JCAHO expands primary source verification with HR standard
Goal is to cut risk of fraudulent credentials

Medical services professionals (MSP) can play an important role in helping hospitals comply with revised JCAHO standard **HR.1.20**.

Starting July 1, if your hospital or state requires clinical staff to have a license, registration, or certification to perform their jobs, facilities must verify those credentials with a primary source.

The revised JCAHO standard will take effect July 2005 “in order to lower the risk of fraudulent credentials,” the accreditor said in announcing the change on its Web site. **HR.1.20** is found in the management of human resources (HR) chapter of the *Comprehensive Accreditation Manual for Hospitals* (CAMH).

Although the JCAHO does not specify who in the hospital must conduct this primary source verification, in most facilities the job will fall to the HR department because it is an HR standard, says Christina Wiggins Giles, MS, CPMSM, of Medical Staff Solutions in Pepperell, MA.

JCAHO considers annual visits, provides standard interpretations
Surveyors get tips on medical staff standards

The big news from this year’s JCAHO surveyor’s conference is that hospitals may be looking at annual visits.

The JCAHO hinted at that possibility during the January conference in Chicago that brought together surveyors for training, according to a source close to the JCAHO.

Instead of one visit per every three years in the accreditation cycle, surveyors could visit one day one year, two days the second year, and three to four days the third year, according to the source.

The source also says Russell Massaro, MD, FACPE, the JCAHO’s executive vice president of accreditation operations, announced the possible change but offered no timeline to surveyors.

“I don’t know that they have the manpower to pull it off, but it makes sense to move to...”
That’s where MSPs can help. Both Giles and consultant Kathy Matzka, CPMSM, CPCS, of Lebanon, IL, say MSPs can provide valuable assistance to HR personnel who may not know all of the ins and outs of primary source verification.

“I don’t think this is going to be a burden for most hospitals,” says Matzka. “I’m willing to bet most [HR] departments are” verifying with a primary source licenses, registrations, or certifications to make sure they are current, she says.

Giles isn’t so sure. “For MSPs who normally do credentialing and primary source verification, this does not seem like a big deal,” says Giles. “But for the [HR] personnel who maybe haven’t been doing it, I think it will cause some concern.”

For example, some hospital HR departments may only require a copy of a nurse’s license, but they never verify with a primary source the validity of that license, Giles says.

“This may have been a weak link in the process. But in terms of patient safety, if we are looking closely at physicians, why should we not be looking at other people? I think it’s a pretty minimal check for clinical staff who are touching our patients,” Giles says about verifying licenses, registrations, and certifications.

**Share MSPs’ wealth of knowledge**

MSPs have long followed the JCAHO’s existing requirements of primary source verification for practitioners credentialled and privileged through the medical staff process under standard **MS.4.10**.

“It might be worthwhile for the medical staff office to share their knowledge,” says Matzka. “They can be a resource on this since they’ve been doing it so long.” She suggests MSPs conduct inservice training for HR department staff.

To comply with the revised **HR.1.20**, hospitals should first determine which clinical staff in their state is required to have a license, registration, or certification. That will vary from state to state.

Along with registered nurses and licensed practical nurses who must hold a license, hospitals need to consider staff such as physical and respiratory therapists, massage therapists, and pharmacy technicians. Even if the state does not require it, individual hospitals may require a license, registration, or certification to work in their facility.

Standard **HR.1.20** requires that hospitals have a process to ensure that employees’ qualifications are consistent with their job responsibilities. The revised element of performance (EP) under **HR.1.20** will require hospitals to verify with the primary source licensure, certification, or registration for practitioners at the time of hire and no less than every two years.

However, the ease of verifying this information on a timely basis also varies from state to state, say both Matzka and Giles. “Some states have easy access, [and] some do not,” says Matzka.

Some states have databases maintained by state licensing agencies available over the Internet. However, in New Jersey, for example, MSPs find that the
Web site that provides practitioner licensing information is often down and, therefore, timely information is difficult to get.

It may also be easier to verify licenses, as opposed to registrations and certifications, Matzka says. “It will depend on what’s available and how easy it is to get the information,” Giles says.

