Benchmarking survey: The ED coverage problem

Editor’s note: This quarter’s MSB benchmarking survey asked respondents whether they had problems with emergency department (ED) coverage. MSB thanks the 235 readers who responded.

The problem of providing adequate specialist on-call coverage to their EDs continues to plague hospitals nationwide, according to our survey, with a full 73% of respondents stating that their medical staff physicians regularly balk at, complain about, or try to evade this responsibility.

“Where are we, as a symptom of the disease, that is the health care system,” Michael Gerardi, MD, spokesperson for the American College of Emergency Physicians, was quoted as saying in a recent New York Times report on the growing number of visitors to the ED across the country. “We are a symptom of the disease that is the health care system.”

Most respondents work in hospitals that have 10–400 beds (83%), with the remaining 17% having more than 400 beds. The size of medical staff offices was 50–100 staff members for 22% of

When systems break up, should the medical staff remain as one?

MSB occasionally features opinions on current issues from professionals in the field. In this issue, quality management professional Jim Bruer, who was directly involved with a “demerging” hospital system in which the medical staff chose to remain united, says that medical staff leaders could benefit from keeping track of the new trend in health care of unwinding many of the hospital mergers of the 1990s. The following are his opinions and suggestions on this controversial phenomenon.

Conflicting missions, visions, and values often are at the root of a failed merger and can tear the system apart after years of work and millions of dollars spent in consolidating departments, medical staffs, information systems, bylaws, and policies. This raises an unexpected and difficult question: What happens when the “divorce” of merged hospitals turns out to be more difficult than the merger and the unified medical staff simply refuses to be split up?

Staying together
The reasons for a medical staff unit staying together can be as

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In brief

Individual physician data available to New York patients
Patients in New York state soon will have access to individual physician profiles, hospital report cards, and health care plan data, thanks to the signing last month by Governor Pataki of the Patient Health Information and Quality Improvement Act.

The Act calls for the New York State Department of Health (DOH) to develop and make available to the public individual physician information and hospital report cards and establishes a Patient Safety Center to work on the reduction of medical errors. In addition, the act modified the present procedures for hospital incident reporting and professional misconduct reporting.

The individual physician profiles will contain information such as medical schools attended, hospitals where physicians have admitting privileges, certain criminal convictions within the past 10 years, actions taken against the physician for professional misconduct, limitations on practice, loss or restrictions of privileges, the number of medical malpractice judgments and awards, and malpractice settlements involving payments if the number of such settlements exceeds two or if the DOH commissioner determines that the settlement is relevant to a patient’s decision-making regarding quality of care.

The surveyor is surveyed
The JCAHO itself was the focus of a recent survey conducted recently by Modern Healthcare on its Web site, and the results were mixed.

Although only 1% of respondents gave the JCAHO’s performance a grade of “excellent,” 52% rated it “very good” or “good.” Twenty-six percent rated its performance as “fair,” and 13% described it as “poor.” Respondents were divided almost in thirds when asked how the performance of the JCAHO has changed in the last five years, with 30% saying it has improved, 32% saying it has not changed at all, and 24% saying it has deteriorated.

Respondents were split 50-50 on the question of whether the JCAHO should conduct more surprise surveys as opposed to being too reactive to adverse events at hospitals. And when asked for their opinions on the JCAHO’s recent proposal to shorten its survey cycle from the current 36 months to 18 months, the responses were mixed, with 27% approving of the change, 26% opposing it, and 35% stating it would have little or no effect.

Shedding physician practices bad move for hospitals?
The many hospitals and health care systems that have divested their physician practices could have made the wrong decision, according to a recent report in Modern Healthcare. Because of the financial losses incurred by hospital-owned physician practices, the trend has been to back away from such ventures. But the problem was not in the strategy itself, but on its implementation, the report says. The root causes of this financial drain, it says, include the following:

- Unforeseen difficulties in merging divergent cultures
- The expected managed care environment that initially drove much of the acquisition activity has not materialized
- Hospitals frequently carved out ancillary revenue from the practices
- Hospitals were wrong in assuming they could manage physician practices more effectively, achieving more profits
- Physician contracts were poorly structured and gave many physicians few or no incentives to maintain productivity
- Prices paid for acquisitions were often too high even though those prices were driven by competition among hospitals themselves

By abandoning their acquired physician practices before taking a closer look at the root causes of financial losses, the report states, these hospitals could be “forgoing tremendous long-term opportunities, squandering capital investments, and irreparably damaging relationships with their most important constituents—doctors.”
respondents, 101–400 for 32% of respondents, and 400 or more for 36%. Two hundred and five respondents provided information on the number of monthly admissions to their EDs. Out of these, most admit between 1,000 and 3,000 or more patients each month.

