# Medical Staff (MS)

## Overview

The self-governing organized medical staff provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process. The organized medical staff is also responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization.

All licensed independent practitioners* are credentialed and privileged by the organized medical staff. Physician assistants (PAs) and advanced practice registered nurses (APRNs) who are not licensed independent practitioners may be privileged through either the medical staff process or a procedure that is equivalent to the medical staff process and criteria set forth in the credentialing and privileging standards contained in this chapter. This procedure must be approved by the governing body and assure communication with and input from the Medical Staff Executive Committee regarding those privileges.

The organized medical staff must create and maintain a set of bylaws that define its role within the context of a hospital setting and responsibilities in the oversight of care, treatment, and services. The medical staff bylaws, rules, and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.

The hospital's governing body has the ultimate authority and responsibility for the oversight and delivery of health care rendered by licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process or any equivalent process. The governing body and the medical staff define medical staff membership criteria, which, as deemed necessary by the governing body and the medical staff, may include licensed independent practitioners and other practitioners. Only licensed independent practitioner members of the medical staff oversee the delivery of

* The Joint Commission defines a licensed independent practitioner as "any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision."

care provided. The criteria used to determine which licensed independent practitioners are eligible to participate in the oversight process is developed by the organized medical staff.

Membership on the medical staff is not synonymous with privileges. The medical staff may create categories of membership, as in active member, courtesy member, and so forth. These categories may be helpful in defining the roles and expectations for the various members of the medical staff.

## Organized Medical Staff Structure

The organized medical staff[†] is structured such that it has the ability to function in guiding and governing its members. The primary function of the organized medical staff is to approve and amend medical staff bylaws and to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges.[‡]

The organized medical staff must be structured using the following guiding principles:

- Designated members of the organized medical staff who have independent privileges provide oversight of care, treatment, and services provided by practitioners with privileges.
- The organized medical staff is responsible for structuring itself to provide a uniform standard of quality patient care, treatment, and services.
- The organized medical staff is accountable to the governing body.
- Applicants for privileges need not necessarily be members of the medical staff.

Self-governance of the organized medical staff includes the following and is located in the medical staff's bylaws:

- Initiating, developing, and approving medical staff bylaws and rules and regulations
- Approving or disapproving amendments to the medical staff bylaws and rules and regulations
- Selecting and removing medical staff officers
- Determining the mechanism for establishing and enforcing criteria and standards for medical staff membership
- Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges

[†] The term "medical staff" takes on various meanings within different organizations. The standards and elements of performance in this chapter are intended to apply to all practitioners privileged through the medical staff process.

[‡] The organized medical staff role and responsibility as a component of hospital leadership is further defined in the "Leadership" (LD) chapter.

- Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges
- Engaging in performance improvement activities

An organized medical staff is self-governing and has the responsibility to oversee care, treatment, and services provided by practitioners with privileges. Oversight of care, treatment, and services is provided by a variety of mechanisms, one of which is the development of bylaws that govern the actions of the medical staff. The governing body must approve the medical staff bylaws.

Under most circumstances, the organized medical staff should be a single, organized medical staff. There may be exceptions to the general requirement for a single medical staff (see note below regarding requirements for exception). When more than one organized medical staff exists, it is incumbent upon the medical staffs to have a mechanism to ensure that the same principles that guide a single medical staff are fully integrated into any multiple medical staff structure.

**Note:** *The following bases are used in determining whether a hospital may have more than one organized medical staff:*[§]

- *A hospital with a single governing body that has multiple inpatient care sites, each of which serves two or more geographically distinct patient populations, may have a separate organized medical staff at each site.*
- *The patient population consists of those individuals who chose the hospital as their primary source of inpatient care, treatment, and services and for whom the hospital designs and delivers services consistent with its mission.*

[§] Please note that The Medicare Conditions of Participation require a single medical staff for each hospital (i.e., provider number).

# Chapter Outline

I. Medical Staff Bylaws (MS.01.01.01, MS.01.01.03, MS.01.01.05)

II. Structure and Role of Medical Staff Executive Committee (MS.02.01.01)

III. Medical Staff Role in Oversight of Care, Treatment, and Services (MS.03.01.01, MS.03.01.03)

IV. Medical Staff Role in Graduate Education Programs (MS.04.01.01)

V. Medical Staff Role in Performance Improvement (MS.05.01.01, MS.05.01.03)

VI. Credentialing and Privileging (MS.06.01.01, MS.06.01.03, MS.06.01.05, MS.06.01.07, MS.06.01.09, MS.06.01.11, MS.06.01.13)

VII. Appointment to Medical Staff (MS.07.01.01, MS.07.01.03)

VIII. Evaluation of Practitioners (MS.08.01.01, MS.08.01.03)

IX. Acting on Reported Concerns About a Practitioner (MS.09.01.01)

X. Fair Hearing and Appeal Process (MS.10.01.01)

XI. Licensed Independent Practitioner Health (MS.11.01.01)

XII. Continuing Education for Practitioners (MS.12.01.01)

XIII. Medical Staff Role in Telemedicine (MS.13.01.01, MS.13.01.03)

# Standards, Rationales, and Elements of Performance

## Introduction to Standard MS.01.01.01

The doctors of medicine and osteopathy and, in accordance with medical staff bylaws, other practitioners are organized into a self-governing medical staff that oversees the quality of care provided by all physicians and by other practitioners who are privileged through a medical staff process. The organized medical staff and the governing body collaborate in a well-functioning relationship, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. This collaborative relationship is critical to providing safe, high-quality care in the hospital. While the governing body is ultimately responsible for the quality and safety of care at the hospital, the governing body, medical staff, and administration collaborate to provide safe, quality care. (*See* the "Leadership" [LD] chapter for more discussion of the relationship among the organized medical staff, administration, and governing body.)

