JCAHO medical staff standards changes for 2004
Dear readers,

After releasing major revisions to its medical staff standards in 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) gave medical staff and credentialing professionals a three-year reprieve to adjust to those changes.

However, that all came to an end when the JCAHO announced its 2004 standards, which reflect the accreditor’s shift in focus from policies and procedures to a quality-driven accreditation process. The 2004 standards complement the JCAHO’s Shared Visions–New Pathways™ initiative that was designed to promote continued survey readiness.

This special report highlights key JCAHO changes for 2004 that directly affect medical staff and credentialing professionals. We hope the following analysis provides the guidance you need to successfully prepare for your next JCAHO survey.

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An overview of the JCAHO’s 2004 survey and standards

After much anticipation, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) posted its revised hospital standards on its Web site (www.jcaho.org) June 12, 2003. The new standards require your medical staff to reconsider how it authorizes physician assistants and advance practice registered nurses to practice and collect practitioner-specific data at initial appointment. They also expand impaired-physician policies to include all licensed independent practitioners.

The revisions aim to eliminate redundant and irrelevant requirements, improve clarity, and better organize the chapters in the Comprehensive Accreditation Manual for Hospitals (CAHM).

New survey process
The JCAHO’s 2004 medical staff and leadership standards are part of the accreditor’s Shared Visions–New Pathways™ initiative. This initiative led to drastic changes in the JCAHO’s survey process, which in turn requires your organization to revise its approach to survey readiness and standards compliance.

Shared Visions introduces a new scoring system for standards, strict deadlines to correct problems, and a new tracer survey process.

According to Robert A. Wise, MS, vice president division of standards and survey methods for the JCAHO, the accreditor’s new survey process

- focuses on organizational systems
- emphasizes care, not documentation
- focuses on relevant organizational issues
- focuses on direct patient care
- enhances consistency in evaluation

In addition, the revamped survey process requires hospitals to provide relevant data to the accreditor prior to the actual survey and forces organizations to implement a more continuous process, says Wise, who spoke during the National Association Medical Staff Services annual conference in San Antonio.

Change in process and terminology
The changes introduced by the JCAHO for 2004 go beyond simple changes in semantics. However, understanding the accreditor’s new terminology is essential to your organization’s compliance efforts.

Take a look below at the following components of Shared Visions:

- **Elements of performance**
  Many medical staff and credentialing professionals have come to rely on a standard’s intent statement to figure out just what had to be done to ensure compliance. However, intent statements are no longer part of the CAHM. In 2004, look to the standard’s elements of performance for guidance.

  Elements of performance explain what the accreditor expects you to do to comply with the standard. Your organization will be scored on the elements of performance—not the standard itself.

- **Evidence of standards compliance**
  The JCAHO requires organizations to submit a report to the accreditor within 90 days after the triennial survey for any standard scored as “noncompliant.” (In 2005, the report must be submitted within 45 days after the conclusion of the survey.)

  The evidence of standards compliance report must detail the actions your organization has taken to comply with the standard since the survey.

  If the hospital disagrees with the JCAHO’s assessment that it was noncompliant, it may state that objection and provide information to support its compliance in the report.

- **Periodic performance review**
  Hospitals must perform periodic performance review to assess compliance with JCAHO standards. This review is done using an electronic tool on the accreditor’s secure extranet site. Corrective plans are created when organizations fail to adequately comply with all standards.

  continued on p.4
Overview  
continued from p. 3

• Measures of success
The JCAHO defines a measure of success as “a numerical or quantifiable measure, usually related to an audit, that determines whether an action was effective and sustained.” The term “quantifiable” refers to an amount or number. For example, you can use a percentage to express your measure of success and level of compliance.

The evidence of standards compliance report and the periodic performance review both include measures of success. When a surveyor determines that an organization fails to meet a standard, the facility must then develop a measure of success for each element of performance scored as partial or insufficient compliance.

A hospital must provide the measure of success four months after the accreditor approves its evidence of standards compliance report.

• Priority focus process
Priority focus areas are the methods, systems, or structures that significantly affect the quality and safety of care. Surveyors will use your organization’s priority focus areas to plan the on-site survey and tracer focus areas.

Top priority focus areas include the following:
✓ Credentialed and privileged practitioners
✓ Assessment and care/service
✓ Communication
✓ Information management
✓ Organization structure
✓ Orientation and training
✓ Patient safety
✓ Staffing

• Tracer methodology
The JCAHO has completely modified the way it performs on-site surveys. The accreditor’s new tracer methodology instructs surveyors to select several patients—typically those who received multiple or complex services at your facility—and use their records to measure your organization’s standard compliance.

Surveyors will assess the care provided by each department and examine how departments work together. Surveyors retrace the specific care processes that the patient experienced by observing and talking with staff.

How to recruit and develop physician leaders: A strategy for medical staff leadership development

Excellent medical staff leadership is the key to an effective medical staff. But the challenge for medical staffs today is to convince quality physicians to assume leadership roles. That’s why we have developed the modern solution to the medical staff leadership challenge. How to recruit and develop physician leaders: A strategy for medical staff leadership development is the definitive guide to how your hospital can identify, attract, and retain successful leaders for an effective medical staff. Don’t be left with the ultimatum of putting untrained or reluctant physicians into leadership positions. Invest in leadership development to reap the benefits and rewards of excellent leadership. Get your copy of this book today and you’ll receive step-by-step advice, field-tested solutions and tools including:

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JCAHO’s next challenge: Gathering practitioner-specific data at initial appointment

Medical staff services professionals everywhere share some common hardships, including collection of practitioner-specific data and soliciting accurate quality information from other facilities. The bad news is the Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) 2004 standards combine these two challenges.

**MS.4.20** and **MS.4.30** require hospitals to gather practitioner-specific data upon initial appointment and reappointment, which forces hospitals to rely on one another when appointing new physicians to the medical staff.

The good news is that the accreditor recognizes the compliance obstacles these standards pose and allows some leeway.

**Comparative data**
The elements of performance for standards **MS.4.20** and **MS.4.30** require the organized medical staff to evaluate, among other items

- relevant practitioner-specific and aggregate data, when available
- morbidity and mortality data, when available

“Comparative data was previously reserved for reappointment,” says **John Rosing**, MHA, FACHE, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. However, the language above is now also included in the standard that guides initial appointment.

Collecting comparative data at initial appointment could prove challenging for hospitals. “The elements of performance acknowledge this challenge by including the words, ‘when available,’ indicating that hospitals won’t always be in a position to obtain this data,” Rosing explains.

**Note:** Comparative data is used to compare an individual physician with other physicians either inside or outside your hospital. Comparative data helps the organization decide what acceptable or excellent performance looks like, explains **Robert Marder**, MD, practice director for quality and patient safety for The Greeley Company.

**Collect the information**
When faced with the challenge of collecting practitioner-specific information at initial appointment, medical staff services professionals can turn to the processes their organization uses to gather this information at reappointment. Many of the same principles apply.

According to **Hugh Greeley**, founder of The Greeley Company, organizations may obtain practitioner-specific data to use during initial appointment through the following resources:

- **Professional references**
  References must comment on specific clinical activity performed by the applicant in a prior practice setting. (See the sample reference letter and questionnaire on p. 7.)

