Successful Regulatory Survey Readiness

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Independent Consultant and Former TJC Surveyor

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Dr. McCourt's career in medicine began as a board-certified family medicine physician in a staff model HMO from 1984-1991. During this tenure, she maintained active staff privileges at Fairview General Hospital in Fairview, Ohio and Lakewood Hospital in Lakewood, Ohio. From 1991-2008, she served as the Medical Director of Brunswick Medical Care Center, a satellite facility of Medina General Hospital. From 2008-2009, she held the position of Physician Quality Liaison at Medina General Hospital. During this time, she was instrumental in the development of the OPPE process. This process was implemented and was also submitted and accepted for the Joint Commission's Leading Practice Library.

In 2004, she began her career with The Joint Commission as a hospital surveyor. She was trained in the Joint Commission's Comprehensive Manuals for Hospitals, Ambulatory Care Facilities, and Office Based Surgery Practices. In addition, Dr. McCourt served in the Special Survey Unit to investigate complaints for The Joint Commission. She served as a team leader for both deemed and non-deemed hospital systems and has surveyed, and now consulted, at a broad range of organizations from rural community hospitals to large academic medical centers.

In September of 2014, Dr. McCourt transitioned to Joint Commission Resources to begin a career as a consultant and ceased being a surveyor. In this role, which she continued in until the end of 2022, she educated healthcare organizations on the Joint Commission standards implementation and compliance. During her career at The Joint Commission, Dr. McCourt was active in the speaker's bureau and has given numerous presentations to a variety of audiences including several national meetings. Her presentations include the hospital and ambulatory accreditation standards and the survey process.

Dr. McCourt is currently an independent healthcare consultant with an emphasis on medical staff standards and compliance.

Goals for Today's Webinar

Analyze Surveyor Expectations: Articulate the evolving expectations and criteria that surveyors apply during regulatory evaluations, including common pitfalls and areas of focus that can impact compliance.

Implement Continuous Readiness Strategies: Develop and implement an ongoing readiness plan that integrates feedback from past surveys, fostering a culture of continuous improvement and preparedness within the organization.

Utilize Effective Resources: Identify and leverage essential tools and resources that can facilitate proactive survey preparation, including credentialing files, documentation practices, and communication techniques that enhance the overall evaluation experience.

Create Actionable Follow-Up Plans: Construct a robust follow-up plan to address any findings post-survey, ensuring sustained compliance and improvement within the organization's practices and procedures.

The Standards

The Joint Commission Standards

- 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.
- MS.08.01.01

Healthcare Facilities Accreditation Program Standards

- Chapter 5, Staffing
  - 05.01.28 – Ongoing Professional Practice Evaluation (OPPE)
  - 05.01.29 – Focused Professional Practice Evaluation (FPPE)

All accreditation standards are derived from the CMS Conditions of Participation (COPs)

- Monitoring Period (MS.08.01.01, EP 3)
  - Date practitioner has activity thru end of current eval period
- Criteria for Reviews (MS.08.01.01, EP 3 & 5)
  - Spelled out in policy
- QI Request Reviews
  - For significant concerns identified by QI

The Joint Commission Standards

- 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.
- 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.

CMS

The Centers for Medicare & Medicaid Services (CMS) provide guidelines regarding provider competency assessments primarily through the regulations governing healthcare facilities, particularly in the context of the Conditions of Participation (CoPs) for hospitals and other healthcare entities. Key aspects of the CMS guidelines around provider competency assessment include:

- Medical Staff CoP 482.22
- https://www.govinfo.gov/app/details/CFR-2011-title42-vol5/CFR-2011-title42-vol5-sec482-22/context

For the most current and specific CMS guidelines, it is advisable to refer directly to the CMS website or relevant resources that contain detailed regulations and interpretations.

CMS

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Scope of Competency Assessments: Providers, including physicians and other clinicians, must demonstrate their competency in delivering care and services. This includes assessments of clinical skills, knowledge, and professional behavior.

Ongoing Evaluation: Providers' competencies should be assessed not only at the time of hiring or credentialing but also on an ongoing basis. This ensures that providers maintain their skills and are updated on best practices and knowledge.

Performance Review: Facilities are required to conduct regular performance reviews that may include peer evaluations, patient outcomes, and other metrics to assess provider competency and effectiveness in delivering care.

Documented Processes: Hospitals and healthcare facilities must have documented processes for assessing and verifying provider competencies. This documentation is crucial for compliance during CMS surveys and inspections.

CMS

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Continuing Education and Training: Providers should engage in continuous education and training programs to keep their skills current and relevant. This could include attending workshops, training sessions, or obtaining certifications.

Interdisciplinary Collaboration: CMS encourages a collaborative approach to competency assessment that may involve different disciplines working together to ensure comprehensive care delivery.

Addressing Deficiencies: If any gaps in competency are identified, facilities must have processes in place to address these deficiencies through additional training, mentoring, or other remedial actions.

Regulatory Updates: CMS guidelines can change, so it's important to stay informed about the latest regulations and standards, especially as new policies regarding provider competency may arise.

DNV

Competency Assessment Requirement: DNV requires healthcare organizations to ensure that all staff members, including medical staff, demonstrate the necessary competencies for their roles. This includes assessing clinical skills, knowledge, and professional behaviors.

Ongoing Evaluation: Like CMS, DNV emphasizes the importance of continuous evaluation of provider competencies. This ongoing assessment is essential for maintaining high standards of patient care and ensuring that providers are up-to-date with current practices.

Performance Improvement: DNV guidelines stress the need for performance improvement programs that monitor and evaluate healthcare providers' competencies over time, using established metrics and outcomes.

