TJC – It's as easy as ABC! or is it?

Melissa Walters, MHA, FMSP, CPMSM, CPCS
Assistant Vice President – Medical Staff Operations
MedStar Health

Objectives

- To gain a basic understanding of essential TJC Standards related to the Medical Staff Chapter
- Compare and contrast survey related experiences while sharing “Tips of the Trade”
- Identify opportunities for improvement for ongoing readiness and the Medical Staff/Credentialing Interview

Bylaws – MS. 01.01.01

38 – Elements of Performance (EPs)

- Effective ONLY upon governing body approval (not MEC or Medical Staff)
- Structure
- Qualifications
- Privileging process
- Categories of the Medical Staff & their perogatives

Bylaws – MS. 01.01.01

- Requirement for completing/documenting H&P by physician or qualified individual—Including time frames 30 days prior to admission/registration or within 24 hours after, and the requirement for update.

Bylaws – MS. 01.01.01

- Voting rights
- Officers (election & removal)
- MEC
  - function/size/composition
  - Authority to act
  - Member selection/removal

Bylaws – MS. 01.01.01

- Adoption/amendment
- Process for credentialing/ recredentialing
- Process for appointment/ reappointment to membership

Bylaws – MS. 01.01.01

- Indications and process for:
  - automatic suspension (mem/priv)
  - summary suspension (mem/priv)
  - termination of membership
  - termination, suspension, or reduction of privileges
- Fair hearing & appeal
  - composition of hearing com.

Bylaws – MS. 01.01.01

Department Chair

- Qualifications
  - Board certified or comparable comparison

Bylaws – MS. 01.01.01

Department Chair

- Roles & Responsibilities
  - Clinically related activities of the department
  - 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

Bylaws – MS. 01.01.01

- Recommending clinical privileges for each member of dept
- Assessing and recommending to hospital authority off-site sources of care
- Integration of dept or service into primary functions of org
- Coordination and integration of inter- and intra-departmental services
- Development and implementation of policies and procedures

Bylaws – MS. 01.01.01

- Recommendations for sufficient number of qualified and competent persons to provide care, treatment, and services
- Determination of qualifications and competence of dept or service non-LIP
- Continuous assessment and quality improvement

Bylaws – MS. 01.01.01

- Maintenance of quality control programs, as appropriate
- Orientation and continuing education of persons in dept or svc
- Recommending space and resources needed by the dept or service


THE BYLAWS OUTLINE TWO DIFFERENT VOTING PROCEDURES!
WELL, THEY ARE BI-LAWS... I THOUGHT THAT MEANT THEY CAN GO BOTH WAYS
gogladly.com/comics
gladly

more Bylaws

MS.02.01.01 (EPs 8 – 12)

- The medical staff executive committee makes recommendations, as defined in the bylaws directly to the governing body on, at least, all the following:
  - Medical staff membership
  - Organized medical staff structure
  - Process used to review credentials and delineate privileges
  - Delineation of privileges for each practitioner privileged through the medical staff process
  - MEC review of and actions on reports of medical staff committees, departments, and other assigned activity groups.

more Bylaws

EM.02.02.13 (EP 2)

- Bylaws must identify individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.

more Bylaws

MS.06.01.03 (EP 4)

- The credentialing process is outlined in the medical staff bylaws

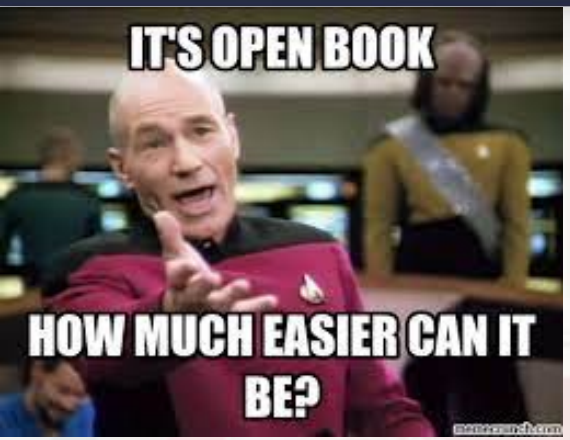
MS.06.01.05 (EP 11)