- **Prior practice settings**
  Send a letter to the organization where the applicant formerly practiced and request a summary of the practitioner’s clinical activity, including number and type of cases. (See sample letter to use when verifying hospital affiliation on p. 11.)

  “All hospitals maintain this information and may, without fear of litigation, release such information to other institutions for use in the initial credentialing process,” Greeley says.

According to Greeley, organizations do not have to amend their practitioner release forms to acquire this data. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provisions do not apply to this exchange of information since all specific patient identification should be removed from a practitioner’s file. (See p. 12 for a sample form that addresses terms and conditions of appointment and release of liability.)

**Tip:** Greeley suggests offering to pay
Data challenge

a small administrative processing fee for this information.

• **State programs**
  “In some states, organizations can obtain practitioner-specific information directly from the state,” Greeley says. This information may be available on the Internet or in a print format. For example, Pennsylvania’s cost/quality initiative publishes helpful practitioner-specific data.

• **Applicant**
When all else fails, hospitals can simply request (or require) that the applicant summarize his or her most recent experience as part of the application process.

This summary should include the practitioner’s recent practice volume, Greeley says.

“This information should then be sent to the prior practice setting for simple confirmation,” he continues.

**Obstacles**
Although hospitals should have access to information obtained from the practitioner’s prior practice setting regarding the results of quality monitoring and performance improvement activities, many institutions are reluctant to share this data because of confidentiality and security concerns, Greeley explains.

**Tip:** When faced with this obstacle, hospitals should place the burden on the applicant to acquire this data, advises Marder. “Make the acquisition of practitioner-specific information a condition of processing the application,” he says.

“The burden should be placed on the applicant to get the hospital to provide the data.”

According to Marder, most hospital appointment and reappointment applications include a release signed by the physician, which allows the hospital to obtain quality information from other institutions.

“However, many hospitals don’t push hard to get [this data] and the requested hospital does not like to go through the effort to provide it,” he explains.

In addition, hospitals use different quality indicators and have different data system capabilities, Marder says. “As we move toward a more universal acceptance of severity adjusted claims data and collection of core indicators by physician identifier, this will become more feasible,” he continues.

**Compliance strategy**
San Juan Regional Medical Center was collecting practitioner-specific information at initial appointment prior to the introduction of the JCAHO’s 2004 standards.

“If physicians want [to be] on your medical staff, they will get you the information,” says Becky Jimerson, CPMSM, CPCS, manager of medical staff services for San Juan.

Jimerson says her organization’s credentials committee will not move forward on an application until it has enough information to confidently make a recommendation to the medical executive committee.

“[This] recommendation [must be] backed by documentation that demonstrates competency for the clinical privileges that the physician has requested,” she says.

In addition, San Juan requires a 12-month “log” of the practitioner’s cases and procedures for review by the credentials committee.

The organization implemented this requirement after discovering that some surgical applicants had not performed the “types of cases required” by the facility for over a year. This information is instrumental to determine the level of proctoring, Jimerson says.

According to Jimerson, most hospitals she contacts to solicit practitioner-specific information respond by forwarding their physician profile information.

“We always provide this type of information to requesting hospitals as we believe it is necessary for those facilities to have this information in make informed decisions regarding membership and clinical privileges,” she says.
Sample letter to accompany professional reference questionnaire

[Date]

Practitioner’s name (including any other name[s] used): _________________________________
Date of birth: _________________________________

The above-named practitioner has applied for medical staff appointment and clinical privileges at [Hospital name]. The applicant listed you as a reference.

Based on your personal knowledge of the applicant, we would appreciate your candid, written appraisal of him or her. The enclosed professional reference questionnaire encompasses clinical ability, ethical character, ability to work cooperatively with others, health status, and other information relevant to this practitioner’s qualifications for appointment and privileges.

We appreciate you providing your knowledge of these matters with respect to the applicant, particularly anything that warrants caution in granting him or her appointment or particular clinical privileges. A copy of his or her request for clinical privileges is attached so you may assess the appropriateness of the privileges for which he or she has applied.

A self-addressed envelope is enclosed for your convenience. Your prompt and full response will be appreciated. Also enclosed is a copy of a release and immunity statement executed by the practitioner in connection with the application. This signed statement constitutes a consent to this inquiry and to your response and releases from liability any individual who provides the requested information to representatives of this hospital.

Thank you for your cooperation.

Sincerely,

[Chief executive officer or vice president of medical affairs]

Enclosures

Sample professional reference questionnaire

Professional evaluation concerning: [Applicant’s full name, including any other name(s) used]

________________________________________________________________________

Specialties: __________________________________________________________________

Date of birth: __________________________________________________________________

Reference provided by: __________________________________________________________________

Please check the accuracy of this information, and change/complete as appropriate.

Field of practice: __________________________________________________________________

Present professional position: __________________________________________________________________

Day phone: __________________________________________________________________

Please answer all questions based on your personal knowledge and direct observations. Your candidness will be greatly appreciated.

I. RELATIONSHIP OF REFERENCE SOURCE TO APPLICANT

1. How long have you known the applicant? __________________________________________________________________

2. During what time period did you have the opportunity to directly observe the applicant’s practice of medicine? __________________________________________________________________

3. a. In what setting(s) and with what frequency did you observe the applicant (i.e., office, hospital, residency program, etc., or daily, weekly, monthly, infrequently)? __________________________________________________________________

   b. Was your observation done in connection with any official professional title or position? Yes ☐ No ☐

   If so, please indicate title and organization: __________________________________________________________________

   c. What was the applicant’s title or position? __________________________________________________________________

4. Were you previously, are you now, or are you about to become related to the applicant as family or through a professional partnership or financial association? Yes ☐ No ☐

   If yes, please explain: __________________________________________________________________

II. PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

If you do not have adequate knowledge to answer a particular question, please indicate “no information.”

<table>
<thead>
<tr>
<th>1. Please rate the following:</th>
<th>Above average</th>
<th>Average</th>
<th>Below average</th>
<th>No information</th>
</tr>
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<tbody>
<tr>
<td>a. Basic medical/clinical knowledge</td>
<td>☐</td>
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<td>b. Knowledge in specialty</td>
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<tr>
<td>c. Technical skills</td>
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<tr>
<td>d. Clinical judgment</td>
<td>☐</td>
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<tr>
<td>e. Availability and thoroughness in patient care</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>f. Appropriate and timely use of consultants</td>
<td>☐</td>
<td>☑</td>
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<td>☐</td>
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<tr>
<td>g. Quality/appropriateness of patient care outcomes</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>h. Appropriateness of resource use (necessary for admissions, procedures, LOS, tests, etc.)</td>
<td>☐</td>
<td>☑</td>
<td>☑</td>
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<tr>
<td>i. Clarity/completeness of medical records</td>
<td>☐</td>
<td>☑</td>
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<td>☐</td>
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<tr>
<td>j. Medical record timeliness</td>
<td>☐</td>
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<td>k. Legibility of records</td>
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<td>l. Participation in committees, leadership, etc.</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>m. Verbal and written fluency in English</td>
<td>☐</td>
<td>☑</td>
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<td>n. Rapport with patients</td>
<td>☐</td>
<td>☑</td>
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<tr>
<td>o. Ability to work with others</td>
<td>☐</td>
<td>☑</td>
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</table>

2. a. My recommendation concerning the specific clinical privileges/services requested is:

☐ Recommend for all requested  ☐ Not recommend certain privileges/services  
☐ Limit certain privileges/services  ☐ Not recommend for any privileges/services

b. Please explain any reservations or concerns regarding any specific privileges/services requested by the applicant.