Documentation: Healthcare organizations must maintain proper documentation of competency assessments, performance evaluations, and any actions taken to address identified deficiencies. This is crucial for compliance during DNV surveys.

For the most detailed and specific DNV guidelines, it is beneficial to consult DNV's official documentation or resources directly, as they regularly issue updates regarding standards and practices in healthcare.

DNV

9

Interdisciplinary Approach: DNV encourages an interdisciplinary approach to competency assessments, involving collaboration among various clinical disciplines to ensure comprehensive assessment practices.

Education and Training: DNV underscores the importance of continuous education and ongoing training to help providers maintain and enhance their competencies. Organizations should implement programs that facilitate professional development.

Quality and Safety Focus: The assessment of competencies is linked to the organization's commitment to quality care and patient safety, with guidelines that seek to ensure all providers contribute effectively to these goals.

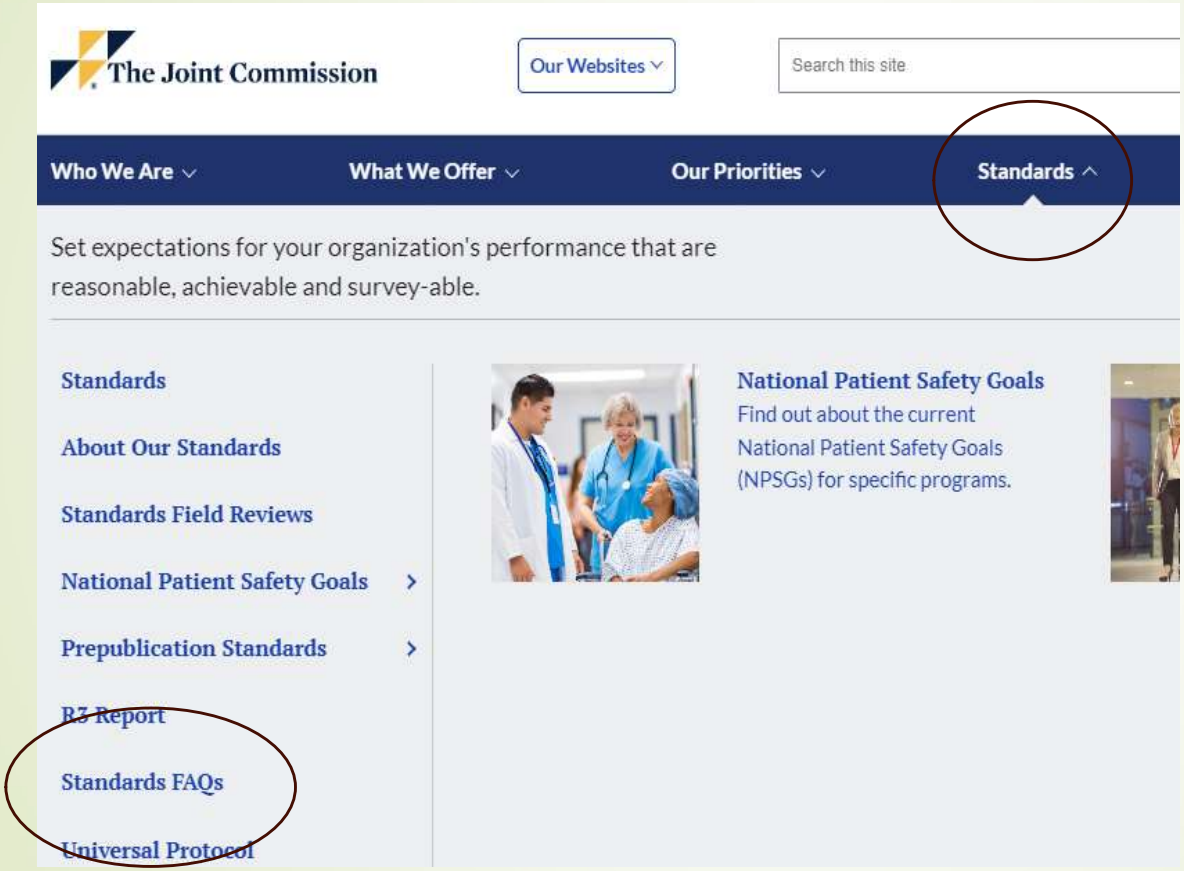
Adapting to Regulatory Changes: DNV's guidelines are regularly reviewed and updated to align with changing healthcare regulations and best practices, ensuring organizations remain compliant.

The Joint Commission: Online Resources

- FAQs
- E-Alerts
- Survey Activity Guide
- Joint Commission Connect/Guest Access (TJC Accredited only)