An opportunity for training
Matzka says she would hate to see medical staff offices saddled with the responsibility of checking nursing licenses. “But I don’t think it is unreasonable for the medical staff office to help train others,” she says.

An MSP can spend about a half-hour on the computer showing HR counterparts the various Web sites used by the medical staff office to conduct primary source verification. HR personnel should bookmark those sites on their own computers, she says.

MSPs may also want to discuss with HR how personnel will maintain the information they collect, Giles says. HR departments will need some kind of database to maintain the information for documenting primary source verification.

Matzka predicts that the number of tasks of hospital HR departments will only increase. She speculates it is only a matter of time before the JCAHO also requires primary source verification for clinical staff’s training or experience and current competence. “That would be a significant change,” she says.

The change to HR.1.20 also applies to The Accreditation Manual for Critical Access Hospitals, second edition. And note that the JCAHO has also proposed the change to standard HR.1.20 in ambulatory care, assisted living, behavioral healthcare, home care, laboratories, long-term care, and office-based surgery organizations. However, as of press time, the revised standard had not yet been adopted in those settings.

If approved by the JCAHO board of commissioners, the anticipated effective date for those programs is January 2006, said JCAHO spokesperson Mark Forstneger.

As noted in the revised EP for HR.1.20, verification through the primary source is acceptable via a secure electronic communication or by telephone if the verification is documented.

A primary source may also designate to an agency the role of communicating credentials information, in which case the designated agency is acceptable as a primary source, the JCAHO also noted in the standard.

Any organization that uses a CVO should follow the JCAHO’s 10 principles for evaluating a CVO, which are also listed under HR.1.20.
Annual visits

an annual model,” the source says.

“It would reinforce the fact that hospitals should always be ready for survey,” he added.

Standards interpretation

During the conference, the JCAHO also provided surveyors with additional insight into many of its standards, including some medical staff standards.

✔ For example, expect surveyors in 2005 to look closely at compliance with standard MS.4.20, which requires setting-specific privileges.

In 2004, the JCAHO amended element of performance #4 under this standard to require that hospitals grant, renew, or revise setting-specific privileges.

The expectation is that hospitals will classify privileges that physicians can perform in certain settings, such as intensive care units (ICU) or catheter labs.

“Basically, whenever you grant privileges, they have to be specific to the facility,” says Beverly Pybus, CPMSM, senior consultant for credentialing and privileging services for The Greeley Company in Marblehead, MA.

Privileges should also be specific to the services provided at the hospital. They should reflect what practitioners are doing in different settings—for example, if they are privileged in a hospital-owned practice or clinic, Pybus says.

Hospitals should indicate, for example, what procedures practitioners are allowed to do in its ICU or in a skilled nursing facility unit based on their experience and qualifications.

Hospitals can include these setting-specific privileges on the privileging forms, she says. “Hospitals should have been doing that for years.”

✔ Also be sure your medical executive committee (MEC) provides input on the credentialing, privileging, and reprivileging of physician assistants (PA) and advanced practice registered nurses (APRN) under standard LD.3.70.

In 2004, JCAHO adopted this new standard for PAs and APRNs who are not licensed independent practitioners.

Hospitals must evaluate those PAs and APRNs through their medical staff process or adopt an “equivalent process” that includes “communication with and input from” the MEC about each applicant.

If hospitals choose an equivalent process through their human resources (HR) department, the JCAHO advised surveyors to make sure the MEC is involved, the source says.

“You’re talking about privileging, and HR may not be the proper place to decide if they [PAs and APRNs] have the appropriate competencies,” he says.

✔ When it comes to telemedicine standard MS.4.120, the JCAHO also provided additional guidance for the use of radiology services that read x-rays through telemedicine links.

Surveyors were reminded that licensed independent practitioners who provide official readings of images through a telemedicine link are credentialed and privileged under the contracted services standard LD.3.50.

If the radiologists only provide an interpretive reading and don’t write prescriptions or treat patients, then standard LD.3.50 applies, the source says.

If a hospital uses a radiology service that is JCAHO-accredited, then that facility can spell out credentialing requirements for those radiologists in its contract and does not have to credential those radiologists itself.
Hold off on any changes to bylaws, JCAHO now says
Accreditor plans to issue additional advice in March

Medical services professionals (MSP) were confused. Medical staff experts were perplexed. And now even the JCAHO is advising hospitals to sit tight when it comes to revising their medical staff bylaws to comply with standard MS.1.20.