3. Have you ever observed or been informed of any problems which the applicant has or had that have or could potentially affect his/her ability to exercise all or any of the privileges requested or to perform the duties of medical staff appointment?  ☐ Yes  ☐ No  ☐ No information

If yes, please explain: _______________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Sample professional reference questionnaire (cont.)

4. To the best of your knowledge, has the applicant’s license, clinical privileges, hospital appointment, affiliation with any healthcare organization, or other professional status ever been denied, challenged, investigated, terminated, reduced, not renewed, limited, withdrawn, suspended, revoked, modified, placed on probation, or voluntarily surrendered, or do you have knowledge of any such actions that are pending?

❑ Yes  ❑ No  ❑ No information

If yes, please explain: _____________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

5. Do you know of any malpractice action instituted or in process against the applicant?

❑ Yes  ❑ No  ❑ No information

If yes, please explain: ___________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

III. SUMMARY
1. My recommendation concerning this practitioner’s application for appointment/affiliation is:

❑ Recommended  ❑ Recommended with reservation  ❑ Not recommended

2. Please use this section for any additional comments, information, or recommendations that may be relevant to our decision to grant appointment/affiliation or specific clinical privileges/services to the applicant.

Signature: _______________________________ Date: __________________________

Sample letter verifying hospital affiliation

Practitioner’s name (including any other name[s] used): _________________________________
Date of birth: _______________________________________________________________________
Dates of affiliation: __________________________________________________________________

Dear [chief executive officer’s name]:

The above-named practitioner has applied for medical staff, [active/associate/courtesy] staff category, and clinical privileges in the department of [e.g., medicine/surgery/pathology, etc].

The application indicates affiliation with your hospital for the above stated period of time. As part of our credentialing process, we must confirm this affiliation and obtain information regarding the practitioner’s performance at your institution.

Enclosed please find:

1. Release/immunity statement. This statement constitutes consent to this inquiry and to your response and releases from liability any individual who provides the requested information.

2. Verification of hospital affiliation. An appropriate representative of your institution should complete this verification.

3. Request for clinical privileges forms. These forms specify the privileges requested by the applicant at this institution.

4. Practitioner performance questionnaire. The appropriate official at your institution should complete this questionnaire.

In connection with the application, the practitioner has requested the privileges listed on the enclosed form(s). Please have the appropriate official review the request and complete the performance questionnaire. For the privileges/services asterisked (*), please indicate the number of procedures performed or cases of that kind treated by the practitioner at your facility during the most recent year of affiliation.

Your prompt attention to this request is appreciated.

When returning the verification statement and performance questionnaire, please include a copy of the clinical privileges the practitioner is/was authorized to provide by your organization.

Thank you for your cooperation and assistance.

Sincerely,

Chief Executive Officer
Enclosures

Sample terms and conditions of appointment and release of liability

By applying for medical staff and clinical privileges at [Hospital], I accept the terms and conditions set forth below and intend to be legally bound thereby and hereby:

- signify my willingness to appear for interviews in regard to my application
- authorize the hospital, its medical staff, and its representatives to consult with my prior and current associates who may have information regarding my professional competence; ethical qualifications; ability to work cooperatively with others; other qualifications for membership and requested clinical privileges; character; and mental, emotional, and physical health status
- authorize the hospital, its medical staff, and its representatives to inspect all documents that may be material to an evaluation of my qualifications and competence, and consent to the release of such information
- release from liability all representatives of the hospital and its staff for actions performed and statements made in connection with the evaluation of my application, credentials, and qualifications to the fullest extent permitted by law
- release from liability any and all individuals and organizations who provide information to the hospital or the medical staff concerning my professional competence, background, experience, ethics, character, utilization practice patterns, and other qualifications for staff appointment and clinical privileges to the fullest extent permitted by law
- acknowledge that I have read the medical staff bylaws, and manuals and policies relevant to the application process and clinical practice at the hospital’s facilities, and agree to be bound by the terms thereof in all matters
- acknowledge that medical staff bylaws provisions relating to confidentiality and release from liability are express conditions to my application for, and acceptance of, staff membership and the continuation of such membership and exercise of clinical privileges
- pledge to maintain an ethical practice, provide for continuous care for my patients, seek consultation whenever necessary, refrain from fee-splitting or other inducements related to patient referral, and refrain from delegating the responsibility for any aspect of patient care to any practitioner not qualified to undertake the responsibility

Sample terms and conditions of appointment and release of liability (cont.)

- agree to inform the medical staff office of any change made or proposed in the status of my professional license or permit to practice, state and federal controlled substances registrations, professional liability insurance coverage, and membership/employment/faculty status or clinical privileges at other institutions/facilities/organizations

- accept committee assignments and other duties and responsibilities assigned to me by the governing board and medical staff

- acknowledge that I, as an applicant for staff membership and privileges, have the burden of producing information for a proper evaluation of my professional, ethical, and other qualifications for membership and clinical privileges

- acknowledge that I have the burden of producing information needed to resolve doubts about my qualifications

- acknowledge that medical staff reappointment and clinical privileges remain contingent upon my continued demonstration of professional competence, cooperation, support of the hospital, and acceptable performance of all related responsibilities, as well as the other factors deemed relevant by the hospital

- acknowledge that any material misrepresentation, misstatements, or omissions from this application, whether intentional or not, constitute cause for denial of appointment and clinical privileges or cause for summary dismissal from the staff

All information I’ve submitted in my application for medical staff appointment is true and complete to my best knowledge and belief. A photostatic copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Said photostatic copy shall have the same force and effect as the signed original.

Signature: _________________________________________________ Date: __________

**Staying abreast of technology, the JCAHO addresses primary-source data from designees**

Changes in technology once again resulted in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) tweaking its standards to keep up with the times. Effective in 2003, the JCAHO informed hospitals that they can accept credentials information provided by an organization that is designated by a primary source as its agent. The JCAHO originally detailed the change in the January 2003 *Joint Commission Perspectives*.

The change was carried over into the 2004 medical staff standards found in the *Comprehensive Accreditation Manual for Hospitals* (CAMH). Under the rationale for standard **MS.4.10**, the JCAHO says that “a primary source of verified information may designate to an agency the role of communicating credentials information. The delegated agency then becomes acceptable to be used as a primary source.” The JCAHO made the change in 2003 recognizing changes in technology, including online verification of credentials-related information.

At the time, *Perspectives* reported that the JCAHO revised the standards in acknowledgement that some primary sources—such as state licensing agencies, medical schools, and others—now contract with outside agencies to respond to requests for credentials-related information. Some primary sources don’t even accept verification requests—they refer the party requesting information to their designated source to handle it. The JCAHO requires primary-source verification of current licensure, relevant training or experience, and current competence.

“As technology becomes better and there are more reliable sources for verification—either online or over the phone—organizations are going to start using that technology,” says **Jodi Schirling, CPMSM**, manager of corporate credentialing for the Nemours Foundation in Wilmington, DE.

**A word of caution**

However, industry experts have warned medical staff services professionals (MSSPs) to use caution when collecting primary-source information from so-called “delegated agencies.” MSSPs should not assume that every Web site or telephone hotline that claims to provide credentialing data on behalf of a primary source is legitimate. The experts say do your homework and keep documentation in the medical staff office that shows you are indeed using an official, acceptable designated source. (See box below.)

