Medical Staff Update
Spring 2021

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Joint Commission Resources

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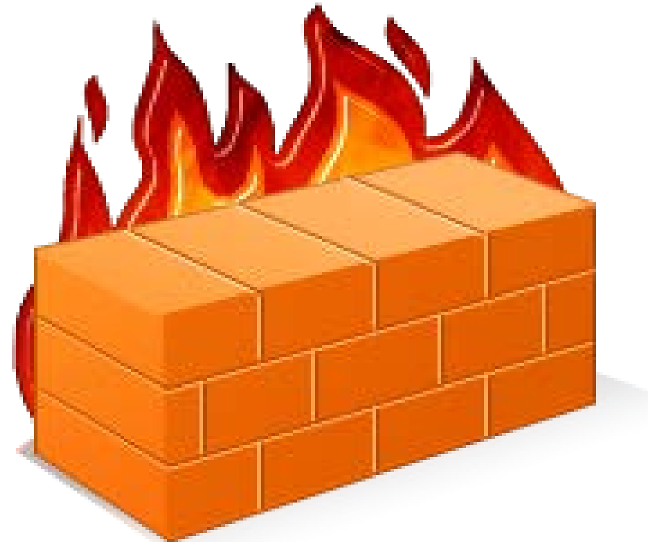

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Objectives

- Review of what's new in the TJC medical staff chapter
- Application of TJC medical staff standards and across health care systems
- Update on current TJC telemedicine requirements
- Medical staff chapter implications due to Covid-19; disaster privileges

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MS Chapter Changes

Effective
January 1, 2021

- MS.01.01.01, EP 3 DELETED
  - Was duplicative since scored individually at MS.01.01.01 EPs 12-38
- MS.06.01.05, EP 11 Revised to allow the time period for processing applications to be addressed in bylaws, rules, regulations, or policies
- MS.13.01.01, EP 1 Telemedicine credentialing and privileging can be from a TJC or CMS-certified organization

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MS Chapter Changes

Effective
July 1, 2020

- MS.01.01.01 EP 38 Bylaws Change
- If allowance for an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific **outpatient** surgical or procedural services, assessment of the patient is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services.

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MS Chapter Changes

Effective
July 1, 2020

- MS.03.01.01, EP 19 Assessment Criteria
  - Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
  - Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
  - Applicable state and local health and safety laws
  - **Expectation that still performed by LIP**

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FAQ Update 11/2020
Provider Identification MS.06.01.03 EP 5

- The Joint Commission requires that organizations verify the identity of the applicant by viewing one of the following:
  - A current picture organizational ID card
  - A valid picture ID issued by a state or federal agency (for example, a driver's license or passport)
- The verification may be done at any point during the application process or when the applicant enters the organization.
  Examples may include:
  - To pick up the application
  - For an interview by the department chair
  - When arriving to first provide services
  - When having their photo ID badge picture taken
  - Use of a telecommunications link that includes both audio and video capabilities

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Survey Activity Guide Tools 2021

- Medical Staff Bylaws Review Guide
- Medical Staff and Related Standards Compliance Evaluation Guide
- Professional Graduate Medical Education Program Standard Compliance Evaluation Guide
- Credentials File Review Tool

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Healthcare Systems and the Medical Staff

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Applicability

- The following slides only apply to HAP (Hospital) Manual
- So, **NOT** applicable to CAH (Critical Access Hospitals)
- If your system of hospitals has a combination of both, the critical access hospital must have its own CCN number and medical staff

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Multi-Campus Hospital vs Hospital System

Multi-Campus Hospital	Hospital System
-Several campuses -Inpatient or Outpatient -Provider Based -Remote from main site: different addresses -All Under same CCN (Medicare Number) -May not have separate medical staffs -EP 37 is not required to be a part of the bylaws	-Several campuses (hospitals) -All under separate CCNs (Medicare Numbers) -May have single, unified medical staff -Must have EP 37 in the bylaws -Single governing body -Single set bylaws, rules, regulations, policies -Hospitals in system must have the option to unify, but even if they opt out, must have EP 37 in bylaws

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MS.01.01.01 Bylaws Requirement Unified Medical Staff

- EP 37
  - Unified Medical Staff
    - One set of bylaws
    - One set of rules/regulations
    - One board
  - Each hospital's medical staff has option to opt out
    - Separate bylaws
    - Separate rules/regulations
    - Separate boards