In a January announcement on its Web site (www.jcaho.org), the JCAHO said it is seeking additional input about MS.1.20 and expects to release further comments and any changes to the standard in March.

“It is recommended that organizations make no bylaw changes specifically related to this requirement” until after the planned release, the JCAHO said.

The comments—and possible changes—due in March will mark the fourth time during the past 15 months that the JCAHO has released information about medical staff bylaws and the processes for corrective actions, fair hearing and appeals, credentialing, privileging, and appointment.

The JCAHO’s ever-changing position on what hospitals need to include in the medical staff bylaws and what items they can include in supplemental documents outside the bylaws has left many medical services professionals feeling like see-saws. “[JCAHO officials] shoot from the hip, then they get deluged with comments from the hospitals, then they try to be responsive,” said one credentialing consultant.

What’s happened
To recap: The JCAHO issued a clarification on MS.1.20 in December 2003 that allowed hospitals to simply reference specific medical staff functions and procedures in their bylaws, as long as they were described in other documents.

Then on September 29, 2004, the JCAHO issued a second clarification that set further conditions that hospitals must meet to include administrative procedures in supplemental documents.

That announcement was followed on October 21 by a third revision that left many shaking their heads, as the JCAHO said hospitals may describe administrative procedures that have a minor effect on the outcome of a process in supplemental documents (e.g., rules, regulations, and policies). However, the third clarification also stated that hospitals must include in their bylaws a description of the steps that have a major effect on outcomes.

On its Web site, the JCAHO said it has received questions and comments about the bylaws requirement—especially the new element of performance (EP) #19—since the October 21, 2004, clarification.

In fact, after the accreditor’s confusing October release many consultants and attorneys who regularly advise hospitals about their medical staff bylaws speculated that it would not be the JCAHO’s last word on the subject and urged hospitals not to panic about rewriting their bylaws.

They were right. The JCAHO announced that it is now collecting comments on the standard, a process expected to continue until February 15. This information will then be analyzed in order to determine whether modifications to the standards are indicated, the JCAHO said.

No survey consequences in 2005
The JCAHO also reminded hospitals that controversial EP #19 will not be part of any organization survey until January 2006.

That point was made to surveyors during the JCAHO’s annual training conference held in January in Chicago. JCAHO officials told surveyors not to score hospitals on the location of processes in either the bylaws or supplemental documents. “Hospitals have all year to decide what goes where,” said a source close to the JCAHO. “So during this year, surveyors will just look for those items somewhere in a [bylaws or supplemental] document.”
Good meeting minutes can help defend hospitals against negligent credentialing lawsuits

Editor’s note: Last month in BOC, consultant Lynn Buchanan provided tips on meeting management to help save hospitals time and money. This month, Buchanan offers advice about how to take good meeting minutes to help protect hospitals against lawsuits.

If you need one more reason why it’s important for medical staff offices to keep good meeting minutes, consider the growing number of lawsuits that allege negligent credentialing.

Minutes that thoroughly document the reasons behind credentialing decisions can help hospitals defend themselves against these lawsuits, says Lynn Buchanan, CPMSM, CPCS, president of Buchanan & Associates Consulting in Flint, TX.

For example, years after your hospital appoints a physician to its medical staff, a plaintiff’s attorney may charge that your hospital knew or should have known that the physician had several malpractice cases against him.

Your minutes from credentials committee or medical executive committee (MEC) meetings may provide evidence of whether hospital leaders knew about the malpractice suits.

“With more and more lawsuits out there for negligent credentialing, it is more and more important to articulate the basis for credentialing a practitioner,” Buchanan says.

Your official record
Taking good minutes is one of the most important things about meeting management, Buchanan says. Webster’s dictionary defines minutes as “an official record of what was said and done at a meeting.”

Buchanan goes into more detail, saying minutes are

• an historical record
• legal documentation
• evidence of compliance
• a management tool
• a form of communication

Minutes should contain documentation of

• findings
• conclusions
• recommendations
• actions
• follow-up

Consider the following tips from Buchanan for taking minutes:

1. Your minutes should always include the basis for any decision made during the meeting.
   “This is where a lot of minutes fall short, especially when it comes to credentialing,” she says.