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**A definition of designated source**

What is a designated source? The Joint Commission on Accreditation of Healthcare Organizations’ standard **MS.4.10** says simply “a primary source of verified information may designate to an agency the role of communicating credentials information. The delegated agency then becomes acceptable to be used as primary source.”

For instance, a designated source is an entity that has an official, contractual relationship with a primary source—such as a medical school, licensing agency, or specialty board—to provide credentials verification on its behalf.

Examples include, but are not limited to, the following:

- **National Student Clearinghouse** ([www.nscl.org](http://www.nscl.org)). Several hundred schools offering college, graduate, and professional degrees have officially delegated this organization the responsibility of responding to all requests for degree verifications of their students. This clearinghouse provides these verifications via a password-protected Web site.

- **CertiFACTS Online** ([www.certifacts.org](http://www.certifacts.org)). The American Board of Medical Specialties (ABMS) contracts with Atlanta-based TMP Medical Listings, Inc. to operate and maintain CertiFACTS Online. This password-protected Web site provides verification of medical specialty board certification for all ABMS member boards.
Telemedicine has brought great advantages to hospitals, but with it has come some unique challenges. In its 2004 medical staff standards, the Joint Commission on Accreditation of Healthcare Organizations has tried to ease some of the burden by clarifying how health care facilities can properly credential telemedicine practitioners.

Credentialing professionals will find an introduction section on telemedicine in the Comprehensive Accreditation Manual for Hospitals that outlines which practitioners must be credentialed. The introduction is followed by the actual telemedicine standards MS.4.120 and MS.4.130.

**Originating and distant sites**

In his book, *The Compliance Guide to the Medical Staff Standards, Fourth Edition*, Richard E. Thompson, MD, summarizes the telemedicine standards. When it comes to telemedicine credentialing and privileging described in standard MS.4.120, understand that the JCAHO defines these two terms:

- The *originating* site as where the patient is
- The *distant site* is the organization of the practitioner is who is being asked to provide some type of care via a telemedicine link

“Practitioners who provide telemedicine services must be credentialed and privileged to do so by the originating site,” Thompson says. “The originating site may use their full credentialing and privileging process, or it may use relevant information from a JCAHO-accredited distant site to credential and privilege the telemedicine practitioner,” Thompson says.

What this means is that, in many cases, organizations can rely on the credentialing process at the telemedicine practitioner’s facility instead of having to duplicate the whole process.

The originating site may also accept the telemedicine privileges of the practitioner at the distant site, if JCAHO-accredited, and the individual is privileged to provide this type of telemedicine services, according to Thompson.

However, the originating site must provide the distant site with information on that practitioner’s performance of telemedicine services, including kudos, complaints, adverse outcomes, or sentinel events, Thompson says.

**Who needs credentialing?**

Privileges are required only for those practitioners who treat patients directly. In the introduction to the standards, the JCAHO says hospitals must grant privileges to telemedicine providers who are licensed independent practitioners with either “total or shared responsibility” for patient care, “as evidenced by having the authority to write, order, and direct care, treatment, and services.”

In addition, the introduction clarifies that any licensed independent practitioner who provides “official readings of images, tracings, or specimens” through a telemedicine link should be credentialed and privileged under standard LD.3.50 in the leadership chapter, not the medical staff process.

In summary, when it comes to standard MS.4.130, Thompson says organizations must comply with these two requirements:

1. Medical staff leaders recommend to the board which clinical services should be provided by telemedicine link. The JCAHO’s interpretive note indicates that one use of this list is to allow for items to be removed if those services become available in the community, such as by the addition of a practitioner to the medical staff.

2. The telemedicine services that are provided are consistent with commonly accepted measures of the quality of such services.

“Benchmarking with other organizations is important in this still young field of medical practice,” he says.
Sample telemedicine policy

Definitions

*Telemedicine* is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. *Originating site* is the site at which the patient is receiving care. *Distant site* is the site from which the prescribing or treating services are provided.

Policy

It is the policy of [hospital name] that telemedicine services will be provided here as a(n) [originating site/distant site/originating and distant site] in a manner that seeks to ensure a high level of care consistent with the standards of care for other hospital services.

Telemedicine privileges

Practitioners who provide telemedicine services must be granted privileges at this hospital if, and only if, these services include prescribing care or otherwise treating patients. Practitioners who provide telemedicine services limited to interpretation and second opinions do not require privileges at this hospital. Practitioners providing official readings of images, tracings, or specimens through a telemedicine mechanism must do so under one of the following two arrangements:

- The practitioner is granted clinical privileges at this hospital.
- The hospital contracts for the provision of these services by the provider. These services must be provided consistent with existing hospital and medical staff policies addressing contracted services.

In order for a practitioner to be eligible to request telemedicine privileges, the following requirements must be met:

- The medical executive committee (MEC) has recommended that the scope of telemedicine services provided at this [originating site/distant site] hospital and the [distant site/originating site] hospital include the privileges requested by the practitioner. Both the originating-site MEC and the distant-site MEC must approve this scope of services.
- The practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant-site hospital as he or she is requesting at the originating-site hospital. Requests for telemedicine privileges at the originating-site hospital will be processed through the established procedure for reviewing and granting privileges at the originating-site hospital. Information included in the completed practitioner application for telemedicine privileges at the originating site hospital may be collected in the usual manner or may be collected from the distant site hospital.

In order for the originating site to utilize credentialing and privileging information from the distant site in credentialing and privileging decisions, the following conditions must be fulfilled:

- The distant site hospital is JCAHO accredited
- The practitioner is privileged at the distant site hospital for those services to be provided at the originating site hospital
- The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement

At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by the JCAHO that result from the telemedicine services provided and complaints about the distant site hospital from patients, other licensed independent practitioners, and staff at the originating site hospital.

Source: “Telemedicine: Credentialing, JCAHO standards, and other hot issues for hospitals.” To purchase a tape of this audioconference, contact our Customer Service Department at 800/650-6787.
Comply with the JCAHO’s new telemedicine standards

In his book, *The Compliance Guide to the Medical Staff Standards, Fourth Edition*, Richard E. Thompson, MD, provides hospitals with a compliance crosswalk to help determine their survey readiness. The following chart shows the telemedicine standards and what hospitals can do to demonstrate compliance.

<table>
<thead>
<tr>
<th>Standard and elements of performance</th>
<th>Matching activity and written confirmation thereof</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MS.4.120</strong> A procedure is in place for privileging practitioners who provide telemedicine services to our patients.</td>
<td>Relevant documents and relevant practitioner files are available for surveyor review.</td>
<td>Some practitioners provide medical services via telemedicine link. Collect information from originating hospitals and use this information when reappraising practitioners (see <strong>MS. 4.40</strong>).</td>
</tr>
<tr>
<td>In JCAHO-ese, the originating site is where the patient is; the distant site is where the practitioner providing telemedicine services is.</td>
<td>Relevant documents, practitioners’ files, and patient records are ready for surveyor review.</td>
<td></td>
</tr>
<tr>
<td><strong>MS.4.130</strong> The leaders of the organized medical staff recommend to the board those clinical services that are appropriate for our clinically active practitioners to provide, and those clinical services that it is appropriate to obtain for our patients via a telemedicine link.</td>
<td>Relevant documents, such as the Telemedicine Services Policy, medical executive committee minutes/board minutes are ready for surveyor review.</td>
<td></td>
</tr>
</tbody>
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Primary source

It’s important that MSSPs make sure the designated sources they use are indeed legitimate. If in doubt, place a quick phone call or e-mail to the primary source itself, such as a medical school, to confirm that it has authorized an entity, such as the National Student Clearinghouse, to provide credentials information to health care organizations on its behalf.