EMTALA fines
Adding to the pressure on hospitals is the fact that the Emergency Medical Treatment and Active Labor Act (EMTALA) went into effect last month. Although 75% of respondents reported that their hospitals had reviewed the EMTALA guidelines with their medical staff within the past year—in most cases, the review was conducted by the medical executive committee (MEC)—just over half (55%) of respondents said that their MECs or boards of directors had taken other actions on this issue in the past year.

In addition, according to William Schumacher, MD, chief executive officer of The Schumacher Group, in Lafayette, LA, 29% of respondents to a recent survey there said that their hospitals already had been subject to EMTALA-related investigations. (EMTALA violations could cost hospitals $50,000 and individual practitioners $25,000 per violation. See the June and August issues of MSB for details on the EMTALA requirements.)

Patient safety
But the stiff EMTALA fines, of course, aren’t the only problem. Patient safety is a top concern and fueled the creation of the EMTALA statute in the first place. Here are some sobering statistics on this problem: More than 20% of hospitals nationwide lack adequate medical specialty coverage, and 11% of hospital executives say that they wouldn’t go to their own ED, giving a lack of specialty coverage as the reason, according to Schumacher.

“The problem is not a lack of training, ability, or equipment in the emergency department,” he explains. “It’s really a matter of physician availability.”

What’s behind the crisis?
There are a variety of reasons for the state of ED coverage in United States hospitals today, and the solution is complex, according to Della Lin, MD, immediate past chief of the anesthesiology department at Queens Medical Center in Honolulu, HI. First, if your hospital does not require ED call duty as a condition of medical staff membership, it should, she says. And although most do, according to our respondents, the key is in unwavering enforcement of this requirement. In addition, Lin says, a big part of the problem is uneven enforcement.

“Physicians say, ‘Why do I have to do this when other specialists don’t? This creates turf battles and other conflicts,’” she explains.

A wider problem has been the constrictive effect of HMO regulations on physicians. HMOs’ cuts on autonomy, authority, compensation, and income, Lin says, have significantly decreased the number of medical students and put working physicians under more financial and time-management stress than ever. Since most providers are not compensated for on-call duties, some say they can’t afford to perform them.

Aggravating the problem further is the recent sharp increase in the number of patients using the ED. This factor has made the time demands on physicians unreasonable in many cases, forcing some practitioners to cut their own patient load.

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complex as the relationship between each system’s medical staff, hospital administration, and board of directors.

Physicians who want to stay with a merged medical staff cite the following:

- Saved time that could be used for better patient care (not having to attend multiple meetings at the hospitals in which they have privileges)
- Frustration at hospital administrations that couldn’t make the merger work and at the fatigue and burnout brought about by yet another major change
- Resistance to new administrative burdens caused by the break
- A chance to “take charge” of their communities’ health care system, which has been damaged by the increased emphasis on profits
- Increasing bargaining power in their dealings with hospitals
- Regaining the professional control lost under managed care

Single-staff advocates seem to agree on one important point: Physicians make up the one constant in the changing world of health care.

Could it work?
The problems inherent in this scenario are numerous, and there are no good precedents to judge whether staying together is even feasible. The JCAHO states in the latest update of its Hospital Accreditation Standards that it allows one medical staff for multiple institutions: “A single group of physicians that constitute a medical staff may be accountable for services in more than one accredited hospital.”

But this standard was created to accommodate situations in which the merged entities continued to operate under individual hospital licenses: Can it be applied in the scenario of system “divorces”? If so, it raises the following questions: What should the single-staff organizational and committee structures look like? How should the various legal issues be addressed? How are the “soft” issues, such as institutional loyalty and fairness, built into such a system? Following are the conditions under which a merged medical staff could serve several hospitals functioning under separate hospital licenses:

- Each hospital within a defined geographic area would have the right to access the “services” of the medical staff and, likewise, each physician would have privileges at that hospital.
- Hospitals would be free to decide whether to participate.
- The medical executive committee (MEC) at each institution would report to local boards of trustees on quality, credentialing, and physician disciplinary issues and to the medical staff at large on all other issues.
- The right to approve or disapprove of its executive committee’s election slate should be reserved for each hospital’s board of trustees.
- The medical staff would be involved in planning, recruitment, education, and, depending on legal issues, reviewing and commenting on payer proposals.