The Joint Commission: FAQs

11



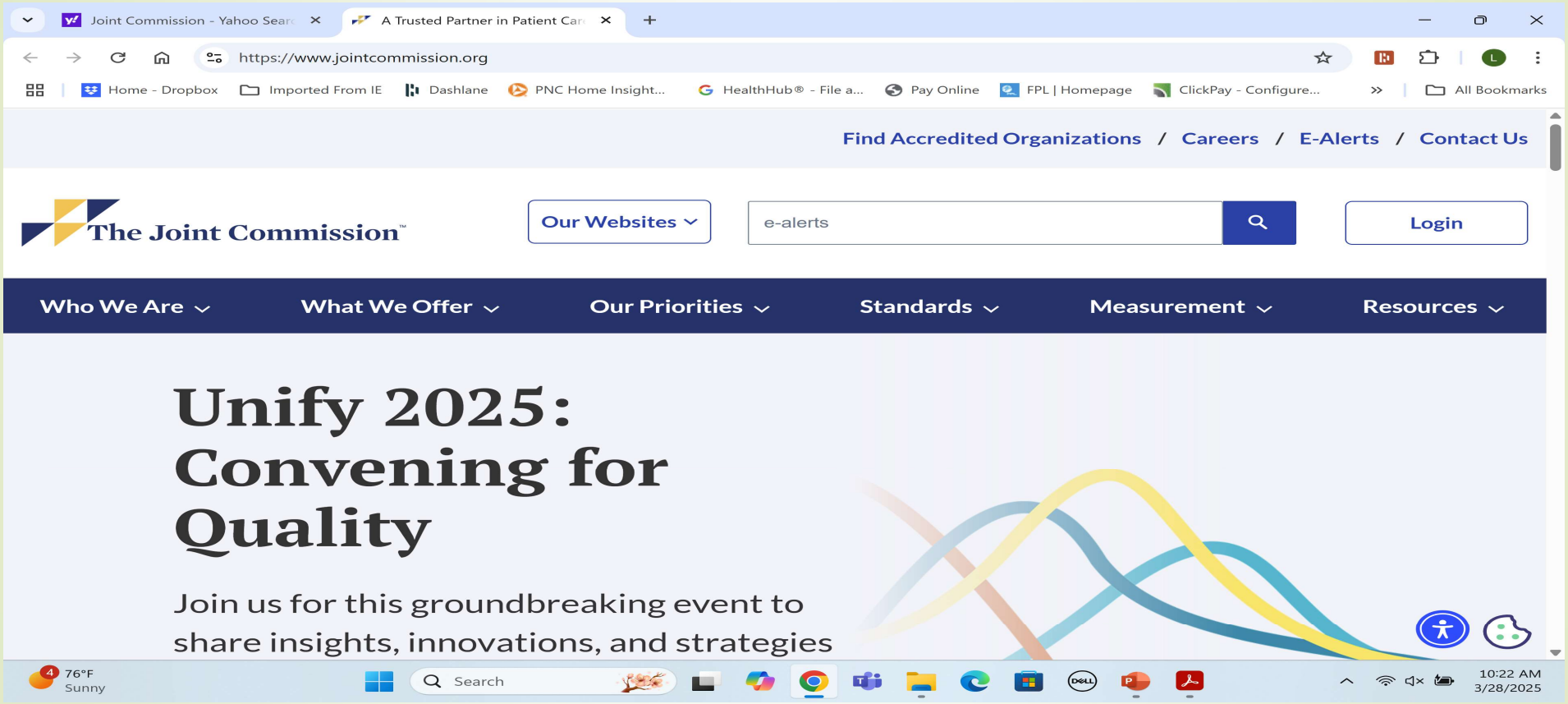
Check for updates once a month!

The Joint Commission: FAQs

TJC FAQs offer clarity on accreditation standards and processes. They are helpful in comprehending the expectations and criteria for achieving and maintaining compliance with standards.

By addressing common queries, these FAQs can enable you to align your practices with TJC standards, ultimately leading to improved patient care and safety.

