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Does Your Medical Staff Process Measure Up to Current Joint Commission Standards?

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Many hospitals have not yet implemented changes to their credentialing process to reflect The Joint Commission's (formerly known as the Joint Commission on Accreditation of Healthcare Organizations, "JC") new medical staff standards that took effect at the start of 2007. The new Medical Staff Standards ("Standards"), which include many changes to the credentialing and privileging process, require that medical staffs develop and implement a systematic process for measuring medical staff performance and competence on an ongoing basis. These key changes then need to be appropriately reflected in the medical staff bylaws and policies and procedures. Some of the most significant changes require medical staffs to take the following actions:

• **Develop a Process to Systematically Evaluate Resources Available to Support Requested Privileges**. New Standard 4.00 requires hospitals to establish a list of clinical privileges and the resources necessary for each privilege. Before the medical staff may take any action on a physician's request for privileges, a hospital must determine whether it has, or can make available within a specified time frame, sufficient resources, including space, equipment, staffing and financial resources, to support the privileges. Documentation that this evaluation has been performed with respect to each applicant should be maintained to demonstrate compliance with Standard 4.0.

While this standard does not require a revision to the medical staff bylaws, it does require the hospital and the medical staff to decide what criteria will be used to determine whether the hospital has sufficient resources available to support various clinical privileges. We recommend that hospitals develop a form to be completed with each application that addresses whether the hospital wants to do the procedure at its facility (for new procedures), whether the privilege is within the hospital's capabilities, whether additional staff training will be required, whether new equipment will be required, etc. The completed form should be included in the applicant's file to document compliance with this standard.

• **Implement New and Broader Criteria for Assessing Medical Staff Competencies**. The new Standards encourage hospitals to expand the range of criteria reviewed in evaluating a practitioner's request for membership and clinical privileges. The Standards describe six "General Competencies" that were

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developed through a joint initiative between the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties and include the following categories: patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. Although the General Competencies suggest certain criteria to be considered in the credentialing process, hospitals must independently determine the qualifications relevant for medical staff membership and clinical privileges at their respective facilities. This process requires significant medical staff input and will also necessitate updates to the medical staff bylaws and credentialing policies.

• **Design an Evidenced-Based Privileging Process**. The revised Standards place significant emphasis on evidenced-based privileging. For example, Standard MS 4.15 now requires hospitals to obtain and consider peer recommendations to determine a practitioner's competency in six specified areas, which are similar (but not identical) to the General Competencies. It is no longer sufficient to obtain a general statement that a practitioner is in good standing on the medical staff of another facility and a general affirmative response that the practitioner is qualified. Rather, peer recommendations must include a written discussion (*i.e.*, in narrative form) regarding the practitioner's competency in each area.

For hospitals that perform "core" privileging, it will be necessary to evaluate a practitioner's ability to perform each of the core privileges on an individual basis and tailor the list of core privileges as appropriate. While core privileging is permitted, each individual privilege needs to be defined, even when it is a subpart of a group of privileges, so that each specific privilege granted to a practitioner is clearly articulated and easily identifiable.

• **Identify Criteria for Focused Professional Practice Evaluation**. New Standard MS 4.30 requires hospitals to conduct a "Focused Professional Practice Evaluation" in two circumstances: (i) when a practitioner first applies for privileges but does not have documented evidence of competence in performing the requested privilege and (ii) when questions arise regarding a specific aspect of a practitioner's performance through the Ongoing Professional Practice Evaluation (discussed below). The Focused Professional Practice Evaluation is a time-limited period in which a hospital evaluates and determines a specific aspect of a practitioner's performance.

Medical staff documents should clearly define the circumstances triggering the need for monitoring and evaluating a practitioner's performance and the manner

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in which the monitoring will be performed, including how information will be gathered, evaluated and, when performance issues are identified, resolved in a uniform and consistent manner. Although the JC has delayed the effective date of Standard MS 4.30 until January 1, 2008 as it relates to the issuance of new privileges, full compliance is required with respect to practitioners who currently possess clinical privileges.

•Create Process for Analyzing Privileging Information and Communicating Decisions. Revised Standard MS 4.20 requires the procedure for reviewing and analyzing information relevant to the credentialing process to be more clearly defined in medical staff documents and consistently applied. Similarly, new Standard MS 4.25 requires medical staff documents to articulate the process in which privileging decisions will be communicated and to specify applicable due process rights. Hospitals that currently address these issues in medical staff documents should review these documents to ensure all required elements of performance are included.

• **Conduct Ongoing Professional Practice Evaluation**. Revised Standard MS 4.40, transforms the privileging process from a cyclical process performed every two years to a continuous process through the performance of "Ongoing Professional Practice Evaluation." While privileges may still be granted for up to a two-year period, practitioners must be reviewed on a continuous basis throughout the two-year period to more quickly detect and resolve practitioner performance issues that affect patient safety and quality of care.

Completion of an Ongoing Professional Practice Evaluation will require hospitals to evaluate each practitioner's professional practice, including practitioner-specific (rather than aggregate) data. Individual departments should determine the data to be collected, with approval of the medical staff. Information acquired through the Ongoing Professional Practice Evaluation must be used in the reappointment process to determine whether to continue, limit or revoke a practitioner's existing privileges. Additionally, new Standard MS 4.45 requires that hospitals have a clearly defined and consistently applied process for collecting, investigating and addressing any clinical practice concerns, including those arising through the Ongoing Professional Practice Evaluation.

Anticipated Future Standards and Next Steps

The JC continues to contemplate the contents of medical staff governance documents, including information that must be included in medical staff bylaws

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as opposed to the rules, regulations, policies and procedures. The field review for Standard MS 1.20, element of performance 19, has been completed and publication of a revised standard is anticipated later this year, with an effective date occurring in 2008.

Compliance with the Standards requires hospitals and their medical staffs to engage in a thoughtful, engaged process whereby new criteria are developed and medical staff documents are updated. Many hospitals have inserted form updates to their documents that have not resulted in the process changes necessary to ensure satisfaction of the Standards. Please contact Larri Broomfield or Heather Fields, shareholders in the Reinhart Health Care Department, to learn more about how hospital administrators and medical staff leaders can proactively assess their compliance with these new Standards.

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