Questions? Comments?
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• The medical staff would be responsible for setting overall policy guidelines to be approved and customized by each of the hospitals’ executive committees.

• Hospital-based physicians would have to abide by contract requirements.

• Case review could be aggregated and blinded, as submitted by the physicians serving the hospital in question, and reviewed at joint department meetings. Secretaries employed or contracted by the medical staff could submit actions and minutes to each hospital’s environment of care, covering only that hospital’s cases.

• Fairness and unbiased treatment toward physicians would be protected by a system of checks and balances that includes room for dissentions.

When contemplating working with a merged staff, the normal reaction is to fall back in horror. How could confidentiality, differing improvement priorities, individual board responsibility, case review, etc. be appropriately handled? How would follow-up on sentinel events and occurrence reporting be handled?

The answer is simple: on a case-by-case, project-by-project basis—the way it is done now. The breakthrough required is more conceptual than organizational.

Control—that is, form and structure—doesn’t matter as much today as function, clear objectives, principles, values, and a system that enhances trust, choice, and fair resolution of differences.

Medical staff wishing to remain united in the face of the dissolution of a merger, or perhaps to unite for the first time, even without a merger, should get organized, take on responsibility, guarantee that all providers compete fairly and openly, and create a professional organization to promote professionalism and the advancement of the art and science of medicine, as well as the advancement of peers.

A hospital simply could refuse to recognize united medical staff members who are unwilling to be pulled apart and set out to create a new team for itself from existing service-area physicians.

But in an emotionally and politically charged setting, what board or hospital president would want to risk alienating key physicians?

Hospitals would do better to help create a principle-based collaborative with the unified medical staff that could examine how competition and a free market and high-quality care—which would be defined by consumers and practitioners—could be successfully “married.”

In summary, the benefits of a successful united medical staff include the following:

• Decision-making authority is placed as closely as possible to those affected

• It actively strives to stimulate innovation, build trust, be inclusive, and focus on strengthening the individual as well as the organization overall

• It embraces innovative ideas and ultimately becomes a model for something that other systems and medical staffs would want to emulate

• Its power is for the good of the community

This is the organized medical staff of the future—and it just may be that it routinely serves several competing hospitals.
The physician leader as an agent of change
by Richard E. Thompson, MD

Change is not always for the better. Furthermore, what’s “better” in some eyes is not necessarily a good thing in the view of others. And sometimes, to the chagrin of management, physician leaders must oppose a management idea that takes into account only one piece of the pie and ignores the rest.

For example, in the early days of the diagnosis-related group (DRG) hospital payment system, a cardiologist successfully opposed a new management rule that would have required heart attack patients admitted from the emergency department to stop in radiology on the way to the coronary care unit for a chest x-ray. The reason? So that the x-ray would be paid for separately, as an outpatient service, instead of being bundled into the after-admission DRG payment! This is an example of how physicians can step in to block change when it is not in the best interest of the patient.

In the face of enormous changes, including new paradigms, a new century, an impending change in national leadership, and the advent of Internet medicine, one thing has not changed: the professional power of physicians and their leaders. Although codified in state licensing statutes, it nevertheless is the kind of power that truly cannot be legislated either in or out of existence. Physician leaders must use this unique power to bring about change when needed.

The following are common obstacles to change, along with brief comments about how to overcome them. Please share this list, as well as your own suggestions, with interested physicians. And please recognize that there are many factors obstructing change that are not beyond your control.

Too much regulation. Free competition is a myth. The reality is still over-regulation. Complaining about excessive regulation usually isn’t productive. Do this instead: Avoid the trap of believing that achieving “compliance” ends the day’s work. Go beyond compliance to show evidence of truly substantive patient care–related organizational activities. You can regain public (and thereby political) support by demonstrating a new ethic in managed care that better balances profit and dependable performance.

Too many attorneys and consultants. I, as a consultant, hate to tell you this, but don’t call an attorney or a consultant until you really need one. Most people don’t exhaust all of their internal resources before calling for outside help. And there are only three good reasons to call an attorney: (1) when there is a body of law to interpret, (2) when you need protection from a bully, and (3) when you are trying to deal with someone by doing what’s legal—not necessarily what’s right.