To support its work, and its relationship with and accountability to the governing body, the organized medical staff creates a written set of documents that describes its organizational structure and the rules for its self-governance. These documents are called medical staff bylaws, rules and regulations, and policies. These documents create a system of rights, responsibilities, and accountabilities between the organized medical staff and the governing body, and between the organized medical staff and its members. Because of the significance of these documents, the medical staff leaders should strive to ensure that the medical staff members understand the content and purpose of the medical staff bylaws and relevant rules and regulations and policies, and their adoption and amendment processes.

Of the members of the organized medical staff, only those who are identified in the bylaws as having voting rights can vote to adopt and amend the medical staff bylaws. The voting members of the organized medical staff may include within the scope of responsibilities delegated to the medical executive committee the authority to adopt, on the behalf of the voting members of the organized medical staff, any details associated with Elements of Performance 12 through 37 that are placed in rules and regulations, or policies.

The medical executive committee plays a vital role in the relationship between the medical staff and the governing body. Medical staffs and governing bodies often rely on the medical executive committee to act expeditiously on urgent and other delegated matters that arise within the hospital. The medical executive committee serves as a voice for the medical staff to communicate to the governing body and is, therefore, accountable to the organized medical staff, regardless of how the medical executive committee members are selected. Because it plays this vital role, it is incumbent upon the medical executive committee to convey accurately to the governing body the views of the medical staff on all issues, including those relating to quality and safety. In order to fulfill this role, the medical executive committee seeks out the medical staff's views on all appropriate issues.

If conflict arises within the medical staff regarding medical staff bylaws, rules and regulations, or policies, it implements its process for managing internal conflict (*see* Element of Performance 10). If conflicts regarding the medical staff bylaws, rules and regulations, or policies arise between the governing body and the organized medical staff, the organization implements its conflict management processes, as set forth in the "Leadership" (LD) chapter.

**Note:** See *the Glossary for definitions of terms used in this standard, including medical staff; medical staff bylaws; medical staff, organized; medical staff, voting members of the organized; and rules and regulations and policies of the medical staff.*

## Standard MS.01.01.01

Medical staff bylaws address self-governance and accountability to the governing body.

## Elements of Performance for MS.01.01.01

1. Ⓓ The organized medical staff develops medical staff bylaws, rules and regulations, and policies.
2. The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (*See* the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes. *See* Element of Performance 17 for information on which medical staff members are eligible to vote.)

3. Every requirement set forth in MS.01.01.01, Elements of Performance (EPs) 12–37, is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those EPs 12–37 that require a process, the medical staff bylaws include, at a minimum, the basic steps required for implementation of the requirement, as determined by the organized medical staff and approved by the governing body. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (*See* the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes.)

   **Note:** *If an organization is found to be out of compliance with this EP, the citation will occur at the appropriate element(s) of performance in MS.01.01.01, EPs 12–37.*

4. The medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation. (*See also* MS.01.01.03, EP 1)

5. The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

6. The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others.

7. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

8. The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.

9. If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This element of

performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.

10. The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

11. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

    **Note:** *Please see the Introduction to this standard for further discussion of the relationship of the voting members of the organized medical staff to the medical executive committee.*

12. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The structure of the medical staff.

13. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff.

    **Note:** ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also*

*include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.*

14. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for privileging and re-privileging licensed independent practitioners, which may include the process for privileging and re-privileging other practitioners. (*See also* EM.02.02.13, EP 2; MS.06.01.13, EP 1)

15. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy).

    **Note:** *Solely for the purposes of this element of performance, The Joint Commission interprets the word "privileges" to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category. Each member of the medical staff is to have specific clinical privileges to provide care, treatment, and services authorized through the processes specified in Standards MS.06.01.03, MS.06.01.05, and MS.06.01.07.*

16. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11.)

    **Note 1:** *The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).*

    **Note 2:** *The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.*

17. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A description of those members of the medical staff who are eligible to vote.

18. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process, as determined by the organized medical staff and approved by the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers.

19. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A list of all the officer positions for the medical staff.

20. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The medical executive committee's function, size, and composition, as determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf; and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.02.01.01.)

21. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.

22. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: That the medical executive committee includes physicians and may include other practitioners and any other individuals as determined by the organized medical staff.

23. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: That the medical executive committee acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.

24. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for adopting and amending the medical staff bylaws.

25. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for adopting and amending the medical staff rules and regulations, and policies.

26. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for credentialing and re-credentialing licensed independent practitioners, which may include the process for credentialing and re-credentialing other practitioners.

27. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for appointment and re-appointment to membership on the medical staff.

28. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for automatic suspension of a practitioner's medical staff membership or clinical privileges.

29. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for summary suspension of a practitioner's medical staff membership or clinical privileges.

30. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.

31. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for automatic suspension of a practitioner's medical staff membership or clinical privileges.

32. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for summary suspension of a practitioner's medical staff membership or clinical privileges.

33. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.

34. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The fair hearing and appeal process (refer to Standard MS.10.01.01), which at a minimum shall include:
    - The process for scheduling hearings and appeals
    - The process for conducting hearings and appeals

35. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The composition of the fair hearing committee.

36. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following:
Qualifications:
- Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

Roles and responsibilities:
- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department
- Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
- Integration of the department or service into the primary functions of the organization
- Coordination and integration of interdepartmental and intradepartmental services
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
- Continuous assessment and improvement of the quality of care, treatment, and services
- Maintenance of quality control programs, as appropriate

- Orientation and continuing education of all persons in the department or service
- Recommending space and other resources needed by the department or service

**Note:** *For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.*

37. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When a multihospital system has a unified and integrated medical staff, the medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.

## Standard MS.01.01.03

Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

## Rationale for MS.01.01.03

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.

## Element of Performance for MS.01.01.03

1. The medical staff bylaws, rules, and regulations are not unilaterally amended. (*See also* MS.01.01.01, EP 4)

## Standard MS.01.01.05

**For hospitals that use Joint Commission accreditation for deemed status purposes:**
Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.

## Elements of Performance for MS.01.01.05

**For hospitals that use Joint Commission accreditation for deemed status purposes:** If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs:

1. Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.
2. The unified and integrated medical staff takes into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital.
3. The unified and integrated medical staff establishes and implements policies and procedures to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are given due consideration.
4. The unified and integrated medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.

## Standard MS.02.01.01

There is a medical staff executive committee.

## Rationale for MS.02.01.01

The organized medical staff delegates authority in accordance with law and regulation to the medical staff executive committee to carry out medical staff responsibilities. The medical staff executive committee carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The medical staff executive committee has the primary authority for activities related to self governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process.

**Note:** *The medical staff as a whole may serve as the executive committee. In smaller, less complex hospitals where the entire medical staff functions as the executive committee, it is often designated as a committee of the whole.*

## Elements of Performance for MS.02.01.01

1. The structure and function of the medical staff executive committee conforms to the medical staff bylaws.
2. The chief executive officer (CEO) of the hospital or his or her designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote.
3. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.
4. The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.
5. The medical staff executive committee acts on behalf of the organized medical staff between medical staff meetings.
6. The medical staff executive committee has a mechanism to recommend medical staff membership termination.
7. The medical staff executive committee requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.

The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following:

8. Medical staff membership.
9. The organized medical staff's structure.
10. The process used to review credentials and delineate privileges.
11. The delineation of privileges for each practitioner privileged through the medical staff process.
12. The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups.

# Introduction to Standard MS.03.01.01

## Management of Patient Care, Treatment, and Services

Caring for patients is the nucleus of activity around which all health care organization functions revolve. The organized medical staff is intricately involved in carrying out, and in providing leadership in, all patient care functions conducted by practitioners privileged through the medical staff process.

## Standard MS.03.01.01

The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

## Rationale for MS.03.01.01

The organized medical staff is responsible for establishing and maintaining patient care standards and oversight of the quality of care, treatment, and services rendered by practitioners privileged through the medical staff process. The organized medical staff designates member licensed independent practitioners to provide oversight of care, treatment, and services rendered by practitioners privileged through the medical staff process. The organized medical staff recommends practitioners for privileges to perform medical histories and physical examinations; the governing body approves such privileges. Licensed independent practitioners (that is, physicians, oral and maxillofacial surgeons, dentists, podiatrists, and some APRNs), physician assistants, and some APRNs may perform medical histories and physical examinations if permitted by law, the medical staff bylaws, and the organization to do so.

## Elements of Performance for MS.03.01.01

1. Licensed independent practitioner members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.
2. Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.
3. Licensed independent practitioners are responsible for the oversight activities of the organized medical staff.
4. The organized medical staff through its designated mechanisms provides leadership in activities related to patient safety.
5. The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.

6. Ⓓ The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. (*See also* PC.01.02.03, EP 4)

7. The organized medical staff monitors the quality of medical histories and physical examinations.

8. The medical staff requires that a practitioner who has been granted privileges by the hospital to do so performs a patient's medical history and physical examination and required updates. (*See also* PC.01.02.03, EP 5)

9. As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination.

10. Ⓓ The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

11. Ⓓ The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.

13. Ⓓ **For hospitals that use Joint Commission accreditation for deemed status purposes:** When emergency services are provided at the hospital but not at one or more off-campus locations, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.