Here’s a precaution some experts recommend, although it is not included in the JCAHO standards: After you’ve confirmed the legitimacy of a designated source, get that confirmation in writing from the primary source. “The Internet is so vast, and so many [Web] sites claim to provide credentials information that it would be easy for someone—especially an MSSP new to the field—to use a source that’s not really a designated source,” cautions Christina Wiggins Giles, MS, CPMSM, a consultant with Medical Staff Solutions in Pepperell, MA.

Some Web sites include a statement as to whether the information provided meets JCAHO primary source requirements.

If a Web site includes disclaimer information, saying the agency is a contracted designated source of an organization, MSSPs can print out this language as documentation that it is indeed a legitimate designated source.
JCAHO issues guidelines—not a prescription—for overcoming common AHP challenges

PAs and APRNs focus of 2004 leadership standard

The credentialing and privileging of allied health professionals (AHPs) has, for many years, been a cause of concern for hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). However, the accreditor’s 2004 standards attempt to clear up some of the confusion over this issue by providing new guidelines regarding specific AHPs—namely, physician assistants (PAs) and advanced practice registered nurses (APRNs). Despite the confusion caused by the JCAHO’s pre-publication standards, which led some medical staff professionals to conclude that their organizations must privilege all AHPs considered licensed independent practitioners (LIPs) by the hospital, the accreditor’s finalized leadership standard LD.3.70 focuses solely on PAs and APRNs. The standards regarding these AHPs provide choices, not limitations, for hospitals. The bottom line is that hospitals must consider PAs’ and APRNs’ licensure status, supervision level, and policies and procedures, to determine whether to grant privileges to these practitioners.

Credentialing and privileging basics

It’s clear that the JCAHO requires hospitals to credential all individuals allowed access to patients. Although the extent of the credentials verification and approval process at many hospitals is dependent on the individual’s role, most organizations have long understood that the human resources (HR) department, medical staff office, or chief executive officer’s office must obtain, verify, and assess the qualifications of practitioners who provide patient care, explains Carol Cairns, CPMSM, CPCS, president of PRO-CON in Morris, IL.

However, the question of privileging AHPs bewildered many medical staff professionals. This is where the 2004 medical staff standards come into play. The overview section of the JCAHO’s revised standards clearly instructs hospitals to grant privileges to all LIPs, explains Cairns.

Note: Remember, the JCAHO defines an LIP as an individual who is permitted by state law and hospital policy to provide patient care independently, regardless of whether he or she is a medical staff member.

Keep in mind that even if your state law authorizes the practitioner to practice independently, the hospital is not bound to do so. Your hospital’s governing board must consider the extent of services that it will offer and determine the scope of practice it will permit to an AHP. Remember, independent activity is not synonymous with LIP.

All organizations have the right to limit a practitioner’s provision of care, regardless of what’s allowed under state law, concurs Hugh Greeley, founder of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

The overview section of the revised medical staff chapter also states that PAs and APRNs who are not LIPs may be privileged through the medical staff process or a process that is “equivalent to the process and criteria set forth in the credentialing and privileging standards.”

This language does not mandate the privileging of PAs and APRNs who are not LIPs. “The JCAHO’s overview language says PAs and APRNs who are not LIPs may be privileged—not must be privileged—through the medical staff process,” Cairns says.

Note: If the PAs and APRNs in your hospital are not LIPs, you do not have to privilege them if you don’t see fit. These practitioners may work under a scope of practice, job description, or other authorization, Cairns asserts.
**Equivalent process**

The JCAHO’s 2004 standard **LD.3.70** also permits hospitals the option of authorizing PAs and APRNs to practice via an “equivalent process” approved by the governing body, rather than granting these practitioners privileges.

According to the JCAHO source, in cases where these practitioners are not LIPs, they can be covered under a job description or scope of practice through the human resource department. However, the HR process must closely mirror the medical staff privileging process.

The elements of performance for leadership standard **LD.3.70** state that the “equivalent process” must at minimum

- evaluate the AHP’s credentials
- evaluate the AHP’s current competence
- include peer review
- involve communication and input from committees, including the medical executive committee (MEC), to make an informed decision about the applicant’s privilege request.

“Although [the] JCAHO does require an equivalent process, it does not require that the medical staff office credential these providers,” asserts Kathy Matzka, CPMSM, CPCS, writer/speaker/consultant based in Lebanon, IL. According to Matzka, although medical staff offices typically credential and privilege APRNs and PAs who are employed by medical staff members, problems arise when the hospital employees APRNs and PAs and the hospital personnel office wants the medical staff to do the credentialing.

“If the APRN or PA is going to be given specific medical staff privileges, they should be credentialed by the medical staff office and put through the medical staff process,” she says. “If the provider is not going to be working independently and will be only following orders or working under established protocols under the supervision of a hospital-employed physician, they can be credentialed by the personnel department through an equivalent process.”

**Note:** Matzka says an equivalent process should evaluate the applicant’s credentials and current competence, include peer review, and involve communication with and input from individuals and committees, including the MEC, to make an informed decision regarding the applicant's request for privileges. However, this does not mean that the MEC has to approve the applicants, just the process.

“Perhaps the most important thing to keep in mind is the safety of the patient,” she continues. “If personnel office employees lack the knowledge to adequately credential these people, for the sake of the patient, it should be done in the medical staff office. After all, [they] are the experts.”

**The standard in practice**

Although the prepublication version of this standard worried many medical staff professionals, few organizations are adopting new policies and procedures regarding PAs and APRNs to comply with the finalized standard.

Because **LD.3.70** requires organizations that decide not to privilege PAs and APRNs, who are considered LIPs, through the medical staff office to develop an “equivalent source” that mirrors the medical staff’s privileging process, many organizations are opting to privilege all LIP PAs and APRNs.

“Why bother creating a separate mechanism when your medical staff privileging mechanism already covers these elements of performance?” asks a JCAHO insider who asked to remain anonymous.

Karen J. Shipsky, manager of medical staff affairs at St. Barnabas Hospital/Partners in Health, Bronx, NY, says her organization is sticking to it's current processes because it has always credentialled and privileged its PAs, [certified registered nurse anesthetists (CRNAs), and nurse practitioners (NPs)] exactly the same way it credentials and privileges physicians, regardless of whether they are employed by the hospital or employed by a private physician.

However, for Trinity Medical Center in Carrollton, TX, the new standard required the **continued on p. 20**
organization to slightly modify its process. “We have always credentialed and privileged our allied health APRNs and PAs through the medical staff structure, but this standard caused us to expand that to include all hospital-employed APRNs and PAs,” explains Bonnie Conley, CPCS, director of medical staff services at Trinity. “Since the equivalent process must mirror the medical staff process with approval from the [MEC] we had no other choice, and it just seemed like a much simpler route for us to take.”