The Joint Commission: E-Alerts



The Joint Commission: E-Alerts

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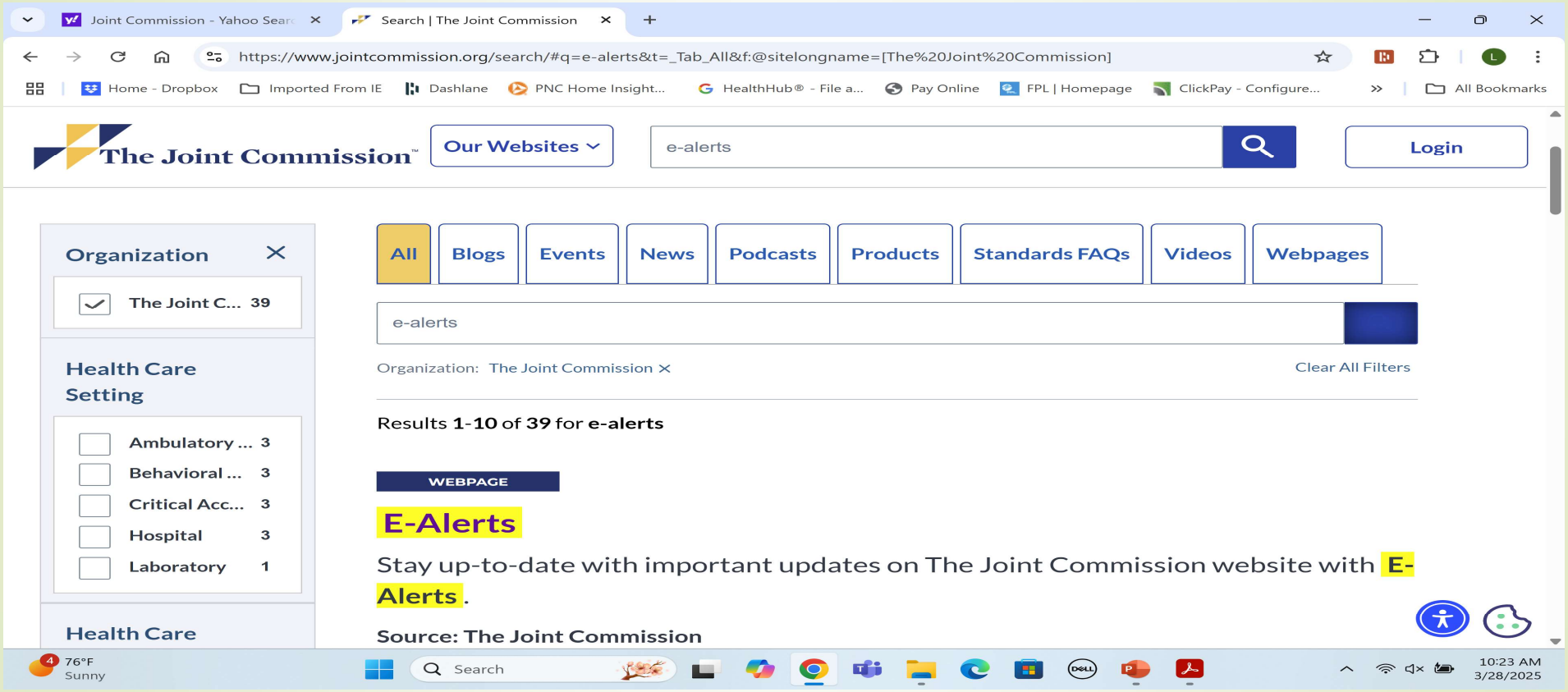
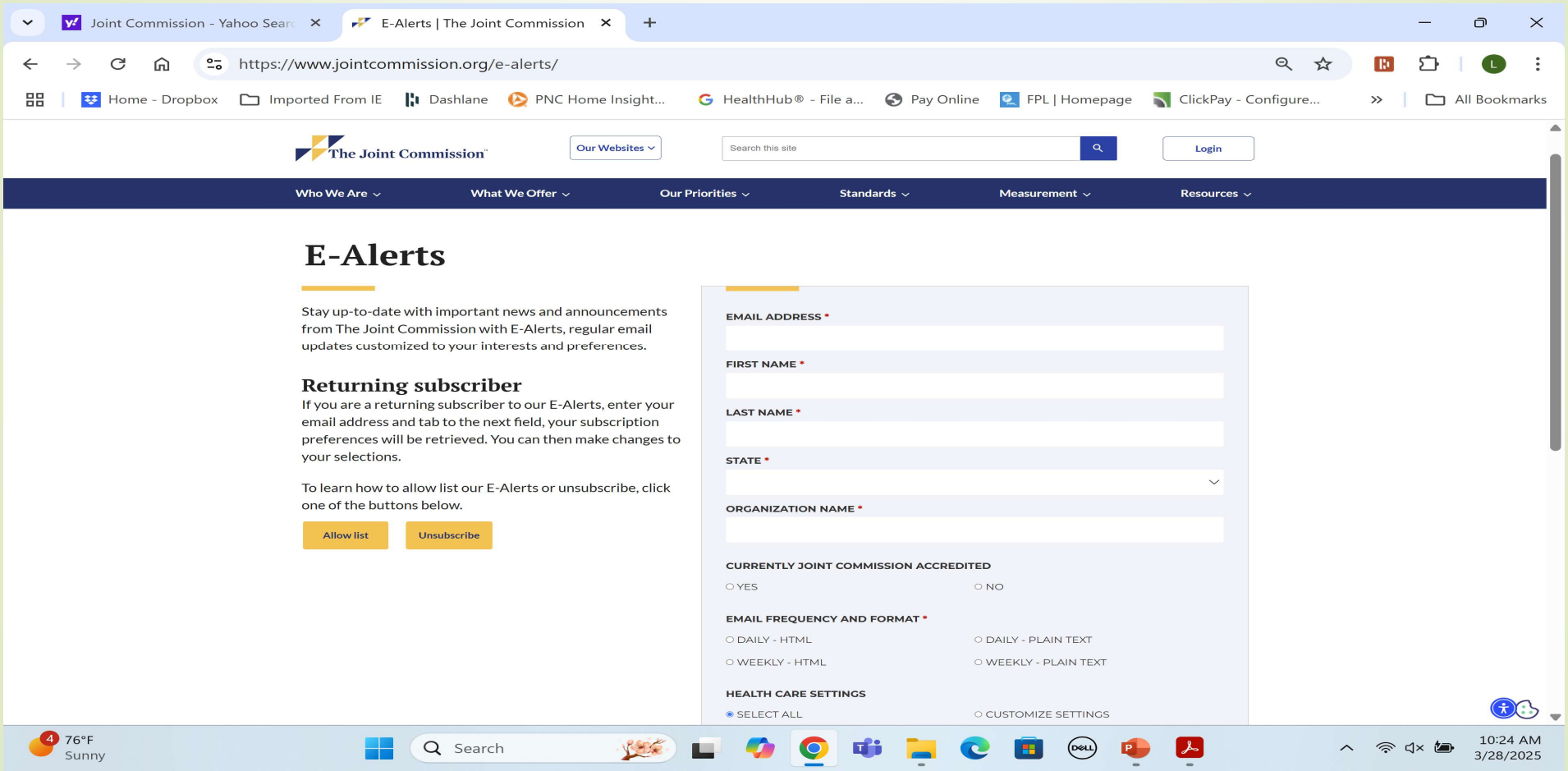
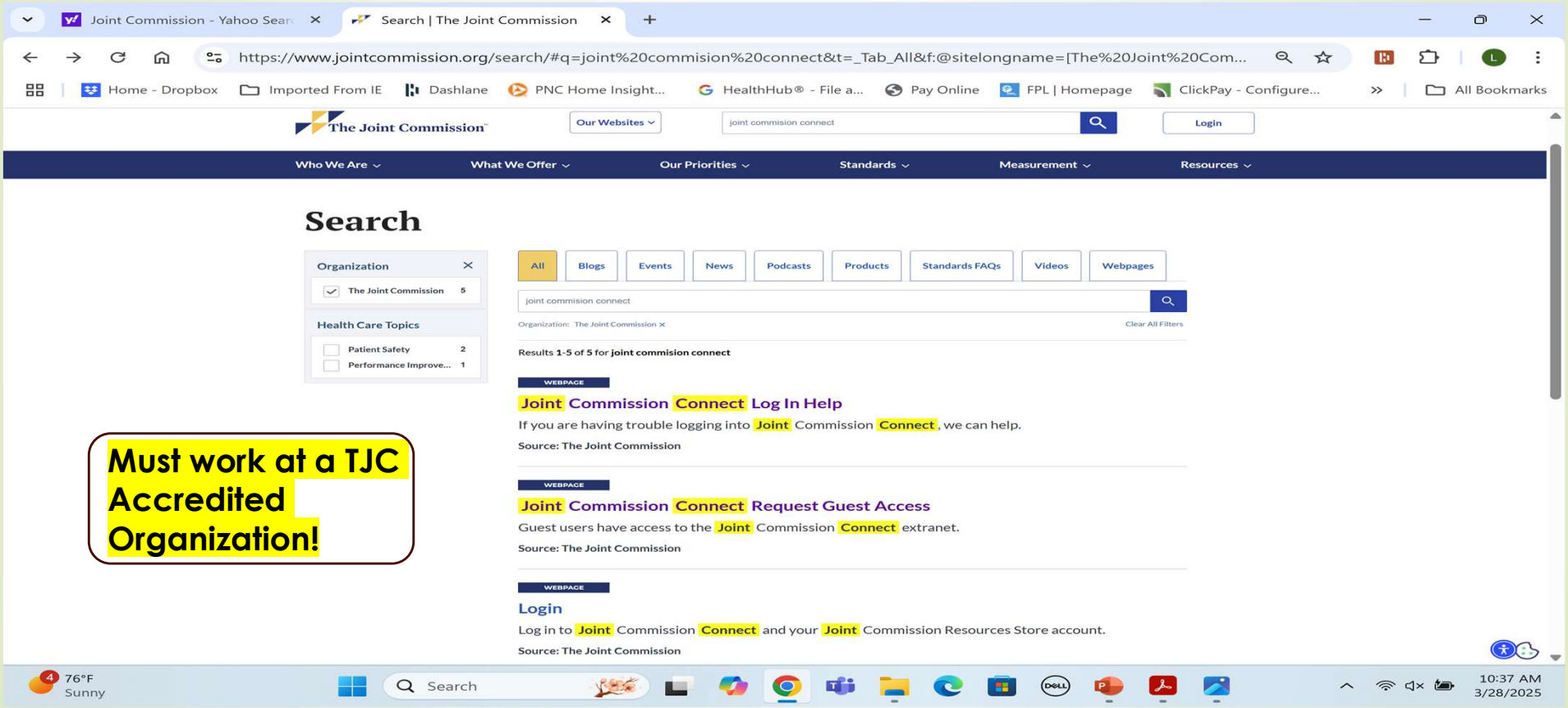