14. Ⓓ **For hospitals that use Joint Commission accreditation for deemed status purposes:** When emergency services are not provided at the hospital, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment of patients, and referral of patients when needed.

16. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.

    **Note:** *Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at HR.01.01.01, EP 32.*

17. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

18. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Through the privileging process, the organized medical staff determines which practitioners are qualified to serve in the role of primary care clinician. (*See also* LD.04.01.06, EP 1)

## Standard MS.03.01.03

The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

## Rationale for MS.03.01.03

Quality of care, treatment, and services is dependent on coordination and communication of the plan of care which is given to all relevant health care providers to optimize resources and provide for patient safety. Practitioners have privileges that correspond to the care, treatment, and services needed by individual patients. Such privileges are specific to each patient's needs and therefore are "appropriate" for that particular patient. Communication and coordination are key to the safe management of patient care, treatment, and services. Communication among all practitioners and staff involved in a patient's care, treatment, and services is vital to ensuring coordinated, high-quality care.

## Elements of Performance for MS.03.01.03

1. Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services.

   **Note:** *The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).*

3. A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A doctor of medicine or osteopathy manages and coordinates the care of any Medicare patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.

4. The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioner, is required.

5. Consultation is obtained for the circumstances defined by the organized medical staff.

6. There is coordination of the care, treatment, and services among the practitioners involved in a patient's care, treatment, and services.

12. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A doctor of medicine or osteopathy is on duty or on call at all times.

13. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital.

## Standard MS.04.01.01

In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities.

## Rationale for MS.04.01.01

This standard applies to participants registered in a professional graduate education program when the graduate practitioner will be a licensed independent practitioner. The management of each patient's care, treatment, and services (including patients under the care of participants in professional graduate education programs) is the responsibility of a licensed independent practitioner with appropriate clinical privileges.

## Elements of Performance for MS.04.01.01

1. Ⓓ The organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities. R

2. Ⓓ Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff. R

3. The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities.

4. Ⓓ Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.

5. There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.

6. There is responsibility for effective communication (whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital).
   - The professional graduate medical education committee(s) (GMEC) must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.
   - If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs.

   **Note:** *The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.*

7. There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants.

8. Information about the quality of care, treatment, and services and educational needs is included in the communication that the GMEC has with the governing board of the sponsoring hospital.

9. The medical staff demonstrates compliance with residency review committee citations.

   **Note:** *Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.*

## Standard MS.05.01.01

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

## Rationale for MS.05.01.01

Relevant information developed from the following processes is integrated into performance improvement initiatives and consistent with hospital preservation of confidentiality and privilege of information. Medical staff involvement in establishing protocols and reviewing performance improvement data improves practitioner engagement and the overall safety and quality of care.

## Elements of Performance for MS.05.01.01

1. The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process. (*See also* PI.03.01.01, EPs 2 and 4)

The medical staff is actively involved in the measurement, assessment, and improvement of the following:

2. Medical assessment and treatment of patients. (*See also* PI.03.01.01, EPs 2 and 4)
3. Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process. (*See also* PI.03.01.01, EPs 2 and 4)
4. Use of medications. (*See also* PI.03.01.01, EPs 2 and 4)
5. Use of blood and blood components. (*See also* PI.03.01.01, EPs 2 and 4)

6. Operative and other procedure(s) (*See also* PI.01.01.01, EP 3; PI.03.01.01, EPs 2 and 4)
7. Appropriateness of clinical practice patterns. (*See also* PI.03.01.01, EPs 2 and 4)
8. Significant departures from established patterns of clinical practice. (*See also* PI.03.01.01, EPs 2 and 4)
9. The use of developed criteria for autopsies. (*See also* PI.03.01.01, EPs 2 and 4)

Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following:

10. Sentinel event data. (*See also* PI.03.01.01, EPs 2 and 4)
11. Patient safety data. (*See also* PI.03.01.01, EPs 2 and 4)

17. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform.

    **Note:** *The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).*

18. The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following:
    - Participating in the establishment of protocols and quality metrics
    - Reviewing performance improvement data

## Standard MS.05.01.03

The organized medical staff participates in organizationwide performance improvement activities.

## Elements of Performance for MS.05.01.03

The organized medical staff participates in the following activities:

1. Education of patients and families.

2. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient.

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3. Accurate, timely, and legible completion of patient's medical records. (*See also* RC.01.04.01, EP 1)
4. Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.
5. Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

# Introduction to Standard MS.06.01.01

## Credentialing and Privileging

### Overview

Determining the competency of practitioners to provide high quality, safe patient care is one of the most important and difficult decisions an organization must make. The development and maintenance of a credible process to determine competency requires not only diligent data collection and evaluation, but also the actions by both the governing body and organized medical staff.

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

Three new concepts are introduced in the revised credentialing and privileging standards. First, the revised credentialing and privileging standards have been informed throughout by the six areas of "General Competencies" developed by the Accreditation

Council for Graduate Medical Education (ACGME)[‖] and the American Board of Medical Specialties (ABMS) joint initiative. The areas of general competencies include the following:

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

Integrating these concepts into the standards allows the organized medical staff to conduct a more comprehensive evaluation of a practitioner's professional practice.