**Hybrid process**

If PAs and APRNs are not considered LIPs in a hospital, does that mean that the HR department has to process and authorize their practice? Again, the process is entirely up to the individual organization, says Greeley.

“JCAHO standard **LD.3.70** basically says it’s okay not to privilege PAs and APRNs,” he said, “as long as the organization still practices due diligence to make sure these AHPs are qualified and competent to treat patients.” The HR department or the medical staff office should check the applicant’s qualifications, or both departments could share the responsibility.

“The medical staff office could do the routine primary-source verification, and then pass on the application to human resources to conduct a background check and assign a scope of practice whatever the hospital deems appropriate,” Greeley says.

Northwestern Memorial Hospital in Chicago has adopted such a “hybrid” process.

Prior to the introduction of **LD.3.70**, the hospital’s medical staff office credentialed certified nurse midwives, CRNAs, and physician-employed PAs, while the HR department handled hospital-employed clinical nurse specialists (CNSs), NPs, and PAs.

The HR department also handled physician-employed CNSs and NPs. However, with the new standard, the hospital developed a new process.

“All midlevel providers will be processed through the medical staff office, but some responsibilities will be assigned to HR,” explains Halina J. Henning, CPMSM, CPCS, manager of medical staff administration and credentialing.

Northwestern’s hybrid process also states that

- credentialing and privileging files for AHPs will be housed in the medical staff office
- midlevel providers will get a scope of collaborative privileges
- the chief nurse executive and senior vice president of medical affairs will make recommendations to the MEC
- the MEC will report to the board
- the midlevel provider committee will review problem applications, corrective actions, etc.

**Note:** Northwestern’s midlevel providers are non-LIPs and work with a supervising physician.

A JCAHO representative who recently visited San Juan Regional Medical Center in Farmington, NM, stated the “intent of the [accreditor] is not to make facilities take AHPs who are employed by the facility out of the HR process,” according to Becky Jimerson, CPMSM, CPCS, manager of medical staff services at San Juan Regional.

Jimerson explains that her facility credentials physician-employed AHPs through the organization’s AHP committee. However, hospital-employed AHPs are processed by the HR department. “The JCAHO [representative] said this was fine,” she asserts.

However, Greeley stresses the importance of medical staff involvement in helping to develop the practice scope and other hiring criteria for PAs and APRNs.

“Just because these individuals may not be privileged doesn’t mean medical staff leadership shouldn’t have input,” he said. “But whatever process the hospital might decide to use, the governing body must approve it, according to the overview section of the 2004 medical staff standards,” he says.
JCAHO clarifies bylaws requirements for 2004; hospital leaders don’t have to do complete rewrite

When the Joint Commission on Accreditation of Healthcare Organizations published its 2004 medical staff standards, it left many hospital leaders in a quandary.

The standards seemed to say hospitals needed to include all medical staff policies and procedures in its medical bylaws, a requirement that contradicted the trend of many hospitals to simplify their bylaws and move policies and procedures into separate documents.

Some hospital leaders began shifting credentialing, privileging, appointment, and fair hearing and appeal processes from separate documents back into the medical staff bylaws.

However, in a December 2003 clarification, the JCAHO put an end to that tedious work. The accreditor said it will allow hospitals the option of continuing to only reference specific medical staff functions and procedures in the bylaws as long as those procedures are detailed in separate documents.

In clarifying standard MS.1.20, from the Comprehensive Accreditation Manual for Hospitals (CAMH), the JCAHO said hospitals can reference the following four items in the bylaws and describe them in detail in other documents:

- Credentialing
- Privileging
- Appointment
- Fair hearing and appeal processes

Cover these three bases
That was good news for hospitals, says Richard Sheff, MD, chair and executive director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

The bottom line is that the JCAHO spelled out that “these documents clearly need to be referenced in your bylaws, but they do not have to be contained in your bylaws,” Sheff says.

Hospitals should include language in its bylaws that says “the following manuals [or policies, or procedures] are hereby incorporated by reference into these bylaws,” Sheff recommends.

To comply with JCAHO standards, hospitals also need to take the following three steps as required in the clarification:

1. The medical staff and the governing body must jointly approve the separate documents that detail these four functions.

2. The process for medical staff approval of the other documents, including their amendment, may be different than the process followed to approve the bylaws.

   However, this alternative approval process must be established by and set forth in the bylaws. (Typically, it takes a percent approval of the entire medical staff to approve or amend the bylaws.)

3. The governing body must approve the processes detailed in documents separate from the bylaws. According to the JCAHO’s clarification, “the bylaws could describe or allow for an alternative process for the medical staff approval of other documents and their amendment.”

   For instance, the clarification says, hospitals could delegate medical staff approval to the medical executive committee (MEC) with subsequent approval by the governing body.

Based on the clarification, make sure both the medical staff and the governing body approve the separate documents that detail the credentialing, privileging, appointment, and fair hearing and ... continued on p. 22
Bylaws  continued from p. 21

appeal process.

“Medical staff bylaws and an organizational plan are usually developed by a bylaws committee of the medical staff/ad hoc group appointed for this purpose by the MEC,” says Richard Thompson, MD, author of *The Compliance Guide to the Medical Staff Standards, Fourth Edition*, published by HCPro, Inc.

“Medical staff bylaws and amendments must then be adopted by the medical staff and approved by the board.”

One way to demonstrate your compliance with standard MS.1.20, is for you to include in your medical staff documents a signature sheet indicating their adoption by the medical staff and the subsequent approval by the hospital board, Thompson advises.

**Bylaws must define method of amendment**

Also, take note that the bylaws must reference how those separate documents will be amended, Sheff says, “The thought being that when the medical staff approves its bylaws, it is hereby authorizing that method of amendment.”

Sheff says it makes sense to have two different methods for amending the bylaws v. the separate documents that detail processes.

“The basic principle behind pulling these things out into separate documents is that the bylaws should function as the constitution of the medical staff and defines the rights and responsibilities of medical staff members and how we will govern ourselves,” Sheff says.

“As such, it should be hard to change the bylaws. We should think long and hard before we change our constitution.”

“How many hospitals have a single document for their bylaws v. having them organized into multiple components (core bylaws and separate documents describing medical staff policies and procedures)?

38%—single document

62%—multiple components

Source: Audioconference audience “How to fix your bylaws: Physician rights, medical staff responsibilities, and new JCAHO standards.” To order the tape, go to www.hcmarketplace.com or call customer service at 800/650-6787.

“We need greater flexibility to change how we do the work of the medical staff. So the logic the medical staff would apply to this is what should be abiding—put that in the bylaws,” he says.

Although the JCAHO does not specify a method, most hospitals usually require a vote of the MEC to change those separate documents, Sheff says.

**The rights of the medical staff**

He also contends that if the medical staff grants authority to the MEC to manage medical staff activities, the bylaws should include clear mechanisms that hold the MEC accountable.

“What do we do if the MEC members start going down a road the rest of medical staff doesn’t support?” Sheff asks.

“In the medical staff members’ rights that belong in the bylaws, there should be a listing of how we would address that problem.”
Sheff recommends hospitals include the following provisions in their bylaws:

- The right of any member of the medical staff for a hearing before the MEC on any subject they choose.

  “So if a medical staff member thinks the MEC is going down a road he or she doesn’t like, they can ask to be heard by the MEC,” he explains.