- Completed applications for privileges are acted on within the time period specified.

more Bylaws

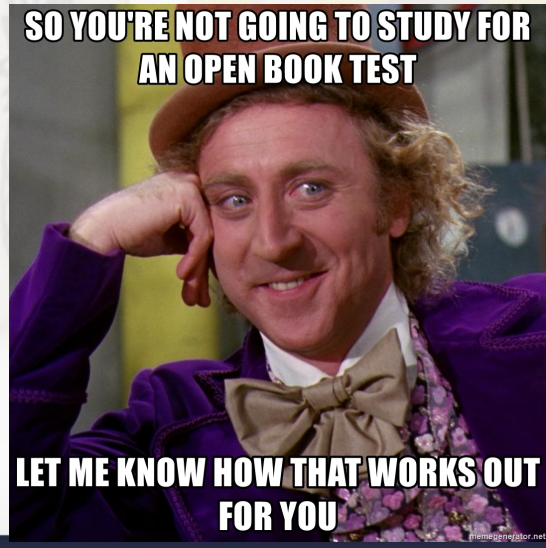
MS.06.01.13 (EP 1)

Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.



The Survey

Open Book Test



File Review

Credentials File Review Tool

LIP info				PSV Documents						Peer Recommendations					FPPE	OPPE	Administration	
Practitioner	Specialty	Application Type	Valid Picture ID (file copy not required)	Current License	Relevant Training	Current Competence	NPDB Review	Health Status	DEA Current? (if required by medical staff)	Medical/Clinical Knowledge	Technical/Clinical Skills	Interpersonal Skills	Communication Skills	Professionalism	Was FPPE process used for new applicant or new privileges?	Was OPPE data used for recredentialing decision?	Timeliness of decision and < 2 yr term	Board approval and letter to applicant

Other Medical Staff Standards to Review		
	Yes	No
Confirm qualifications of key department leaders—name, license and board certification:		
Respiratory		
Radiology		
Nuclear Medicine		
Emergency Department		
Psychiatry (Inpatient)		
Anesthesia		
(Refer to the Credentialing and Privileging System Tracer template for relevant standards and EPs.)		

Updated: 12.2.20

Credentialing Discussion

- The process (how do you credential?)
- How you perform PSV?
- Evidence of Provider ID verification
- Peer recommendations (ACGME core competencies)
- NPDB (when do you query?)
- Process for evaluation of “red flags”

Credentialing Discussion

- Expedited credentialing
  - 2 voting members of the board on the approving committee
- How are criteria for granting privileges determined and approved?
- Temporary privileges
  - No more than 120 days

Credentialing Discussion

- Telemedicine – how are they credentialed?
  - They should all be granted privileges by the originating site but may do so in the usual way

OR

  - By contractual arrangement to accept the credentialing information from a Joint Commission Accredited or CMS certified Organization