The Joint Commission: E-Alerts

15



The Joint Commission: Guest Access/Joint Commission Connect



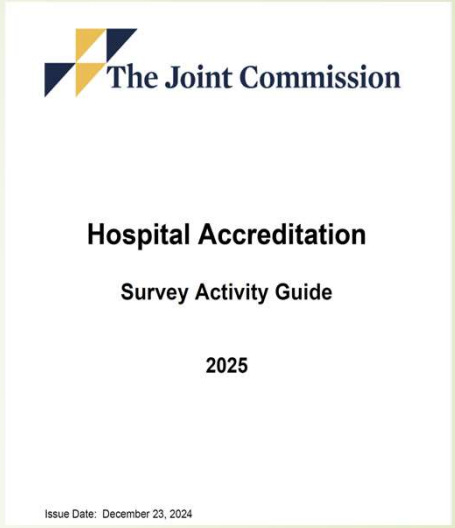
Must work at a TJC Accredited Organization!

The Joint Commission Survey Activity Guide

- Roadmap to Survey

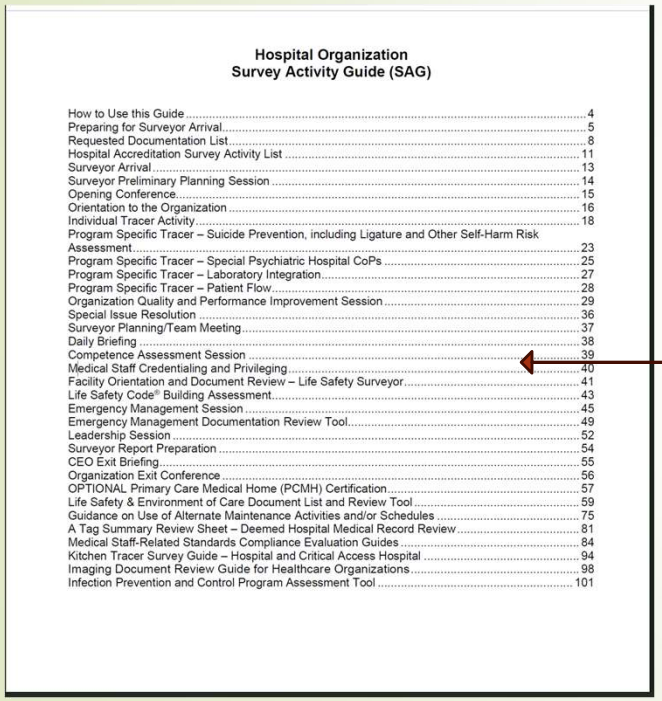
- Link to Survey Activity Guide:

https://www.jointcommission.org/what-we-offer/accreditation/health-care-settings/hospital/prepare/snapshot-of-survey-day/#94b8e9c66aaa40bbb8a14bd1c6295986_e0f419d491f940c897087a8bd13204d4



The Joint Commission Survey Activity Guide

Roadmap to Survey



Hospital Organization
Survey Activity Guide (SAG)

Medical Staff Credentialing and Privileging

Organization Participants
Suggested participants include the President of the medical staff; Medical Director and Medical Staff Coordinator, if applicable; and medical staff credentials committee representatives.