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System Board

- Meeting minutes must be clear when actions apply to a specific hospital in system
- Functions as the final say in granting of privileges
- May have local MEC, as long as following system bylaws, policies, procedures, rules, regulations
- If have local MEC, must report to system board

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MS.01.01.05 EP 1
Unified Medical Staff Creation

– Must be able to demonstrate that every hospital in system has voted to either opt into the unified medical staff or opt out of the unified medical staff

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MS.01.01.05 EP 2
Unified Medical Staff: Privileges

- Privileges granted only at hospitals where the provider actually performs those privileges
  - Hospital must be able to support privilege
  - Can develop a table with a list of privileges for a given provider with columns for the organizations, then indicate which hospitals they are requesting the privileges with an “x” in that column
- If an organization in the system has “opted out” of the unified medical system, then the provider must apply separately to that organization
- Satisfies compliance with MS.03.01.01 EP2
  - Practice within scope of privileges

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Disaster Privileges in a System COVID-19

– CMS and TJC have stated that a system leader can grant disaster privileges for providers for all hospitals in a system even if the hospitals have separate CCNs (Medicare numbers) and separate medical staffs.

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MS.01.01.05 EP 3
Unified Medical Staff: Rights

– Must have systemwide policies and/or 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.

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MS.01.01.05 EP 4
Unified Medical Staff: Local Issues

– Must have mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.

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MS.08.01.01 FPPE, MS.08.01.01 OPPE Unified Medical Staff

- Should still collect local data first
- Data from other CMS-certified organizations can be used, but considered supplemental
- If choose to do at system level, must be able to separate by organization

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MS.05.01.01 Unified Medical Staff
Quality Assurance/Performance Improvement (QAPI)

- System board responsible for at least two hospitals
  - May elect to have unified QAPI program
  - Must be allowable according to state and local laws
  - Must have data from each local hospital

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Telemedicine

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Definitions

Telehealth: The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

Telemedicine: The use of medical information exchanged from one site to another via electronic communication to improve patients' health status. Telemedicine is a subcategory of telehealth.

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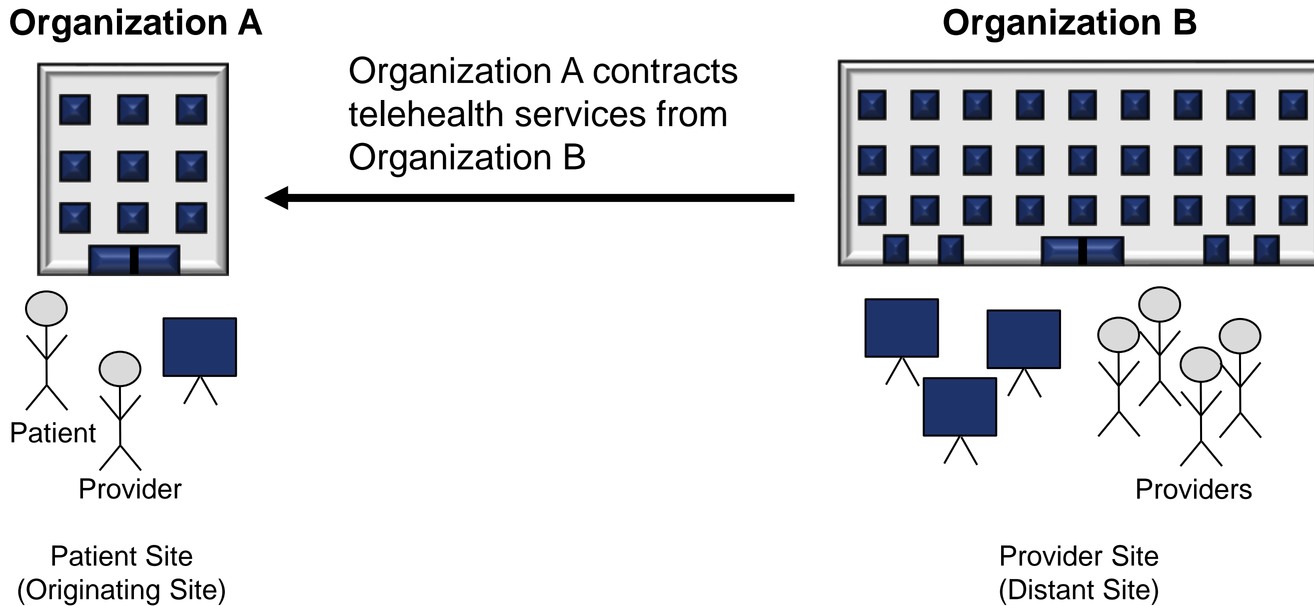
Scenario 1

Organization receives telehealth services through a contractual agreement.