The second new concept is Focused Professional Practice Evaluation. This concept allows the organized medical staff to focus evaluation on a specific aspect of a practitioner's performance. This process is used in the following two circumstances:

- When a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization's setting
- If questions arise regarding a practitioner's professional practice during the course of the Ongoing Professional Practice Evaluation

The third new concept is the Ongoing Professional Practice Evaluation. Traditionally, the credentialing and privileging process has been a procedural, cyclical process in which practitioners are evaluated when privileges are initially granted, and every two years thereafter. The process outlined in these credentialing and privileging standards is designed to continuously evaluate a practitioner's performance. The process requires the medical staff to conduct an ongoing evaluation of each practitioner's professional performance. This process not only allows any potential problems with a practitioner's performance to be identified and resolved as soon as possible, but also fosters a more efficient, evidence-based privilege renewal process.

**Note:** *While the specific information that will be collected and analyzed to make decisions about granting privileges and medical staff appointment is developed by the organized medical staff and recommended to the governing body, the ultimate authority for granting,*

[‖] ACGME launched its Outcome Project in September 1999. Through an extensive review process, six general competencies for resident and fellow development were identified. These six competencies have been incorporated into the Institutional Requirements and all sets of Program Requirements for implementation July 1, 2002.

*restricting, and revoking privileges rests with the governing body. The range of information collected to make such decisions is clearly defined in governance documents.*

## Standard MS.06.01.01

Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame.

## Rationale for MS.06.01.01

Essential information, such as resources, equipment, and types of personnel necessary to support the requested privilege, is gathered in the process of granting, renewing, or revising clinical privileges.

## Elements of Performance for MS.06.01.01

1. There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege. **R**
2. The hospital consistently determines the resources needed for each requested privilege. **R**

# Introduction to Standard MS.06.01.03

## Credentialing

Credentialing involves the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Verification is sought to minimize the possibility of granting privilege(s) based on the review of fraudulent documents.

The verification of current licensure informs the organization that the applicant is appropriately licensed to practice as a health care provider as required by state and/or federal law. The license verification process is conducted prior to the granting of initial privileges, re-privileging, and at the time of each practitioner's professional license expiration.

The verification of an applicant's education and relevant training informs the organization of the applicant's clinical knowledge and skill set. Whenever feasible, verification should be obtained from the original source of the specific credential. Primary sources include the specialty certifying boards approved by the American Dental Association for a dentist's board certification, letters from professional schools (for example, medical, dental, and podiatric), and letters from postgraduate education or postdoctoral programs for completion of training. Information from credentials verification organizations (CVOs) may also be used. (*See* the Glossary for guidelines to evaluate CVOs.) When it is not possible to obtain information from the primary source, reliable secondary sources may be used.

Designated equivalent sources may be used to verify certain credentials in lieu of using the primary source. *See* the Glossary for the list of designated equivalent sources.

Experience, ability, and current competence in performing the requested privilege(s) is verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment for proficiency in the following six areas of "General Competencies" adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

For relevance in this chapter, the term "practitioner" replaces "resident" in each competency principle.

## Patient Care

Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

## Medical/Clinical Knowledge

Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

## Practice-Based Learning and Improvement

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

### Interpersonal and Communication Skills

Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

### Professionalism

Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

### Systems-Based Practice

Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

**Note 1:** *A reliable secondary source can be another hospital that has documented primary source verification of the applicant's credentials.*

**Note 2:** *The Joint Commission considers diversity to include race, culture, gender, religion, ethnic background, sexual preference, language, mental capacity, and physical disability.*

## Standard MS.06.01.03

The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

## Rationale for MS.06.01.03

There must be a reliable and consistent process in place to process applications and verify credentials. The organized medical staff then reviews and evaluates the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

## Elements of Performance for MS.06.01.03

1. The hospital credentials applicants using a clearly defined process.
2. The credentialing process is based on recommendations by the organized medical staff.
3. The credentialing process is approved by the governing body.

4. Ⓓ The credentialing process is outlined in the medical staff bylaws.

5. The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following: R
   - A current picture hospital ID card
   - A valid picture ID issued by a state or federal agency (for example, a driver's license or passport)

6. Ⓓ The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:
   - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration
   - The applicant's relevant training
   - The applicant's current competence

7. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** Inpatient psychiatric services are under the direction of a clinical director, service chief, or equivalent who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

9. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy qualified by education and experience in radiology supervises ionizing radiology services.

# Introduction to Standard MS.06.01.05

## Privileging

The organized medical staff is responsible for planning and implementing a privileging process. This process typically entails the following:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information

- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality of care issues

The criteria for granting a new privilege(s) to a practitioner with a record of competent professional performance at the organization (for example, a practitioner seeking an additional privilege[s]) should include information from the practitioner's professional practice evaluation data, which are collected and assessed on an ongoing basis.

For the applicant who does not have a current professional performance record at the privileging organization, current data should be collected during a time-limited period of privilege-specific professional performance monitoring conducted at the organization.