- The right to petition for a meeting of the general medical staff. “Say we think the MEC is not hearing us on this, and the will of the majority of the medical staff is substantially different than the direction the MEC is leading, then we have the right to call a meeting of the general medical staff with the sole purpose of addressing that particular issue,” Sheff says.

- The right to recall and remove officers and members of the MEC.

  “After all this, what if we think the MEC, the leadership, the department chairs are really going down a road that no longer has the support of the organization. We have a right to recall. These are the trappings of any representative form of democracy,” he says.

Those provisions provide protection for the medical staff, he says. “If we have those rights, it really is okay to empower the MEC to do these things because we have ways of reeling them back if they go out on a limb that doesn’t have the support of the medical staff,” Sheff says.

**No unilateral amendments**

Another hotly debated issue surrounding changes to the bylaws involves the unilateral amendment of those bylaws, Sheff says.

On the one side are those who argue that a hospital’s governing board should not have the unilateral right to amend the medical staff bylaws.

On the other side are those who argue that case law makes the governing board responsible for everything that happens in the hospital, Sheff says. Those proponents say it hampers the ability of the board to govern, when they cannot change the bylaws.

In standard **MS.1.30**, the JCAHO says “neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules or regulations.”

“Any amendments to the medical staff bylaws must be first adopted by the medical staff and then approved by the board,” says Thompson.

“Such amendments must carry the signature of the medical staff president (or duly authorized designee) indicating medical staff adoption, and the signature of the board chair or duly authorized designee indicating board approval.”

In its rationale for MS.1.30, the JCAHO says that “a hospital with an organized medical staff and governing body that cannot agree on amendments to critical documents has evidenced a breakdown in the required collaborative relationship.”

“The Joint Commission considered this and says that the moment when a board unilaterally amends the bylaws, it’s a symptom of a breakdown in communication—a symptom of a hospital and medical staff in trouble,” Sheff says.

Based on case law, the board may need the authority to amend the bylaws, but if the board ever exercises that authority, it will trigger noncompliance with MS.1.30, Sheff says.

In the case of such a dispute, the issue should be send to a joint conference committee that includes leaders of the board and leaders of the medical staff.

The issue should be resolved at that level, rather than at the level where the board if forced to vote unilaterally to amend the bylaws, he says.

*Editor’s note: Go to www.hcmarketplace.com/Prod.cfm?id=2003 for more information about The Compliance Guide to the Medical Staff Standards, Fourth Edition, or call customer service at 800/650-6787.*
Impaired practitioner policies: No longer just for physicians

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) added standard MS.2.6 to its medical staff chapter, which mandated a mechanism for identifying and providing assistance to impaired physicians.

The accreditor’s 2004 standard, MS.4.80 expands this requirement by mandating that your organization applies its impaired physician policy to all licensed independent practitioners (LIPs), not just physicians.

LIP health
Your organization should not have much trouble complying with MS.4.80 if you previously implemented an effective impaired physician policy and process to comply with 2001 JCAHO standards.

“This standard requires institutions to recognize that an LIP must be included in the impaired practitioner program if he or she is allowed to practice without supervision,” says Hugh Greeley, founder of The Greeley Company, a division of HCPro, Inc.

According to Greeley, compliance with this new standard requires your organization to simply amend the language of its current impaired physician policy to include all LIPs who provide patient care at your facility.

Standard specifics
MS.4.80 requires your hospital to train its medical staff leaders to recognize and effectively address mental, emotional, or physician illness that impairs a practitioner’s ability to practice, says Richard Thompson, MD, author of The Compliance Guide to the Medical Staff Standards, Fourth Edition, published by HCPro, Inc., in Marblehead, MA.

These procedures must allow the affected practitioner the opportunity to seek help and rehabilitate him- or herself, Thompson explains. In addition, your impaired practitioner policy must include mechanisms that allow others to request help on the practitioner’s behalf.

“The confidentiality of informants must be protected,” Thompson says.

The impaired practitioner policy and procedure must also:
- include mechanisms for referring the affected individual to a qualified program for diagnosis, treatment, and beginning rehabilitation
- ensure that the confidentiality of an affected practitioner is protected except when it is impossible due to relevant laws, ethical obligations, or when a patient could be at risk due to the practitioner’s impairment
- validate the credibility of any allegations of impairment before going forward
- include monitoring the behavior and, if practicing, the clinical performance of individuals alleged to be impaired

Note: “The JCAHO reminds us that care must be taken to comply with any relevant measure of the Americans with Disabilities Act,” Thompson says. “This need does not cancel out the responsibility for helping impaired physicians and protecting patients.”

From the field
In response to this standard, North General Hospital in New York City, made changes to its current impaired practitioner policy that specifies the process for reporting a suspected impaired practitioner.

“While [my organization’s] policy is strictly related to physician health issues, all other LIPs will be processed through the hospital’s human resources system for impairment issues,” explains Nilda Conrad, MBA, CPMSM, CPCS, assistant vice president of medical-surgical and professional affairs at North General.

Conrad explains that the hospital created a separate HR process for handling impairment of salaried LIPs. “Our LIPs, as well as other medical caregivers, are a part of the nursing service and, therefore, they have a procedure in place for handling them, which is something like [impaired physician policy] but for nonphysicians,” she says.

Editor’s note: Turn to p. 25 to review a sample policy for addressing possible impaired physicians and other practitioners.
Sample policy: Addressing possible impairment of practitioners’ granted privileges

Background
The problem of impairment is complex, and the investigation and hearing process is not appropriate in this situation. The American Medical Association defines the impaired physician as “one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.” This policy is intended to provide some overall guidance and direction on how to proceed when confronted with a potentially impaired physician or other practitioner granted privileges (hereinafter such a physician or other practitioner shall be generically referred to as a “practitioner”).

Because of the independent nature of most physicians’ practices and the serious implications of any disability, impairment is often hard to identify early and is always difficult for the impaired practitioner to acknowledge. It is also hard to face the practitioner with a problem. For all these reasons, a hospital and medical staff leadership often wait too long to address the problem. Nevertheless, the hospital and medical staff leadership must address it. The following policy provides the framework within which to do so.

Because the term “impaired practitioner” includes a variety of problems from age to substance abuse to physical or mental illness, the steps provided below will not be suitable in every circumstance. No one procedure will cover all situations. Specific needs and varying circumstances preclude a single, inflexible mechanism for dealing with impaired practitioners. The number and seriousness of incidents involving a practitioner, for example, may dictate the appropriate response by the hospital. If the hospital carries out the investigation suggested in the policy, the individuals conducting the inquiry will vary from hospital to hospital, depending upon personalities, circumstances, and the structure of the medical staff. Whatever mechanism a hospital chooses, the risk of patient harm must be of paramount concern. Immediate action may be necessary.

Hospitals and their medical staffs are encouraged to consult with “impaired physician programs” established by state medical societies for assistance when needed.

One exception to this policy is impairment due to age and irreversible medical illness or other factors not subject to rehabilitation. In such cases, the sections of the policy dealing with rehabilitation and reinstatement of the practitioner are not applicable.

Key factors to keep in mind while dealing with any issue relating to a practitioner’s illness or disability are state reporting statutes and the Americans with Disabilities Act. Application of this policy should be legally appropriate and consistent with these statutes. The hospital and medical staff should consult appropriate legal counsel when approving this policy.