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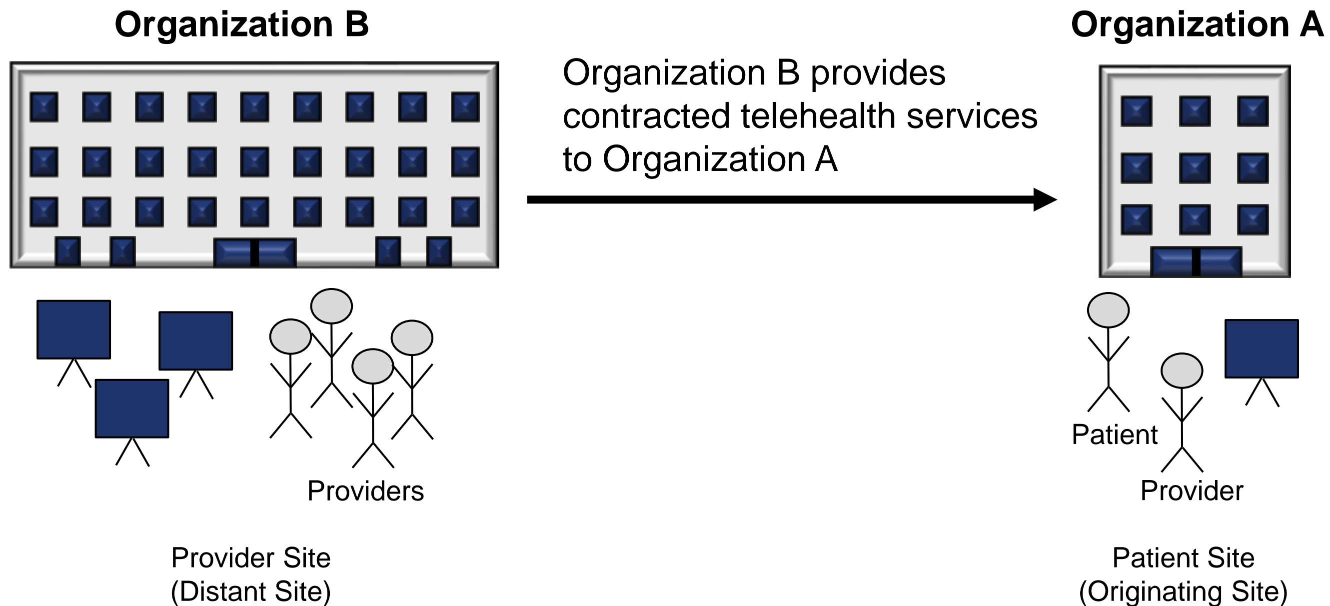
Scenario 2

Organization provides telehealth services through a contractual agreement.