Natural fear of change. People arguing against a change may not truly disagree with its objectives; they may simply not understand the change. Or they might bristle at what appears to be the “railroading” of a change. All stakeholders must be identified and, insofar as possible, offered early on the opportunity to offer their ideas to the decision-makers.

Natural conflict over purpose. There is room for genuine disagreement about the raison d’être of a hospital or other health care facility. The utilitarian view is, “Do what’s best for the public in general, and ration care.” The traditional medical ethic is, “Do everything possible for each individual patient.” Change is impossible as long as health care leaders believe these are the only two choices. A third choice is adopting a new ethic that reasonably addresses both concerns.

The past. “My objection to this proposed change is that 21 years ago, when the medical staff proposed the building of a new hospital wing, the proposal was rejected . . . ” Don’t do the 21-years-ago thing. It’s not only counterproductive; it’s self-defeating. It’s not helpful input, and it tends to turn off decision-makers.

Blame. Above all, remember it’s not all your fault, and it’s not all theirs, either. Fix the problem, not the blame. This is the bottom line. 🦸‍♂️
Medical staff officers should be taking steps toward revising the language of their bylaws, particularly in light of the JCAHO’s September release of its revised Medical Staff chapter in the Comprehensive Accreditation Manual for Hospitals. Medical staffs should be busy making any necessary adjustments, changes, or additions to their bylaws (and any relevant policies and procedures, as well) if they want to comply with JCAHO requirements during their next survey.

Attendees of the National Association of Medical Staff Services (NAMSS) conference, also in September, took note of some important strategies and ideas on how best to go about the difficult and often cumbersome task of revising medical staff bylaws. The source of this information was Christina Wiggins Giles, CMSC, MS, president of the consulting firm Medical Staff Solutions, in Pepperell, MA.

“Getting your bylaws properly worded is an important task,” Giles said, and you should not delay, as the JCAHO revisions go into effect January 1, 2001. In addition, Giles adds, outdated bylaws could be used against your hospital by plaintiffs in a lawsuit, since they are considered contracts.

Important points to keep in mind
Before getting started, Giles advises, medical staff personnel should keep in mind a few important points. All bylaws should

• represent current practice at your institution;

you can’t use ones that have been around for, say, 30 years. And you can’t borrow another hospital’s bylaws.
• reflect current medical staff categories, roles, and responsibilities.
• serve the needs and protect the rights of the hospital, members of the medical staff, and ultimately, the patients.
• emphasize commonly held principles at the hospital (details belong in policies and procedures).
• clearly outline and define points of disagreement.
• provide time frames (perhaps a maximum time limit, for example) for the resolution of problems.
• include a revision process that is simple and that works, outlining a series of incremental steps toward consensus.

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“Bylaws should be as simple as you can make them. My motto is ‘Simplicity, simplicity, simplicity,’ ” says Ellen Janos, JD, an attorney with the firm Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, PC, in Boston, MA, also at the NAMSS conference.

Getting ready
The bylaws revision process traditionally has been seen as a complicated, lengthy, and difficult chore, but this doesn’t have to be the case if you know how to approach the process, says Giles. She suggests taking the following steps for an effective bylaws revision process:

1. Identify your goals. Are they to simplify the bylaws or to make major changes?
Bylaws

2. Set a reasonable time schedule. Even if you can’t stick to it religiously, it helps to have one, says Giles. “One client I had took two years to revise his bylaws,” she recalls.

3. Research and collect required information. Don’t wait for your physicians to do it; prepare yourself well in advance of the bylaws committee meeting.

4. Prioritize meeting topics. Always present first the sections or topics that most urgently need review, for instance, changes to the credentialing procedures manual, to the hearing and review section, etc. In addition, identify in advance any “hot topics” that might come up at the meeting and be prepared to discuss them knowledgeably, Giles says. Some of today’s important issues could include the following:
   - Telemedicine
   - Physician health
   - Peer review
   - On-call emergency department duties
   - Complementary medicine
   - Confidentiality issues regarding the Internet
   - Criminal background checks
   - Hospitalists

5. Create a draft of the proposed language changes or additions. To save time and to avoid conflict, Giles advises that you bring proposed bylaws language to the meeting. “Go in from the start with proposed language and don’t let [other committee members] haggle over wording during a meeting,” she explains.