## Standard MS.06.01.05

The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

## Elements of Performance for MS.06.01.05

1. All licensed independent practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation. **R**

2. Ⓓ The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner's ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
   - Current licensure and/or certification, as appropriate, verified with the primary source
   - The applicant's specific relevant training, verified with the primary source
   - Evidence of physical ability to perform the requested privilege
   - Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
   - Peer and/or faculty recommendation
   - When renewing privileges, review of the practitioner's performance within the hospital

3. All of the criteria used are consistently evaluated for all practitioners holding that privilege.

4. Ⓓ The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.

5. The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.

6. Ⓓ An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.

   **Note:** *The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed doctor of medicine or osteopathy approved by the organized medical staff. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.*

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

8. Ⓓ Peer recommendation includes written information regarding the practitioner's current:
   - Medical/clinical knowledge
   - Technical and clinical skills
   - Clinical judgment
   - Interpersonal skills
   - Communication skills
   - Professionalism

   **Note:** *Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.*

9. Before recommending privileges, the organized medical staff also evaluates the following:
   - Challenges to any licensure or registration
   - Voluntary and involuntary relinquishment of any license or registration
   - Voluntary and involuntary termination of medical staff membership
   - Voluntary and involuntary limitation, reduction, or loss of clinical privileges
   - Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
   - Documentation as to the applicant's health status
   - Relevant practitioner-specific data as compared to aggregate data, when available
   - Morbidity and mortality data, when available

10. The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege. R

11. Completed applications for privileges are acted on within the time period specified in the medical staff bylaws.

12. Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.

15. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The surgical service maintains a current roster listing each practitioner's surgical privileges.

    **Note:** *The roster may be in paper or electronic format.*

## Standard MS.06.01.07

The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner's current licensure status, training, experience, current competence, and ability to perform the requested privilege.

## Elements of Performance for MS.06.01.07

1. The information review and analysis process is clearly defined.

2. Ⓓ The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.

**Note:** *Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.*

3. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges.
4. The hospital completes the credentialing and privileging decision process in a timely manner.
5. The hospital's privilege granting/denial criteria are consistently applied for each requesting practitioner.
6. Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.
7. If privileging criteria are used that are unrelated to quality of care, treatment, and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment, and services is evaluated.
8. The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges.
9. Privileges are granted for a period not to exceed two years.

## Standard MS.06.01.09

The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws.

## Elements of Performance for MS.06.01.09

1. Requesting practitioners are notified regarding the granting decision. R
2. In the case of privilege denial, the applicant is informed of the reason for denial.
3. The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law.
4. Ⓓ The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff.
5. The hospital makes the practitioner aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions. (*See also* MS.10.01.01, EPs 1–5)

## Standard MS.06.01.11

An expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and for granting privileges when criteria for that process are met.

## Elements of Performance for MS.06.01.11

1. Ⓓ The organized medical staff develops criteria for an expedited process for granting privileges.

   **Note:** *To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body.*

2. The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred:
   - The applicant submits an incomplete application.
   - The medical staff executive committee makes a final recommendation that is adverse or has limitations

3. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: There is a current challenge or a previously successful challenge to licensure or registration.

4. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received an involuntary termination of medical staff membership at another hospital.

5. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

6. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

7. The organized medical staff uses the criteria developed for the expedited process when recommending privileges.

## Standard MS.06.01.13

Under certain circumstances, temporary clinical privileges may be granted for a limited period of time.

## Rationale for MS.06.01.13

There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges is acceptable are:

- To fulfill an important patient care, treatment, and service need
- When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body

**Note:** *"Applicant for new privileges" includes an individual applying for clinical privileges at the hospital for the first time; an individual currently holding clinical privileges who is requesting one or more additional privileges; and an individual who is in the reappointment/reprivileging process and is requesting one or more additional privileges.*

Medical staff bylaws or other documents may stipulate that, in an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license.

## Elements of Performance for MS.06.01.13

1. Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws. (*See also* MS.01.01.01, EP 14) R
2. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.
3. Temporary privileges for applicants for new privileges may be granted while awaiting review and approval by the organized medical staff upon verification of the following: R
   - Current licensure
   - Relevant training or experience
   - Current competence
   - Ability to perform the privileges requested
   - Other criteria required by the medical staff bylaws

- A query and evaluation of the National Practitioner Data Bank (NPDB) information
- A complete application
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

4. All temporary privileges are granted by the chief executive officer or authorized designee.
5. All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.
6. Temporary privileges for applicants for new privileges are granted for no more than 120 days.

## Standard MS.07.01.01

The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

## Elements of Performance for MS.07.01.01

1. Ⓓ The organized medical staff develops criteria for medical staff membership.

   **Note:** *Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.*

2. The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services.
3. The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.
4. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership.
5. Membership is recommended by the medical staff and granted by the governing body.

## Standard MS.07.01.03

Deliberations by the medical staff in developing recommendations for appointment to or termination from the medical staff and for the initial granting, revision, or revocation of clinical privileges include information provided by peer(s) of the applicant.