Logistical Needs
The suggested duration of this session is approximately 60 minutes. The surveyor requests specific credential files of physicians and other licensed practitioners who are identified from tracers, from OR log, from the ICU and special procedures unit logs, etc. The type of files a surveyor requests are from high-risk specialties, non-physician specialties, non-physician licensed practitioners, moonlighters, hospitalists, practice outside the usual scope of specialty, and low volume specialties. When a **Nursing Care Center** is integrated with the hospital, the surveyor reviews credential files of the Medical Director of the NCC and other physicians and licensed practitioners.

The surveyor also requests the Medical Staff Bylaws, Rules, and Regulations, Medical Executive Committee minutes, peer review and focused monitoring records for the session.

Objectives
The surveyor will:

- Learn about the process used to collect data relevant to appointment decisions, the process for granting and delineating privileges, and the structures that guide consistency of implementation (e.g., bylaw requirements)
- Evaluate the credentialing and privileging process for the medical staff and other physicians and licensed practitioners who are privileged through the medical staff process

Overview
During this session, the surveyor discusses with organization participants:

- How your organization collects data used in making decisions on appointment, granting and delineating privileges
- Consistent implementation of the credentialing and privileging process for the medical staff and other licensed practitioners who are privileged through the medical staff process
- Processes for granting privileges and the delineation of privileges
- Whether physicians and other licensed practitioners practice within the limited scope of delineated privileges
- The link between peer review and focused monitoring to the credentialing and privileging process
- Potential concerns in the credentialing, privileging, and appointment process
- Education on antibiotic resistance and antibiotic stewardship (Note: surveyors will not review medical staff records related to antibiotic stewardship)

The Joint Commission Survey Activity Guide

Contains the tools surveyors will use to evaluate your medical staff processes can be found in the Activity Guide

Medical Staff-Related Standards Compliance Evaluation Guides

The material presented in this section is representative of what surveyors use when they are evaluating compliance with the Medical Staff-related standards in the Hospital accreditation program. Organizations may find these tools useful to continuous compliance and survey readiness efforts.

1. Medical Staff Bylaws Review Guide

2. Medical Staff and Related Standards Compliance Evaluation Guide

3. Professional Graduate Medical Education Program Standard Compliance Evaluation Guide

4. Credentials File Review Tool

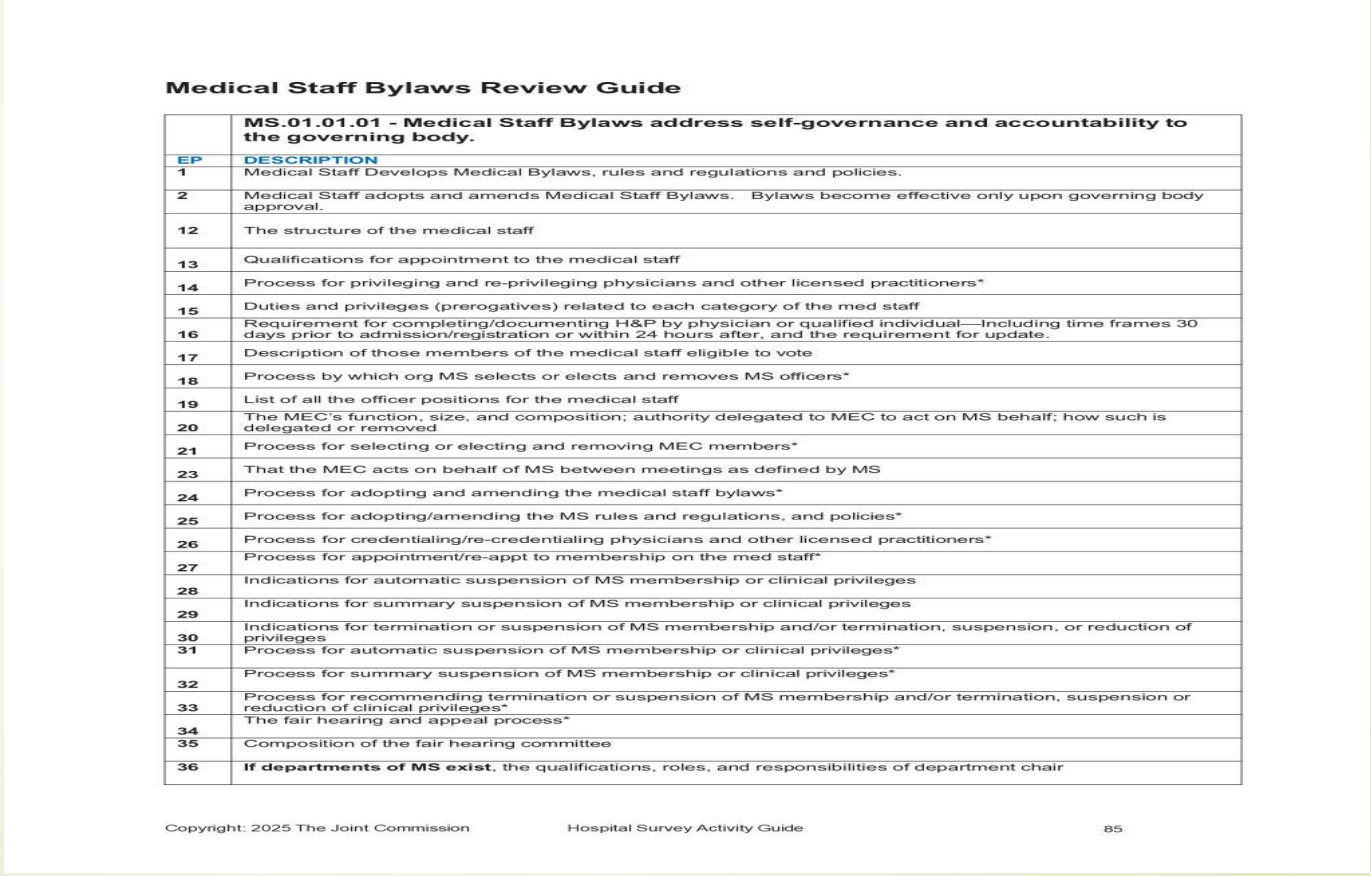
Check for updates in January and June!

