

Does this include: a physician’s private nurse?

- Typically not as they are not Independent
- If were included: there is an expectation of OPPE
- Refer to standards HR.01.06.01 EP 3 and HR.01.07.01 EP 5

Could include LISW, PT, Pharmacists

- If employed: would have HR file in addition to Credentialing/Privileging file similar to employed physician

The requirements (expectations) and HOW?

- Must have comparable data to physicians
- If part of a group, same data as applied to other group members should be available
- Professional organizations sites
- Need to avoid bias
- Organizations have developed secure electronic logging processes
Focused Professional Practice Evaluation for New
Privileges – Data to be collected
– Review type can vary, direct observation for certain
privileges vs. chart audits for other privileges
• Chart review (Internal or External)
• Direct observation
• Simulation
• Discussion with other individuals involved in the care of
each patient including consulting Practitioners, assistants
at surgery, nursing, and administrative personnel

Ongoing Professional Practice Evaluation – Data to be
collected
– Defined by individual medical staff departments and
approved by the organized medical staff
• This can be as department specific as warranted by the
organization’s service lines
– Departments will know best what type of data will
reflect both good and problem performance for the
various practitioners in their departments
– Data not just negative/outlier/trending data, but also
data on good performance

New Standards/EPs
July 2014
NEW! – July 2014

- **Standard MS.03.01.03** The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

  **EP 13.** For hospitals that use Joint Commission accreditation for deemed status purposes: Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital.

NEW! – July 2014

- **MS.06.01.05** The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

  **EP 15.** For hospitals that use Joint Commission accreditation for deemed status purposes: The surgical service maintains a current roster listing each practitioner’s surgical privileges.

  - Note: *The roster may be in paper or electronic format* (482.22 (a)(1))

NEW! – July 2014

- **PC.03.01.01 EP 10** For hospitals that use Joint Commission for deemed status purposes: In accordance with the hospital’s policy and state scope-of-practice laws, anesthesia is administered only by....

  - An anesthesiologist’s assistant supervised by an anesthesiologist who is immediately available if needed.
NEW! – September 2014

- CMS Standards Changes Related to Efficiency, Transparency, and Burden Reduction Part II
  - Practitioners not on MS who order outpatient services
  - MS structure in multihospital systems

PC.02.01.03

- EP 1… Note: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
  - Responsible for the care of the patient
  - Licensed in the state where he or she provides care to the patient
  - Acting within his or her scope of practice under state law
  - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

NEW! – September 2014

- MS.01.01.01 EP 37
  - For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the bylaws describe the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.

(482.22 (b)(4))
For hospitals that use Joint Commission accreditation for deemed status purposes: Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.

If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs:

Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.
NEW! – September 2014

- **MS.01.01.05 EP 2**
  - The unified and integrated medical staff takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.

NEW! – September 2014!

- **MS 01.01.05 EP 3**
  - The unified and integrated medical staff establishes and implements policies and procedures to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are given due consideration.

NEW! – September 2014

- **MS 01.01.05 EP 4**
  - The unified and integrated medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.
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On The Horizon….

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MS.01.01.01  New!  Effective 7/01/15

- The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff.
- Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.

  (482.22 (a))

What’s coming next….

- Proposed new radiology standards that completed field review stage of evaluation last year
- Implementation delayed due to field response
- Radiology requirements were reintroduced for implementation expected by 7/01/15 without MS standards
- NO current plan to reintroduce these for implementation at this time
For hospitals that provide computed tomography (CT) services: At the time of granting initial privileges, the hospital verifies and documents that a radiologist who interprets CT exams is board certified in radiology or diagnostic radiology by the American Board of Radiology, American Osteopathic Board of Radiology, or an equivalent source. If the radiologist is not board-certified, then the hospital verifies and documents that he or she has achieved the following qualifications and experience:

- Completed an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) diagnostic radiology residency
- Performance and interpretation of 500 CT examinations in the past 36 months

For hospitals that provide computed tomography (CT) services: Upon renewal of privileges, the hospital verifies and documents that a radiologist who interprets CT examinations has the following experience:

- The radiologist meets the Maintenance of Certification (MOC) requirements of their certifying body.
- A radiologist reading CT examinations across multiple organ systems has read 135 exams in the past 24 months.
- A radiologist reading organ system-specific CT examinations (for example, abdominal, musculoskeletal, head), has read a minimum of 40 organ system specific CT examinations in the past 24 months. In addition, he or she must have also read a total of 135 cross-sectional imaging studies for MRI, CT, PET/CT and ultrasound in the past 24 months.

For hospitals that provide computed tomography (CT) services: Upon renewal of privileges, the hospital verifies and documents the ongoing education of a radiologist who interprets CT examinations. Ongoing education must include As Low As Reasonably Achievable (ALARA), Image Gently, Image Wisely, and one of the following:

- Meeting the Maintenance of Certification (MOC) requirements of their certifying body
- Completing 100 hours of relevant continuing medical education (CME) in the past 24 months; this must include 50 hours of Category 1 CME
- Completing 10 hours CME in the past 24 months specific to the imaging modality or organ system
Questions?

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