6. Submit your proposed changes for review before the committee meeting. Once the draft is completed, make sure a hospital attorney and key medical staff leaders review it before your presentation at the formal bylaws committee meeting. It’s much simpler to make adjustments and changes at this stage.

7. Give committee members 15 days’ notice before the committee meeting and voting. Include highlights of the proposed changes in your notice. If some members cannot be present for the vote, mail-in ballots are acceptable. If a member is not present and does not mail in her or his vote, it counts as a “yes.” You could also change the quorum to “a majority of those present” to get around the problem of absenteeism.

8. Forward the final draft of proposed changes to the board of trustees for approval.

9. Distribute copies of any changes by the board and arrange a meeting during which to take a final vote on all revisions.

Once you reach this point, you will have “survived” the bylaws revision process, and your medical staff will be well on its way to full compliance with the new JCAHO standards and changes.

Tips from the experts on changing your bylaws

The chief of staff at a hospital is the person who chooses members for its bylaws committee, explains Christina Wiggins Giles, president of Medical Staff Solutions in Pepperell, MA. “You need to educate your chief of staff on whom you need on the committee,” she says, adding that the group should include two or more physicians, a representative of the governing board, and a medical staff service professional (MSSP).

Another important factor is the support of the MSSPs and the hospital administration. “If [administration representatives] won’t come, you [the medical staff coordinator or the MSSP] must serve as the liaison to keep the administration informed,” Giles says. MSCs and MSSPs involved in the revision process also should make every effort to prevent physicians from using the revision process to benefit only their own departments, and strive to avoid escalation of conflicts of interest. Finally, try to get your proposed changes approved privately by the relevant parties before the bylaws committee meeting. That way, members need only carry out a brief formal vote.
Update on the Federal Credentialing Program

Why should your medical staff credentialing department take time to familiarize itself with the Federal Credentialing Program (FCP)? After all, even though it’s a centralized credentialing database on health care providers, it covers only providers who are employed by the federal government, right?

At the National Association Medical Staff Services (NAMSS), in Las Vegas, NV, in September, it became apparent that the FCP wants to convert itself into a valuable resource that includes credentialing professionals in health care organizations that are not affiliated with the federal government as well—nationally and internationally.

At the NAMSS conference, Stephen Permison, MD, former chief medical officer of the National Practitioner Data Bank and currently a health care consultant for the FCP, invited NAMSS and other professional and accreditation organizations nationwide to form a partnership with the FCP that will “guarantee the development of appropriate national and international credentialing policies, standards, and role definitions. All of our credential information must be exchangeable between institutions.”

“The idea is to create a database with common fields we could all agree on to use that would give us all access to national information,” explained Nilda Conrad, CMSC, CPCS, director of medical staff services at North General Hospital in New York City and member of the NAMSS executive committee. The information on the FCP database would be primary source-verified.

“It would take away the nitty-gritty work and leave you [credentialing professionals] to do other things; it would allow you to credential physicians at a whole other level,” Conrad added.

How it all began
The FCP was developed in 1996 by a team of health care experts led by Permison with the mission of creating a national network “that banks and exchanges core credentials of all health care providers” working for the federal government, according to an FCP statement. In other words, the FCP’s core mission was to create a centralized database that would make it possible for federal agencies and departments such as the Department of Health and Human Services (DHHS), the Department of Defense, the Department of Veterans Affairs, and all other federal agencies to quickly and easily exchange primary source-verified health care provider information for credentialing purposes.

“We should make it possible for all databases to communicate nationally and even internationally,” Permison said. “This will be especially good for telemedicine because as there is more demand for it, there [will be] more need for better credentialing processes.”

At an FCP forum held in Albuquerque, NM, last July, the FCP reached out to the JCAHO, the
NCQA, and the American Accreditation Health Care Commission/URAC with the idea of opening up the FCP to nonfederal health care institutions. The objectives of the forum, according to Permison, were to “broaden collaboration between the FCP and the rest of the world; to work in an integrated manner with others who do what we do in order to capture as much of the secular world as possible.”

Software update
A national steering committee of the FCP guided the development of credentialing and management software called VetPro that meets the standards of the JCAHO, the NCQA, and URAC. Presently, VetPro is being migrated from the beta testing stage into the production platform, and the user manuals are almost completed. The FCP’s VetPro system works as follows:

• Providers go online and fill in their own data
• FCP personnel conduct primary verification
• 8–10 letters requesting professional references are automatically sent to sources provided by the provider
• The finalized file is then locked to permit access only to authorized users who must have identification and a password

The FCP has created a work group to delineate requirements for acceptance of participating members such as credentialing organizations, CVOs, licensing boards, and professional organizations.