The Joint Commission Survey Activity Guide

20

Bylaws Review Guide

3 Pages



Medical Staff Bylaws Review Guide

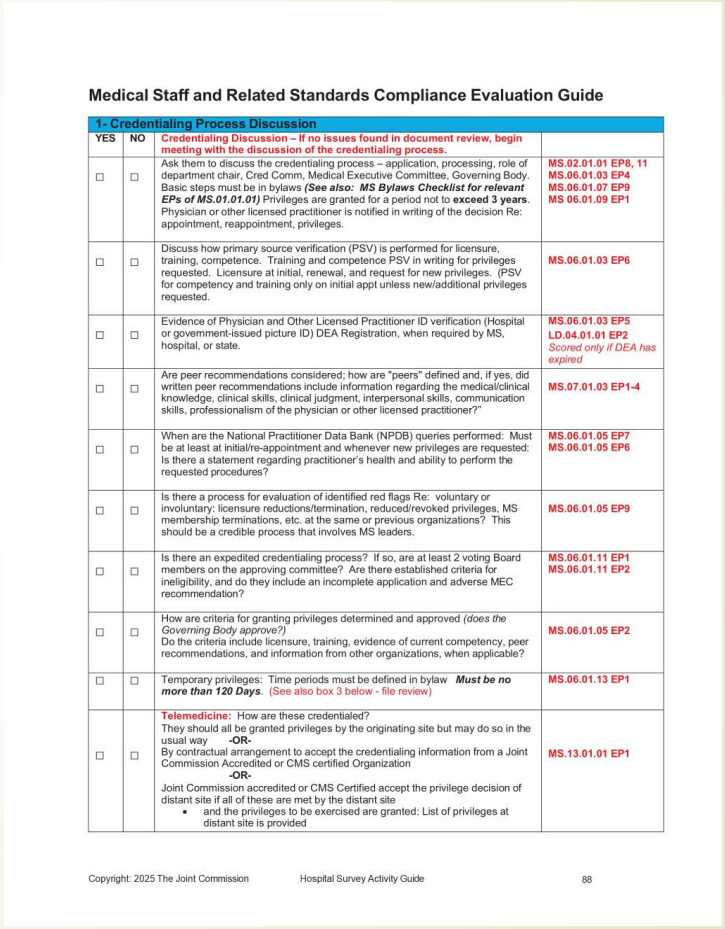
EP	MS.01.01.01 - Medical Staff Bylaws address self-governance and accountability to the governing body. DESCRIPTION
1	Medical Staff Develops Medical Bylaws, rules and regulations and policies.
2	Medical Staff adopts and amends Medical Staff Bylaws. Bylaws become effective only upon governing body approval.
12	The structure of the medical staff
13	Qualifications for appointment to the medical staff
14	Process for privileging and re-privileging physicians and other licensed practitioners*
15	Duties and privileges (prerogatives) related to each category of the med staff
16	Requirement for completing/documenting H&P by physician or qualified individual—Including time frames 30 days prior to admission/registration or within 24 hours after, and the requirement for update.
17	Description of those members of the medical staff eligible to vote
18	Process by which org MS selects or elects and removes MS officers*
19	List of all the officer positions for the medical staff
20	The MEC's function, size, and composition; authority delegated to MEC to act on MS behalf; how such is delegated or removed
21	Process for selecting or electing and removing MEC members*
23	That the MEC acts on behalf of MS between meetings as defined by MS
24	Process for adopting and amending the medical staff bylaws*
25	Process for adopting/amending the MS rules and regulations, and policies*
26	Process for credentialing/re-credentialing physicians and other licensed practitioners*
27	Process for appointment/re-appt to membership on the med staff*
28	Indications for automatic suspension of MS membership or clinical privileges
29	Indications for summary suspension of MS membership or clinical privileges
30	Indications for termination or suspension of MS membership and/or termination, suspension, or reduction of privileges
31	Process for automatic suspension of MS membership or clinical privileges*
32	Process for summary suspension of MS membership or clinical privileges*
33	Process for recommending termination or suspension of MS membership and/or termination, suspension or reduction of clinical privileges*
34	The fair hearing and appeal process*
35	Composition of the fair hearing committee
36	**If departments of MS exist**, the qualifications, roles, and responsibilities of department chair