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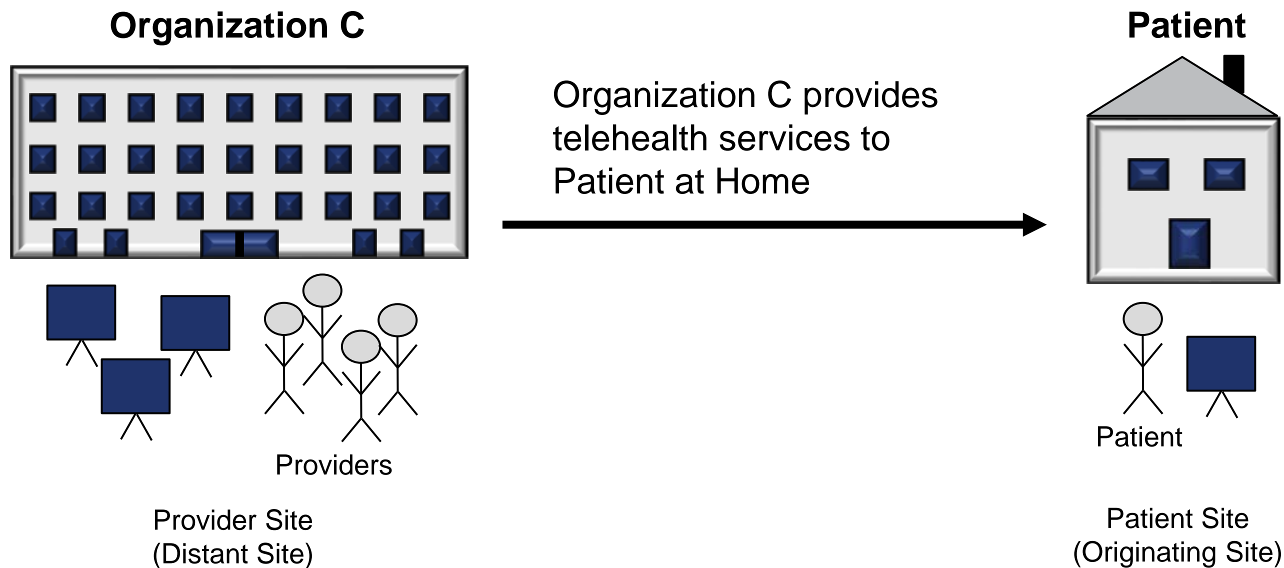
Scenario 3

Organization uses its own practitioners to provide telehealth services directly to patients at home.



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Advantages of Telehealth During COVID-19

Enables timely delivery, continuity of care while preventing exposure to the coronavirus

Promotes social distancing

Reduces the use of personal protective equipment (PPE)

Helps patients with transportation barriers

Allows monitoring of home-quarantined COVID-19 patients

Enables quarantined practitioners to provide care remotely

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Increased Use of Telehealth During COVID-19

- Regulatory flexibility
  - CMS waivers
  - HIPAA enforcement discretion
- Payment parity
  - Medicare
  - Medicaid
  - Private Insurers
- License portability

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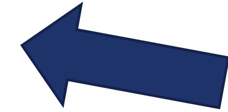
Quick Safety

Issue 55 | October 7, 2020

The optimal use of telehealth to deliver safe patient care



Set up your telehealth system for success

Consider how clinical services can be provided via telehealth

Follow-through on details for your workflow

Use data and other feedback to make improvements

- Real-time access to patient data
- Build on success

https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-55/

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Approach to Telehealth

- The Joint Commission's expectations for the quality and safety of care, treatment, and services **are the same** whether the care, treatment, and services are **provided in person or via telehealth.**

- Many of the current standards can be used to evaluate telehealth services across programs.
  - **Requirements may not specifically mention "telehealth" or "telemedicine"**

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Provider Identification for Telemedicine MS.06.01.03 EP 5

- Applicant identity verification may be completed offsite at the distant (provider) location, as the practitioner never comes onsite where the patient is located
- The organization determines the process for verifying practitioner identity
- Ideally should be included in the contractual language that they are responsible for positive ID if using a group entity

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Credentialing by Proxy Requirements

- Distant Site is CMS-participating organization
- Provider holds privileges at distant site that are requested by originating site; list available
- Distant site provider has license in state where originating site and/or patient is located
- Originating site has evidence of internal review of distant site provider to provide distant site (OPPE) Must include at a minimum: adverse events and all complaints

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Credentialing by Proxy Requirements

- Originating site should still do PSV of Licensure; especially important as patients may not reside in same state as originating site
- Originating site should still do NPDB unless it has identified the distant site as its agent in the NPDB system

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LD.04.03.09 Telemedicine COVID-19 Changes

For hospitals that use Joint Commission accreditation for deemed status purposes: When telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following:
- The distant site is a contractor of services to the hospital.
- The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation
- The originating site makes certain through the written agreement 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). (See also MS.13.01.01, EP 1)

– 4/7/20 Requirement for written contract lifted if granting disaster privileges under EM.02.02.13

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MS.13.01.01 Telemedicine COVID-19 Changes

Medical Staff Process for Credentialing and Privileging Telemedicine Physicians

- Originating site does entire process
- Originating site uses information from distant site if TJC accredited*
- Originating site accepts the credentialing/privileging decision from distant site if TJC accredited*

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

- At this time, CMS has lifted the requirement that a practitioner be licensed in the state in which the patient care is occurring. Joint Commission will also allow this based on your state's position on this practice.
- *** or CMS-Certified (effective January 2021)**