OR

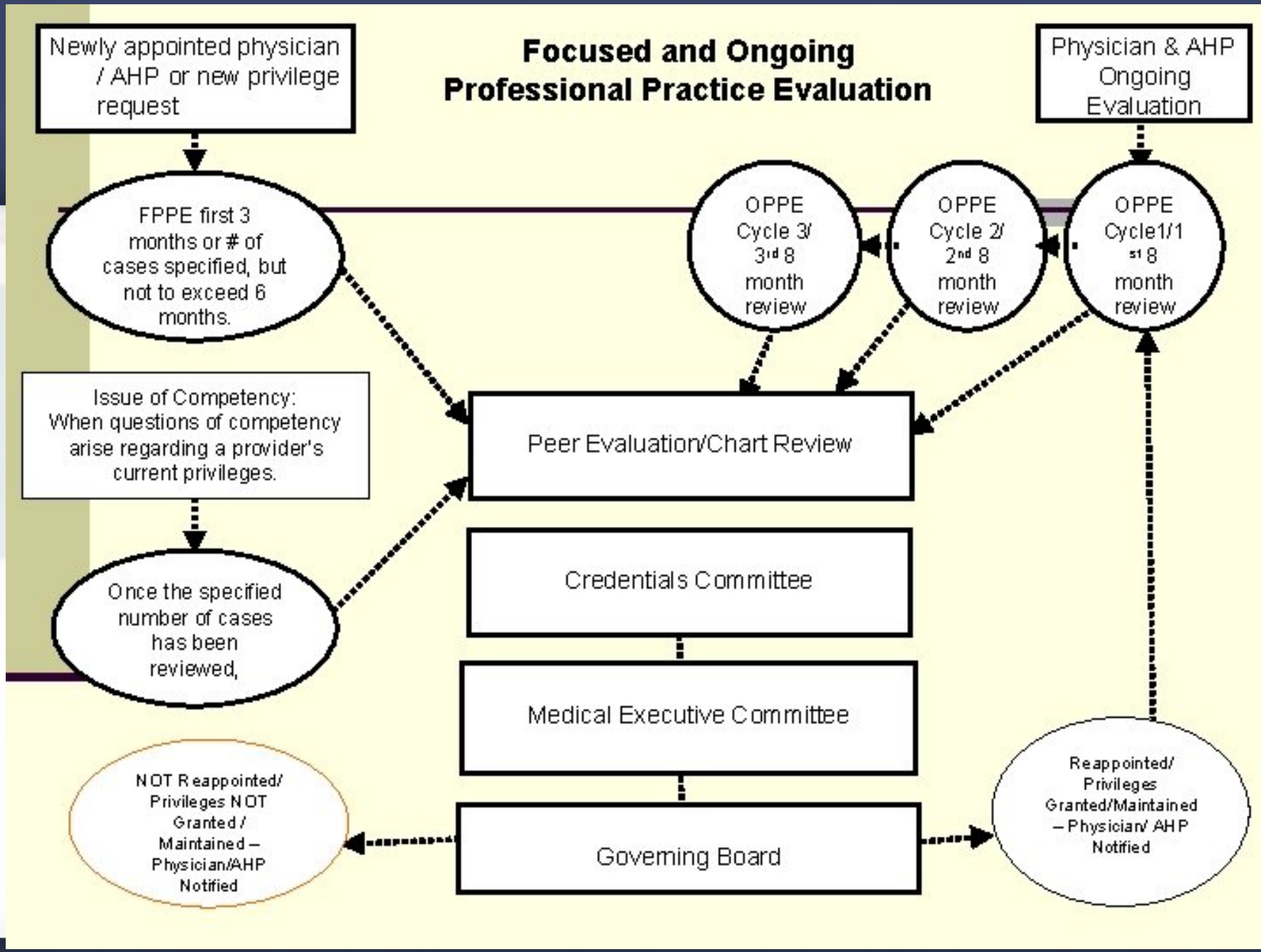
Credentialing Discussion

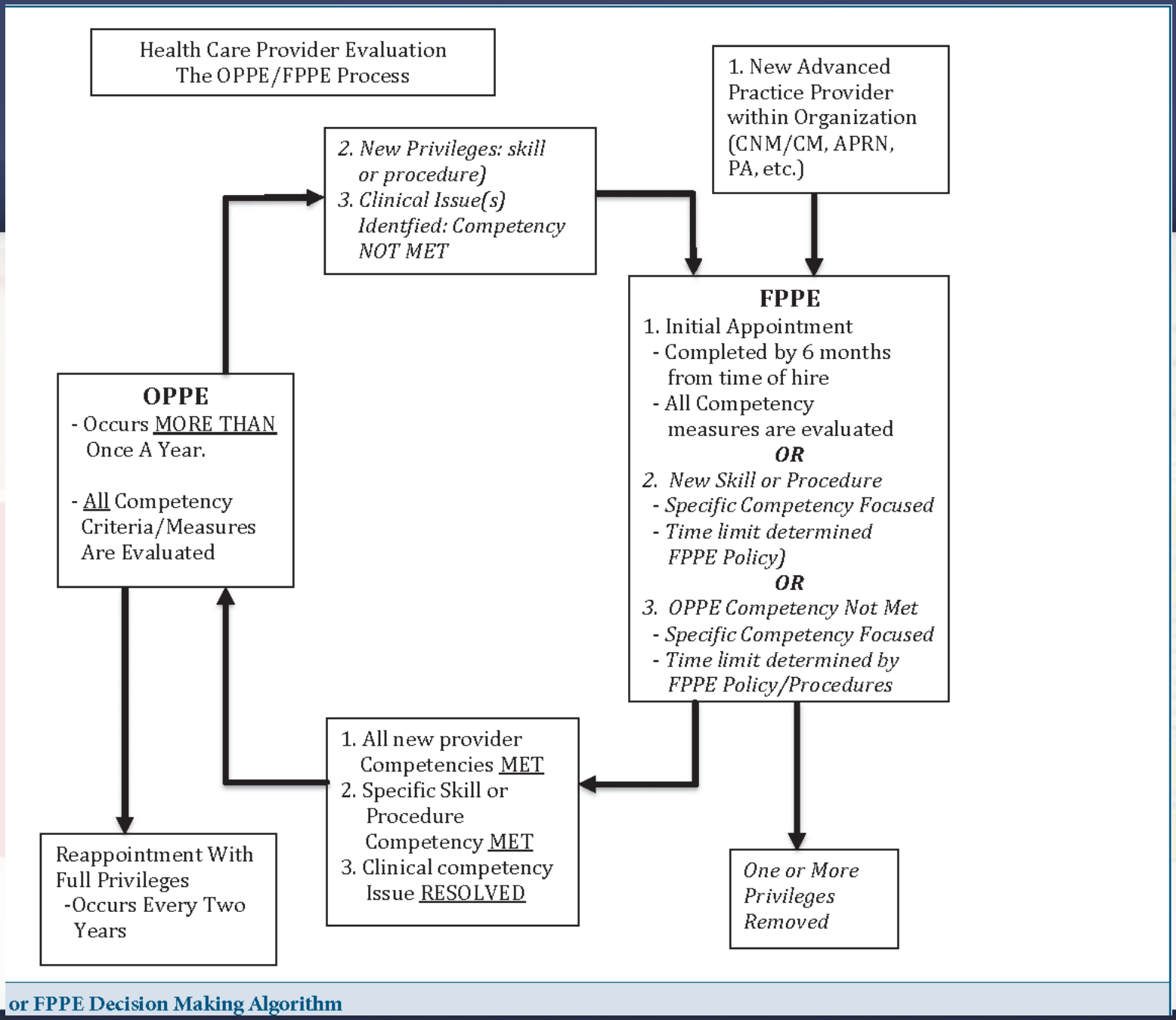
- Telemedicine – how are they credentialed?
  - Joint Commission accredited or CMS Certified accept the privilege decision of distant site if all of these are met by the distant site:
    - ✓ and the privileges to be exercised are granted: List of privileges at distant site is provided
    - ✓ FPPE/OPPE information is shared
    - ✓ Practitioner is licensed in the originating site's state

Credentialing Discussion

- CME (MS.12.01.01) requires that the Medical Staff set priorities for CME topics
  - CME resources are related to the cope of services of the organization
  - CME should be related to the outcomes of PI activities
  - Documentation of CME
  - CME to be considered in the credentialing process