## Rationale for MS.07.01.03

In circumstances where there are insufficient peer review data available when evaluating an applicant for privileges, the organized medical staff uses peer recommendations. A recommendation(s) from peers (appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant) reflects a basis for recommending the granting of privileges.

Sources for peer recommendations may include the following:

- An organization performance improvement committee, the majority of whose members are the applicant's peers
- A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant's professional performance and competence
- A department or major clinical service chairperson who is a peer
- The medical staff executive committee

## Elements of Performance for MS.07.01.03

1. Recommendations from peers are obtained and evaluated for all new applicants for privileges.

2. Upon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.

3. Peer recommendations include the following information:
   - Medical/clinical knowledge
   - Technical and clinical skills
   - Clinical judgment
   - Interpersonal skills
   - Communication skills
   - Professionalism

4. Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.

# Introduction to Standard MS.08.01.01

## Focused Professional Practice Evaluation

Focused professional practice evaluation is a process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance.

The organized medical staff does the following:

- Evaluates practitioners without current performance documentation at the organization
- Evaluates practitioners in response to concerns regarding the provision of safe, high quality patient care
- Develops criteria for extending the evaluation period
- Communicates to the appropriate parties the evaluation results and recommendations based on results
- Implements changes to improve performance

## Standard MS.08.01.01

The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance.

## Rationale for MS.08.01.01

The focused evaluation process is defined by the organized medical staff. The time period of the evaluation can be extended, and/or a different type of evaluation process assigned. Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (for example, consulting physicians, assistants at surgery, nursing or administrative personnel).

Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with the organization's policies and procedures that are intended to preserve confidentiality and privilege of information.

## Elements of Performance for MS.08.01.01

1. A period of focused professional practice evaluation is implemented for all initially requested privileges.
2. Ⓓ The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.
3. Ⓓ The performance monitoring process is clearly defined and includes each of the following elements:
   - Criteria for conducting performance monitoring
   - Method for establishing a monitoring plan specific to the requested privilege
   - Method for determining the duration of performance monitoring
   - Circumstances under which monitoring by an external source is required
4. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.
5. Ⓓ The triggers that indicate the need for performance monitoring are clearly defined.

   **Note:** *Triggers can be single incidents or evidence of a clinical practice trend.*
6. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.

   **Note:** *Other existing privileges in good standing should not be affected by this decision.*
7. Ⓓ Criteria are developed that determine the type of monitoring to be conducted.
8. Ⓓ The measures employed to resolve performance issues are clearly defined.
9. The measures employed to resolve performance issues are consistently implemented.

# Introduction to Standard MS.08.01.03

## Ongoing Professional Practice Evaluation

### (Maintaining Privileges)

The ongoing professional practice evaluation allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff. The criteria used in the ongoing professional practice evaluation may include the following:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner's use of consultants
- Other relevant criteria as determined by the organized medical staff

The information used in the ongoing professional practice evaluation may be acquired through the following:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel

Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. These activities adhere to the organization's policies or procedures intended to preserve any confidentiality or legal privilege of information established by applicable law.

If there is uncertainty regarding the practitioner's professional performance, the organized medical staff should follow the course of action defined in the medical staff bylaws for further evaluation of the practitioner.

**Note 1:** *Privileged practitioners have access to the medical staff fair hearing and appeal process should the intervention result in corrective action. (*See *Standard MS.10.01.01)*

**Note 2:** *Operative and other clinical procedures Include operative and other invasive and noninvasive procedures that place the patient at risk. The focus is on procedures, and is not meant to include medications that place the patient at risk.*

## Standard MS.08.01.03

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

## Elements of Performance for MS.08.01.03

The process for the ongoing professional practice evaluation includes the following:

1. Ⓓ There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.
2. The type of data to be collected is determined by individual departments and approved by the organized medical staff.
3. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

## Standard MS.09.01.01

The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence.

## Rationale for MS.09.01.01

A well-structured internal reporting process supports the ongoing professional practice evaluation and enhances the quality of care and patient safety.

## Elements of Performance for MS.09.01.01

1. Ⓓ The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. (*See also* RI.01.07.01, EPs 1, 4, 6, and 7)
2. Reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.

## Standard MS.10.01.01

There are mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and services issues.

## Rationale for MS.10.01.01

Mechanisms for fair hearing and appeal processes are designed to allow the affected individual a fair opportunity to defend herself or himself regarding the adverse decision to an unbiased hearing body of the medical staff, and an opportunity to appeal the decision of the hearing body to the governing body. The purpose of a fair hearing and appeal is to assure full consideration and reconsideration of quality and safety issues and, under the current structure of reporting to the National Practitioner Data Bank (NPDB), allow practitioners an opportunity to defend themselves.

## Elements of Performance for MS.10.01.01

The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics:

1. Ⓓ Is designed to provide a fair process that may differ for members and nonmembers of the medical staff. (*See also* MS.06.01.09, EP 5)
2. Ⓓ Has a mechanism to schedule a hearing of such requests. (*See also* MS.06.01.09, EP 5)
3. Ⓓ Has identified the procedures for the hearing to follow. (*See also* MS.06.01.09, EP 5)
4. Ⓓ Identifies the composition of the hearing committee as a committee that includes impartial peers. (*See also* MS.06.01.09, EP 5)
5. Ⓓ With the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws. (*See also* MS.06.01.09, EP 5)

## Standard MS.11.01.01

The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes.