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Credentialed Providers Telemedicine during COVID 19

– Licensed Independent Practitioners (LIP) CURRENTLY credentialed and privileged by the organization, who would now provide the same services via a telehealth link to patients, would not require any additional credentialing or privileging. The medical staff determines which services would be appropriate to be delivered via a telehealth link. **There is no requirement that 'telehealth' be delineated as a separate privilege**.
For **volunteer** Licensed Independent Practitioners that are NOT currently credentialed and privileged by the organization, disaster privileges may be granted to volunteer LIPs by following the requirements in EM.02.02.13 (EOP must be activated)

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Disaster Privileges Current State

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MS.01.01.01, EP 14 Bylaws

- 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 Disaster Privileges, EP 2; MS.06.01.13, EP 1 Temporary Privileges)

- Still required even though no EP 3

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EM.02.02.13 EOP Activation

- **EP 1** The hospital grants disaster privileges to volunteer licensed independent practitioners **only when** the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

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EM.02.02.13 Authority to Grant

- **EP 2** The medical staff identifies, in its **bylaws**, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.

  (See also MS.01.01.01, EP 14, description of credentialing and privileging in this setting should be in **bylaws**, as well)

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EM.02.02.13 Identification

- **EP 3** The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. (See also EM.02.02.07, EP 9)

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EM.02.02.13 Oversight

- **EP 4** The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review), **recommend including intervals for this oversight when a significantly long PHE occurs.**
- This should have been identified in the EOP (Emergency Operations Plan) prior to a disaster. If it was not, a process must be developed and used.

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EM.02.02.13 Identity Verification

- **EP 5** Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) **AND** at least one of the following:
  - A current picture identification card from a health care organization that clearly identifies professional designation
  - A current license to practice
  - Primary source verification of licensure
  - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
  - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
  - Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster

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EM.02.02.13 Evidence of Oversight

- **EP 6** During a disaster, the medical staff oversees the performance of each volunteer licensed independent practitioner.
- Should follow process established in EOP, documentation should be available for review. Due to the longitudinal nature of current PHE, should be done at interval defined in EOP.

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EM.02.02.13 Volunteers >72 hours

- **EP 7** Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue.
- Due to the longitudinal nature of the COVID-19 scenario, each organization should document the continued need for the volunteer practitioners and then it is recommended it be done weekly/monthly thereafter. (my recommendation)

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EM.02.02.13 Volunteers > 72 hours

- During a long PHE, if have several disaster privileged LIPs, it is recommended to:
  - Review of list of disaster privileged LIPs at MEC meetings monthly
  - Divide list(s) to indicate LIPs:
    - Privileged and working
    - Privileged and not working currently
    - Privileged and never worked

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Reappointment During a National Emergency

- If an established provider's privileges are scheduled to expire during the time of the **declared national, regional, or state emergency (whichever is longer)**, The Joint Commission will allow an automatic extension of medical staff reappointment beyond the 2-year period under the following conditions:
  - A national emergency has officially been declared
  - The organization has activated its emergency management plan
  - Extending the duration of providers' privileges during an emergency is NOT prohibited by State Law

- **The duration of the extension cannot exceed 60 days after the declared state of emergency has ended.**
  The organization determines how the extension will be documented.

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American Heart Association

- All AHA certifications (ACLS, BLS, etc.) are extended past their expiration dates by 120 days if their expiration dates fall during the time that the EOP is activated.
- As of October 30, 2020, all AHA certifications should be able to have been updated and should now be current

EXPIRED

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LIPs and Emergency Management

- EM.01.01.01 EP 1 – This is not specific to LIPs but this EP states that medical staff participate in the planning of the organization's emergency operation plan (EOP).
- EM.01.01.01 EP 2 – This states that medical staff will participate in the DEVELOPMENT of the EOP.
- EM.02.02.01 EP 2: The EOP describes how the hospital will communicate information and instructions to its staff and licensed independent practitioners during an emergency
- EM.02.02.01 EP 20 – As part of the communication plan, the hospital must maintain the names and contact information of all physicians/LIPs

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LIPs and Emergency Management

– EM.02.02.07 EP 8 – The hospital must communicate in writing how it will communicate with each of its LIPs as to their role and who they report to in an emergency
– EM.02.02.07 EP 9 – The EOP describes how the hospital will identify LIPs during an emergency
– EM.02.02.07 EP 14 – EOP describes the integration of state or federally designated health care professionals during an emergency