“We need to figure out how to determine which organizations have acceptable procedures and deserve deemed status,” Permison explained.

Still to come
In summary, the FCP’s agenda is to collaborate with its many health care industry partners to achieve the following goals, according to a recent FCP statement:

• Create a national standard for electronic exchange of credentialing data elements between federal and commercial credentialing software programs. This will involve the development of a technical conduit for the exchange of data, as well as a common lexicon.

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**Mission statement of the Federal Credentialing Program**

**The mission.** The mission of the Federal Credentialing Program (FCP) is to develop a national network that banks and exchanges core credentials of all health care providers.

The mission builds on three principles:

1. **Autonomy.** The autonomy of health care organizations in determining the credentials required of providers

2. **Efficiency.** The need for efficient, automated credentialing processes

3. **Automation.** The need to network the outputs of CVOs into a national electronic system for credentialing

**The vision.** The vision of the FCP is to collaborate with all aspects of the health care industry to develop a software-driven, Internet-based credentialing model applicable to all health care professions.

**The environment.** These principles operate in an environment respectful of the autonomy of all organizations concerned with public protection and provider credentials:

• Credentialing organizations/boards that serve the public interest by issuing credentials to providers that meet established criteria

• Health care organizations requiring credential verification for their providers

• CVOs that compile and verify the currency and authenticity of credentials held by providers
• Develop prototype software, based on the output of the Albuquerque work groups, for the credentialing of health care providers in dietetics, nursing, occupational therapy, and pharmacy.
• Convene a focus group to study the usability of the FCP software.
• Expand the availability of the FCP.
• Establish “deemed status” standards that will facilitate the collection of multiple data/documentation elements from a single source. Organizations will be invited to demonstrate that they meet these standards.
• Study applicability of FCP data bank model to emergency medicine and telehealth.
• Explore models for health care provider data banking and exchange used internationally.
• Further explore the interface of professional ethics, health care credentialing, and the globalization of professions.

For more information, visit the FCP’s Web site at http://bhpr.hrsa.gov/dqa/fcp.htm.

Top problematic JCAHO medical staff standards in 2000

During the first six months of 2000, the Joint Commission surveyed 579 hospitals under the Comprehensive Accreditation Manual for Hospitals and released a list of the top 40 most problematic standards. The following are the problematic medical staff standards contained in that list. The numbers correspond to their position within the top 40 list. Organizations receiving a score of 3, 4, or 5 usually receive a Type I recommendation from the JCAHO.

16. MS.2.3.4.1.3: Organization, Bylaws, Rules, and Regulations
Hospital bylaws must define conditions and mechanisms for removing officers.

17. MS.5.11: Credentialing
Appointment and reappointment to the medical staff and renewal and granting of clinical privileges are made for a period of no more than two years.

18. MS.5.5.1: Credentialing
Medical staff bylaws require applicants to provide previously successful or currently pending challenges to licensure or registration or voluntary relinquishment of licensure.

25. MS.8.5: Credentialing
The medical staff, with other appropriate hospital staff, develop and use criteria that identifies deaths in which an autopsy should be performed.

29. MS.5.7: Credentialing
Medical staff deliberations to develop recommendations for appointment, or to terminate from the medical staff, and for the initial granting, revisions, or revocation of clinical privileges include information provided by a peer(s) of the applicant.

35. MS.5.4.3.1: Credentialing
For initial appointment to the medical staff and for initial granting of clinical privileges, the hospital verifies information about the applicant’s licensure, specific training, experience, and current competence provided by the applicant with information from the primary source(s) whenever feasible.

Source: Briefings on JCAHO, a sister publication to MSB.
**Medical Staff Briefing**

**Briefing,** and click on the title

Web site information:
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<td>Wilmington, DE</td>
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<td>William A. Thompson, MD, MBA</td>
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<td>John D. Archbold Memorial Hospital</td>
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<td>Thomasville, GA</td>
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<td>Robert G. O’Driscoll, MD</td>
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<td>Saint Barnabas Medical Center</td>
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<td>Livingston, NJ</td>
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<td>Raymond E. Sullivan, MD, FACS</td>
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<td>Waterbury Hospital Health Center</td>
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<td>Waterbury, CT</td>
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