FPPE/OPPE


Focused and Ongoing
Professional Practice Evaluation
Newly appointed physician / AHP or new privilege request
Physician & AHP Ongoing Evaluation
FPPE first 3 months or # of cases specified, but not to exceed 6 months.
OPPE Cycle 3/ 3rd 8 month review
OPPE Cycle 2/ 2nd 8 month review
OPPE Cycle1/1 st 8 month review
Issue of Competency: When questions of competency arise regarding a provider's current privileges.
Peer Evaluation/Chart Review
Once the specified number of cases has been reviewed,
Credentials Committee
Medical Executive Committee
NOT Reappointed/ Privileges NOT Granted / Maintained – Physician/AHP Notified
Governing Board
Reappointed/ Privileges Granted/Maintained – Physician/ AHP Notified



or FPPE Decision Making Algorithm

FPPE (MS.08.01.01)

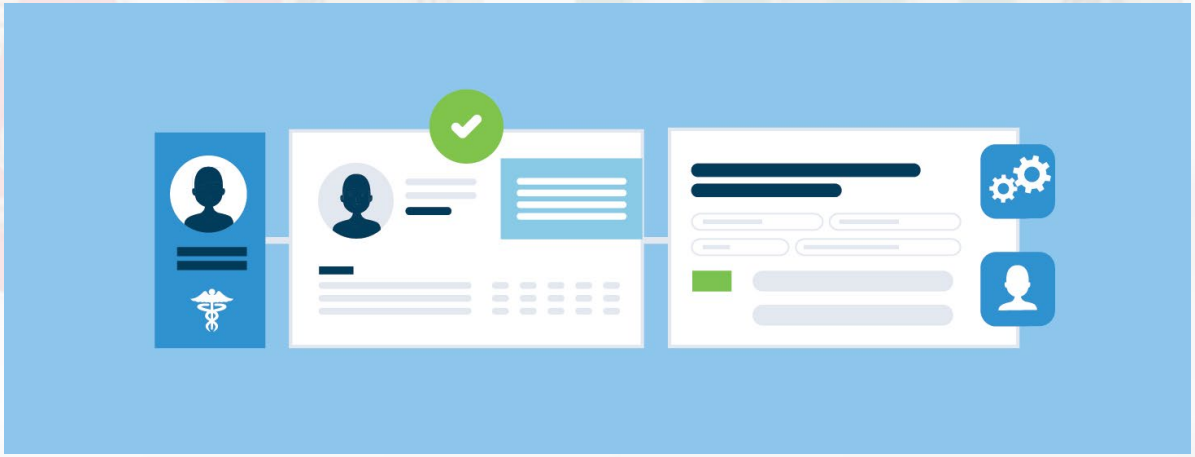
Initial or New Privilege

- Implemented for all practitioners in all clinical sites and privilege specific (includes LIPs, PAs, APRNs, CRNAs, Dietitians granted privileges to write orders, pharmacists with prescriptive authority, telemedicine provider, etc., exercised in all settings- inpatient or outpatient-on-site or off-site within the scope of the organization's survey

FPPE (MS.08.01.01)

Initial or New Privilege

- The process including criteria is approved by the MS (qualitative and quantative)
- Clearly defined (POLICY)
- Consistently applied



FPPE (MS.08.01.01)

For Cause:

- Triggers should be defined clearly (POLICY)
- Decision to initiate is based on objective measures of current performance reflective of quality and/or safety concerns
- Criteria are developed for type of monitoring to be conducted
- Measures/actions to address performance are defined
- Measures/actions are consistently implemented

OPPE (MS.08.01.03)

- Clearly defined (POLICY)
  - Ongoing (i.e. more than annually) 6mths; 8mths
  - All practitioners in ALL clinical sites
  - Methodology of data collection
  - Who/how data is reviewed and acted upon

OPPE (MS.08.01.03)