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Miscellaneous Medical Staff Updates

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MS.06.01.13 Temporary Privileges

- Two reasons to grant:
  - Important patient care need
  - New practitioner or current practitioner requesting new privileges whether at reappointment or not
- Description of process must be in the **bylaws**

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MS.06.01.13 Temporary Privileges

- The process for granting depends on the reason for the request
  - If important patient care need, can be documented and granted by CEO or their designee typically after medical staff president recommendation
  - If a new applicant or **current practitioner with new privileges**, then a complete application with all of the elements in MS.06.01.13, EP 3 can be presented to CEO or their designee for temporary privileges to be granted. Typically also after a recommendation of medical staff president.

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MS.06.01.13 Temporary Privileges

- This would be a good mechanism to expand the privileges of a currently credentialed practitioner in order to be able to expand their capabilities **within the scope of their license, board certification, etc.**
- Link to FAQ
  - https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000002257/

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MS.08.01.01 FPPE COVID

- Modifying or bypassing the FPPE process may create risk to the delivery of safe, quality care. Therefore, the evaluation of Licensed Independent Practitioners (LIP) currently under FPPE should continue per the defined medical staff process.

- **Does not apply to disaster privileges** (remember disaster privileges have an oversight requirement)

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MS.08.01.03 OPPE COVID

- To the extent possible, practitioner performance data collection for OPPE should continue based on the established process.
- If unable to do review due to reallocation of resources, then document this modification of process.
- Any modifications to the review process should allow the medical staff to detect – and address – downward trending performance.
- Reassess and reinstitute established process once emergency is over (i.e. emergency operations plan is no longer in effect)

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Perspectives, August 2019

- There is now an allowance to use data from other CMS-certified organizations for the OPPE process
- This is not to be used in lieu of organization-specific data
- There is no requirement to do this, so “zero” data is still allowed for a given OPPE time frame as long as the medical staff leadership is aware that there has been no activity and the reason for the lack of activity.

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FAQ for Low Volume Practitioners

- https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000001500/

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Environment of Care

- EC.02.03.01 EP 9: LIPs are incorporated into and can speak to the organization's fire response plan.
- EC.02.03.01 EP 12: Those LIPs that work in surgery need to be able to speak to the surgery-specific fire response plan and to the requirements outlined in this EP.
- EC.03.01.01 EP 2: LIPs know and can explain what they would do in the event of an EC incident and how to report it.

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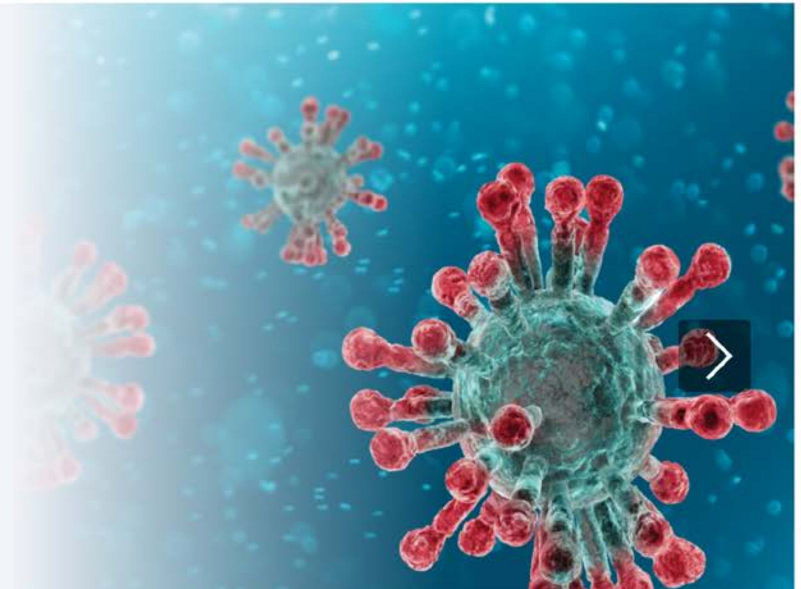

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TJC Resource Links

- COVID Resources
  - https://www.jointcommission.org/covid-19/

- Standards Interpretation Group FAQ
  - https://www.jointcommission.org/standards/standards-faqs/

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