Because of the importance of addressing impairment or possible impairment in a proactive manner, the medical staff should periodically provide educational programs and other forms of educational information concerning practitioner impairment to all individuals granted privileges.

Note: The chief executive officer (CEO) plays a significant role in this process in conjunction with medical staff leadership. Hospital employees also play an important role in reporting possible impairment. This is because an impaired practitioner is not only a medical staff problem, but a hospital problem as well. It is also appropriate, therefore, for the hospital to adopt an expanded version of this policy that addresses impairment in whatever manner it may present and impact patients and hospital operations, including impairment of employees, contracted individuals, volunteers and individuals granted privileges.

Definition
Impairment of an individual

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Impaired policy

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granted privilege is defined as a change in the health status of that individual that either does or could jeopardize the practitioner's ability to provide clinical services safely and effectively, or interact with others in the institution safely and effectively.

Policy

It is the policy of this hospital and its medical staff that all physicians and other practitioners granted privileges to provide patient care do so safely and effectively. Any practitioner with privileges whose health status changes in a manner that jeopardizes his or her ability to provide care safely and effectively shall notify the president of the medical staff or CEO of such change in a timely manner. Any individual working in the hospital who has a reasonable suspicion that an individual with privileges may be impaired shall notify the president of the medical staff or CEO [or the physician’s help committee] of his or her concern in a timely manner. Once the president of the medical staff or CEO receives notification about the possible impairment, he or she shall ensure that an appropriate investigation is undertaken consistent with the procedure outlined below. The president of the medical staff or CEO will take appropriate action based upon the results of this investigation to ensure good quality of care to patients of this hospital.

Procedure

Report and investigation

If any individual working in the hospital has a reasonable suspicion that a physician appointed to the medical staff or any other practitioner granted privileges is impaired, the following steps should be taken:

1. The individual who suspects the practitioner of being impaired must give an oral or, preferably, written report to the CEO or the medical staff president [or the physician's help committee]. The report must be factual and shall include a description of the incident(s) that led to the belief that the practitioner might be impaired. The individual making the report does not need to have proof of the impairment, but must state the facts that led to the suspicions.

2. If, after discussing the incident(s) with the individual who filed the report, the CEO or the medical staff president believes there is enough information to warrant an investigation, the CEO shall request that an investigation be conducted and a report of its findings rendered by
   a. the medical staff president
   b. a standing committee of the medical staff
   c. an outside consultant
   d. another individual or individuals appropriate under the circumstances

   Such an investigation shall be conducted in a manner that is separate from the usual medical staff disciplinary process and is appropriate to the circumstances of the incident(s) and individual(s) involved.

3. If the investigation produces sufficient evidence that the practitioner is or may be impaired, the CEO shall meet personally with that practitioner or designate another appropriate individual to do so. The CEO or a designee will also meet personally with a practitioner upon receiving a report from the practitioner concerning a change in his or her health status that does or could jeopardize the individual's ability to carry out privileges. The practitioner shall be told that the results of an investigation or the self-reported change in health status indicate that the practitioner may suffer from an impairment that affects his or her practice. The practitioner should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

4. Depending upon the severity of the problem and the nature of the impairment, the hospital has the following options:
   a. Require the practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges
   b. Impose appropriate restrictions on the practitioner's privileges
   c. Immediately suspend the practitioner's privileges in the hospital until rehabilitation has been
accomplished if the practitioner does not agree to discontinue practice voluntarily

Whichever option is selected, the action(s) shall be taken in a manner that is separate from the usual medical staff disciplinary process and is appropriate to the circumstances of the incident(s) and individual(s) involved.

5. The hospital shall seek the advice of its legal counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

6. The original report and a description of the actions taken by the CEO or medical staff president should be included in the practitioner’s personnel file. If the investigation reveals that there is no merit to the report, the hospital shall destroy it. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the hospital will include the report in a confidential portion of the practitioner’s personnel file. In addition, the hospital will monitor the practitioner’s activities and practice until it can establish whether there is an impairment problem.

7. The CEO or medical staff president shall inform the individual who filed the report that the hospital has taken follow-up action, but shall not disclose details of such action.

8. Throughout this process, all parties involved shall take appropriate steps to ensure appropriate confidentiality of all information concerning the actual or alleged impairment. All parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

9. In the event that there is an apparent or actual conflict between this policy and the hospital or its medical staff bylaws, rules, and regulations, or other policies—including the due process sections of those bylaws and policies—the provisions of this policy shall supersede such bylaws, rules, regulations, or policies.

Rehabilitation

10. Hospital and medical staff leadership shall assist the practitioner in locating a suitable rehabilitation program. The hospital shall not reinstate a practitioner until it is established, to the hospital’s satisfaction, that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

Reinstatement

11. Upon sufficient proof that a practitioner has successfully completed a rehabilitation program, the hospital may consider reinstating the practitioner’s privileges/medical staff membership.

12. When discussing an impaired practitioner for reinstatement, the hospital and its medical staff leadership must consider patient care interests to be paramount. The burden is upon the practitioner to provide adequate information that demonstrates, on an ongoing basis to the satisfaction of the hospital in its sole discretion, that the practitioner’s health status does not adversely affect his or her ability to carry out privileges.

13. The hospital must first obtain a letter from the physician director of the rehabilitation program where the practitioner was treated. The practitioner must authorize the release of this information. The letter from the director of the rehabilitation program shall state:

a. whether the practitioner is participating in the program
b. whether the practitioner is in compliance with all of the terms of the program
c. whether the practitioner attends program meetings regularly (if appropriate)
d. to what extent the practitioner’s behavior and conduct are monitored
e. whether, in the opinion of the rehabilitation program physicians, the practitioner is rehabilitated
f. whether an after care program has been recommended to the practitioner and, if so, a description of the after-care program

continued on p. 28
g. whether, in the program director’s opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients

14. The practitioner must inform the hospital of the name and address of his or her primary care physician and must authorize the physician to provide the hospital with information regarding his or her condition and treatment. The hospital has the right to require an opinion from other physician consultants of its choice.

15. The hospital shall request the primary care physician to provide information regarding the precise nature of the practitioner’s condition and the course of treatment.

16. Assuming all information the hospital receives indicates that the practitioner is rehabilitated and capable of resuming patient care, the hospital must take the following additional precautions when restoring clinical privileges:

a. The practitioner must identify two physicians who are willing to assume responsibility for the care of his or her patients in the event that the practitioner is unable or unavailable to care for them.

b. The hospital shall require the practitioner to provide the hospital with periodic reports from his or her primary care physician—for a period of time specified by the CEO and the medical staff president.

The reports should state that the practitioner is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

17. The department chair or a physician appointed by the department chair shall monitor the practitioner’s exercise of clinical privileges in the hospital. The credentials committee shall determine the nature of that monitoring after reviewing all of the circumstances.

18. The practitioner must agree to submit to an alcohol- or drug-screening test (if appropriate to the impairment) at the request of a member of hospital management, a physician, or a nurse who suspects that the practitioner may be under the influence of drugs or alcohol.

19. All requests for information concerning the impaired practitioner shall be forwarded to the CEO for response.

*If the medical staff establishes a physician’s help committee or its equivalent, then the language within brackets throughout this policy should be inserted.

Source: Top 30 Medical Staff Policies and Procedures, published by HCPro, Inc., in Marblehead, MA.