- Data to be collected is approved by department & MEC or just MEC if no departments:
  - Aggregate (quantitative) or trended quality metrics are encouraged - e.g., SSI rates, complications, BUT:
  - Qualitative or chart review data may be used
  - The data must be RELEVANT to the specialty or privileges granted
  - Review of data that occurs only when triggered by an incident is NOT acceptable
  - When there are situations in which there is no other way to collect data or assets, then peer recommendations may be used (*low or no volume providers)*

OPPE (MS.08.01.03)

- Data to be collected is approved by department & MEC or just MEC if no departments:
  - Data must be from the organization except for low volume providers who have available data from other accredited or CMS certified organizations. However, any data obtained must be supplemental and cannot be used in lieu of a process to attempt to capture 'local' performance data
  - Use of quantitative (raw) data may be used, however, it cannot be the only type of data used to evaluate performance

OPPE (MS.08.01.03)

- The data collection, review, and analysis must be used to inform the credentialing process (i.e., it must be used in the process of determining whether to continue, reduce, or otherwise modify a provider's privileges.)
  - The review process should be consistent and documented.
  - The review process should be ongoing, i.e., - reports reviewed when they are produced - not just at the time of the 2-year reappointment

Provider: **ID #:** **Department: Radiology**

Status: **Department Chairman:**

Specialty: Radiology

Indicator	Most Current 6-mo. Period Q3–16	Q4–16	Q1–17	Q2–17	Q3–17	Q4–17	6-Month thresholds Exceeds	Meets	Below	Applicable competency
Number of dictated reports										
Peer review referrals -Level 3							0	1–3	>3	1, 2, 3
Post-lung biopsy chest tube (%)							0	≤10	>10	1, 2, 3
Mammo recall rate (%)								≤15	>15	1, 2, 3
Mammo cancer detection rate per 1000 (%)							> 5	1–5	<1	1, 2, 3
Significant report transcription/editing errors (%)								≤ 5	>5	1, 4, 5, 6
Report finalization <24hrs (%)							> 95	80–95	<80	1, 4, 5, 6
Validated patient complaints							0	1–3	>3	1, 4, 5
Validated staff complaints/code critique reports							0	1–3	>3	4, 5

ND = No data

1	Patient Care	4	Interpersonal and Communication Skills
2	Medical / Clinical Knowledge	5	Professionalism
3	Practice based Learning & Improvement	6	Systems-Based Practice

https://www.youtube.com/watch?v=WUydwrPAY-M

Survey Tips/Experience

TIPS

- Be prepared
  - Create a listing of files to pull
    - Department chiefs, committee chairs
    - Temps
    - For cause FPPE
    - Electronic; if paper files
    - Adobe
  - No more binders
    - Consolidate documents in one pdf (bookmark it)
      - Bylaws, Rules and Regs (include standard & EP)
      - MEC minutes

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Experience

Hospital A:

- New credentialing
- Re-credentialing
- ACP (PA/NP)
- Nurse Anesthetist
- Hospitalist
- Med Dir of Anesthesiology
- Director of Emergency Medicine
- Psychiatrist
- Telemedicine Provider
- Non-Anesthesia providing moderate sedation (ED/Cardiology)

Experience

Hospital A:

- File review – paper
- FPPE/OPPE: reviewed policy and discussed
- Primary focus: COVID/disaster privileges

Experience

Hospital B:

- Files pulled:
  - Chief of Anesthesia
  - CRNA
  - New applicant
  - Reappointment
  - Telemedicine
  - FPPE for cause
  - Tracers

Experience

Hospital B:

- Addressed validation of ID/telemedicine
- Peer references
- NPDB
- Board Certification (required; MOC)
- Reviewed DOPs – looking for criteria and selected privileges to compare with FPPE/OPPE

Experience

Hospital B:

- FPPE/OPPE policy – what are the triggers
- FPPE/OPPE for APPs
- FPPE/OPPE for Locums
- COVID & impact on FPPE data collection
- Medical Education & Residency Agreement
- CME – copies or attestation

QUESTIONS???