This example of minutes doesn’t sufficiently describe what occurred during the meeting: “After discussion, motion was made and carried to approve application.”

This example provides the correct documentation:

“Following a review of the documentation, no adverse information was identified concerning the practitioner’s application for medical staff membership and clinical privileges. Motion made . . .”

2. Document to defend. Your minutes could be a factor in a future lawsuit.
For example, these minutes could help provide defense in a lawsuit:

“The committee reviewed and discussed documentation pertaining to the applicant’s previous malpractice suit from seven years ago and concluded that it was an isolated incident of sufficient age to have no adverse effect on the applicant’s eligibility or current competence.”

These minutes are proof that medical staff leaders knew of a malpractice suit and that they took that information into consideration when making their recommendations.

3. **Know what to avoid putting in your minutes.** What you leave out of your minutes can be just as important as what you include.

“You just want to know what is pertinent to the discussion. Don’t put debates in the minutes,” says Buchanan.

Here are points to avoid in your minutes:

- Incomplete CRAF, which is a format used by minute-takers and stands for conclusions, recommendations, actions, and follow-up
- Verbatim minutes
- Excessive detail
- Brevity to the point that the reader cannot understand what the decision/action was, or on what information it was based
- Defamatory remarks
- Attributing discussion points to specific individuals
- Subjective information
- Debates
- Lengthy discussions
- Use of practitioner names related to peer-review discussion (use numbers instead)
- Embarrassing statements
- Expressed opinion or point of view of scribe or chair expressed
- Poor grammar

4. **Identify follow-up items in your minutes.** Specify the expectations related to the request. For example, indicate a time frame for completion of the actions discussed and who is responsible for the tasks.

Process any query letters, referrals to other committees, or information letters that should be sent.

For example, indicate in your minutes that a policy must be sent to the MEC for recommendation and approval so there is follow-up to that action.

Buchanan recommends you use a standard status report to keep track of meeting actions and follow-up.

Review and update your report at least monthly. For example, when tracking a particular item through the approval process, note that it is in committee this month and will go to the board on a specific date (e.g., June 30). This way you can follow up to see whether it is approved.

Enter all actions and activities with dates and accountability and include them on the next agenda. Buchanan suggests e-mailing copies of the minutes to committee members whenever appropriate as a reminder to follow up on items they may be responsible for.

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**Upcoming Events**

**Audioconferences:**

**03/08/05**—Criteria-based Privileging: How to Comply with CMS and JCAHO Requirements

*Call Frank Morello at 781/639-1872, Ext. 3283 for more information. To register, call customer service at 800/650-6787.*
JCAHO clarifies reappointment protocol when practitioner is on leave of absence

What do you do when a practitioner who is on an extended leave of absence from your hospital comes up for reappointment and reprivileging?

That question didn’t have a clear answer until the JCAHO clarified the situation in the January Perspectives. “It’s been an ongoing issue, [and] it’s been a gray area,” says consultant Kathy Matzka, CPMSM, CPCS, of Lebanon, IL.

The JCAHO outlined three options that hospitals have when a practitioner is on a leave of absence for reasons such as medical, legal, personal, or military obligations, when the time of the two-year reappointment and reprivileging comes up.

According to Perspectives, hospitals can

1. reappoint/reprivilege practitioners prior to the start of their leaves of absence, even if the two-year reappointment date is months away.

2. allow the appointment or privileges to lapse. Upon a practitioner’s return, a hospital can implement the process to grant temporary privileges for new applicants for up to 120 days. As outlined in the Comprehensive Accreditation Manual for Hospitals, organizations can grant temporary privileges based on the verified credentials information in the practitioner’s existing file, an updated query of the National Practitioner Data Bank, and verification of current licensure with the ability to perform the privileges granted. Before those temporary privileges expire, the hospital should fully recredential, reprivilege, and reappoint the practitioner “with the expectation that all the information from the previous two years of activity be the basis of the decisions,” according to the JCAHO.

3. reappoint/reprivilege practitioners during their leaves of absence based on information gathered to date, on the condition that they submit evidence of their ability to perform the privileges granted on their return.