## Rationale for MS.11.01.01

The organized medical staff and organization leaders have an obligation to protect patients, its members, and other persons present in the hospital from harm. Therefore, the organized medical staff designs a process that provides education about licensed independent practitioner health; addresses prevention of physical, psychiatric, or emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition.

The purpose of the process is to facilitate the rehabilitation, rather than discipline, by assisting a practitioner to retain and to regain optimal professional functioning that is consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

**Note:** *Organizations should consider the applicability of the Americans with Disabilities Act (ADA) to their credentialing and privileging activities, and, if applicable, review their medical staff bylaws, policies, and procedures. Federal entities are required to comply with the Rehabilitation Act of 1974.*

## Elements of Performance for MS.11.01.01

Process design addresses the following issues:

1. Education of licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria).
2. Self referral by a licensed independent practitioner.
3. Referral by others and maintaining informant confidentiality.
4. Referral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.
5. Maintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.
6. Evaluation of the credibility of a complaint, allegation, or concern.

7. Monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.
8. Reporting to the organized medical staff leadership instances in which a licensed independent practitioner is providing unsafe treatment.
9. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.
10. The medical staff implements its process to identify and manage matters of individual health for licensed independent practitioners.

## Standard MS.12.01.01

All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education.

## Rationale for MS.12.01.01

Continuing education is an adjunct to maintaining clinical skills and current competence.

## Elements of Performance for MS.12.01.01

1. Hospital-sponsored educational activities are prioritized by the organized medical staff.
2. These activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.
3. Education is based on the findings of performance improvement activities.
4. Ⓓ Each individual's participation in continuing education is documented.
5. Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.

# Introduction to Standard MS.13.01.01

## Telemedicine

### Introduction

The services covered under these standards are narrowly defined, focusing solely on licensed independent practitioners who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine[#] link. For hospitals that do not use Joint Commission accreditation for deemed status purposes, licensed independent practitioners who provide official readings of images, tracings, or specimens (interpretive services) through a telemedicine link are credentialed and privileged under the contracted services (Standard LD.04.03.09). If the organization has a pressing clinical need and a practitioner can supply that service through a telemedicine link, the organization can evaluate the use of temporary privileges (Standard MS.06.01.13) for this clinical situation.

These standards allow for the option of credentialing and privileging by proxy. Under special circumstances, the originating site (the site where the patient is located at the time the service is provided) is allowed to accept the privileging decisions of the distant site (the site where the practitioner providing the professional service is located). As in all other standards, these standards assume that the organization is following applicable law and regulation such as appropriate licensure to practice medicine or telemedicine in the states where the originating sites and distant sites are located.

This approach does the following:

- Reduces the credentialing and privileging burden for the originating site, especially where there are large numbers of licensed independent practitioners who might provide telemedicine services
- Recognizes that the distant site has more relevant information upon which to base its privileging decisions
- Acknowledges that the originating site may have little experience in privileging in certain specialties

[#] Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Telemedicine is a subcategory of telehealth. Source: American Telemedicine Association.

### Other Standards Related to the Delivery of Telemedicine

Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner. *See* Standards EC.02.04.01 and EC.02.04.03 for additional standards related to maintaining telemedical equipment.

## Standard MS.13.01.01

**For originating sites only:** Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

## Rationale for MS.13.01.01

The originating site retains responsibility for overseeing the safety and quality of services offered to its patients.

## Element of Performance for MS.13.01.01

1. All licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
   - The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.

   Or
   - The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization. The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

   Or
   - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
     - The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
     - The practitioner is privileged at the distant site for those services to be provided at the originating site.
     - **For hospitals that use Joint Commission accreditation for deemed status purposes:** The distant site provides the originating site with a current list of licensed independent practitioners' privileges.

- ❑ 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 includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (*See also* LD.04.03.09, EPs 4, 9, and 23)

**Note:** *This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.*

- ❑ The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

**Note 1:** *In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the* Comprehensive Accreditation Manual for Ambulatory Care.

**Note 2:** ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). For the language of the Medicare Conditions of Participation pertaining to telemedicine,* see *Appendix A.*

## Standard MS.13.01.03

**For originating and distant sites:** The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites.

## Rationale for MS.13.01.03

Telemedicine will continue to evolve making novel services and approaches through technology more readily available. Medical staff at the originating site evaluates the organization's ability to safely provide services on an ongoing basis. Medical staff at the distant site evaluates performance of those services as part of privileging and as part of the reappraisal conducted at the time of reappointment, renewal, or revision of clinical privileges.

## Elements of Performance for MS.13.01.03

1. Ⓓ The medical staff recommends which clinical services are appropriately delivered by licensed independent practitioners through this medium.
2. The clinical services offered are consistent with commonly accepted quality standards.