The Joint Commission Survey Activity Guide

21

Standards Evaluation Guide

3 pages



Medical Staff and Related Standards Compliance Evaluation Guide

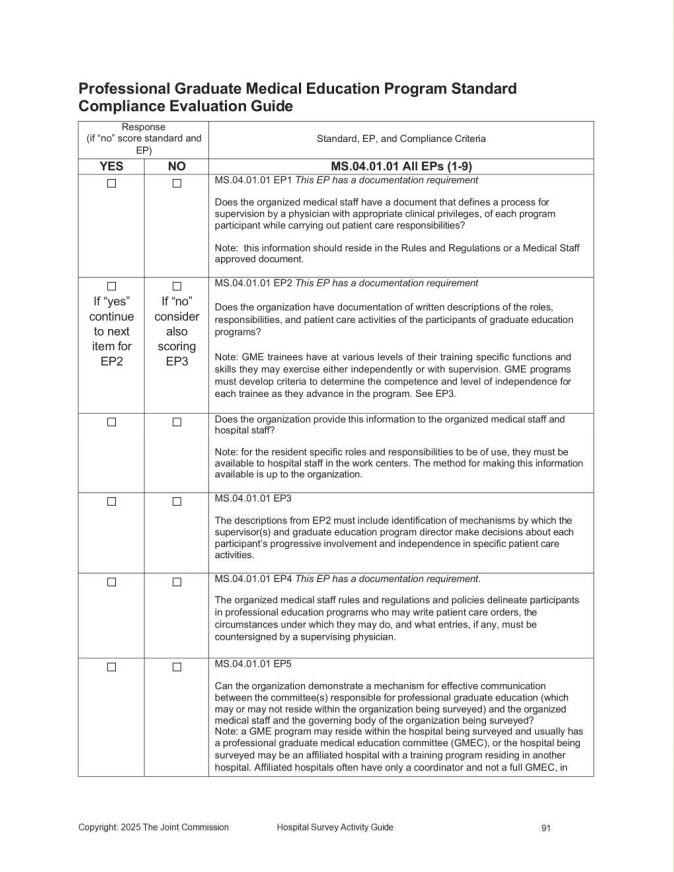
1- Credentialing Process Discussion			
YES	NO	**Credentialing Discussion – If no issues found in document review, begin meeting with the discussion of the credentialing process.**	
☐	☐	Ask them to discuss the credentialing process – application, processing, role of department chair, Cred Comm, Medical Executive Committee, Governing Body. Basic steps must be in bylaws ***(See also: MS Bylaws Checklist for relevant EPs of MS.01.01.01)*** Privileges are granted for a period not to **exceed 3 years**. Physician or other licensed practitioner is notified in writing of the decision Re: appointment, reappointment, privileges.	**MS.02.01.01 EP8, 11** **MS.06.01.03 EP4** **MS.06.01.07 EP9** **MS 06.01.09 EP1**
☐	☐	Discuss how primary source verification (PSV) is performed for licensure, training, competence. Training and competence PSV in writing for privileges requested. Licensure at initial, renewal, and request for new privileges. (PSV for competency and training only on initial appt unless new/additional privileges requested.	**MS.06.01.03 EP6**
☐	☐	Evidence of Physician and Other Licensed Practitioner ID verification (Hospital or government-issued picture ID) DEA Registration, when required by MS, hospital, or state.	**MS.06.01.03 EP5** **LD.04.01.01 EP2** *Scored only if DEA has expired*
☐	☐	Are peer recommendations considered; how are "peers" defined and, if yes, did written peer recommendations include information regarding the medical/clinical knowledge, clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism of the physician or other licensed practitioner?"	**MS.07.01.03 EP1-4**
☐	☐	When are the National Practitioner Data Bank (NPDB) queries performed: Must be at least at initial/re-appointment and whenever new privileges are requested: Is there a statement regarding practitioner's health and ability to perform the requested procedures?	**MS.06.01.05 EP7** **MS.06.01.05 EP6**
☐	☐	Is there a process for evaluation of identified red flags Re: voluntary or involuntary: licensure reductions/termination, reduced/revoked privileges, MS membership terminations, etc. at the same or previous organizations? This should be a credible process that involves MS leaders.	**MS.06.01.05 EP9**
☐	☐	Is there an expedited credentialing process? If so, are at least 2 voting Board members on the approving committee? Are there established criteria for ineligibility, and do they include an incomplete application and adverse MEC recommendation?	**MS.06.01.11 EP1** **MS.06.01.11 EP2**
☐	☐	How are criteria for granting privileges determined and approved *(does the Governing Body approve?)* Do the criteria include licensure, training, evidence of current competency, peer recommendations, and information from other organizations, when applicable?	**MS.06.01.05 EP2**
☐	☐	Temporary privileges: Time periods must be defined in bylaw ***Must be no more than 120 Days***. (See also box 3 below - file review)	**MS.06.01.13 EP1**
☐	☐	**Telemedicine:** How are these credentialed? They should all be granted privileges by the originating site but may do so in the usual way **-OR-** By contractual arrangement to accept the credentialing information from a Joint Commission Accredited or CMS certified Organization **-OR-** Joint Commission accredited or CMS Certified accept the privilege decision of distant site if all of these are met by the distant site • and the privileges to be exercised are granted: List of privileges at distant site is provided	**MS.13.01.01 EP1**

The Joint Commission Survey Activity Guide

22

GME Program Evaluation Guide

2 pages

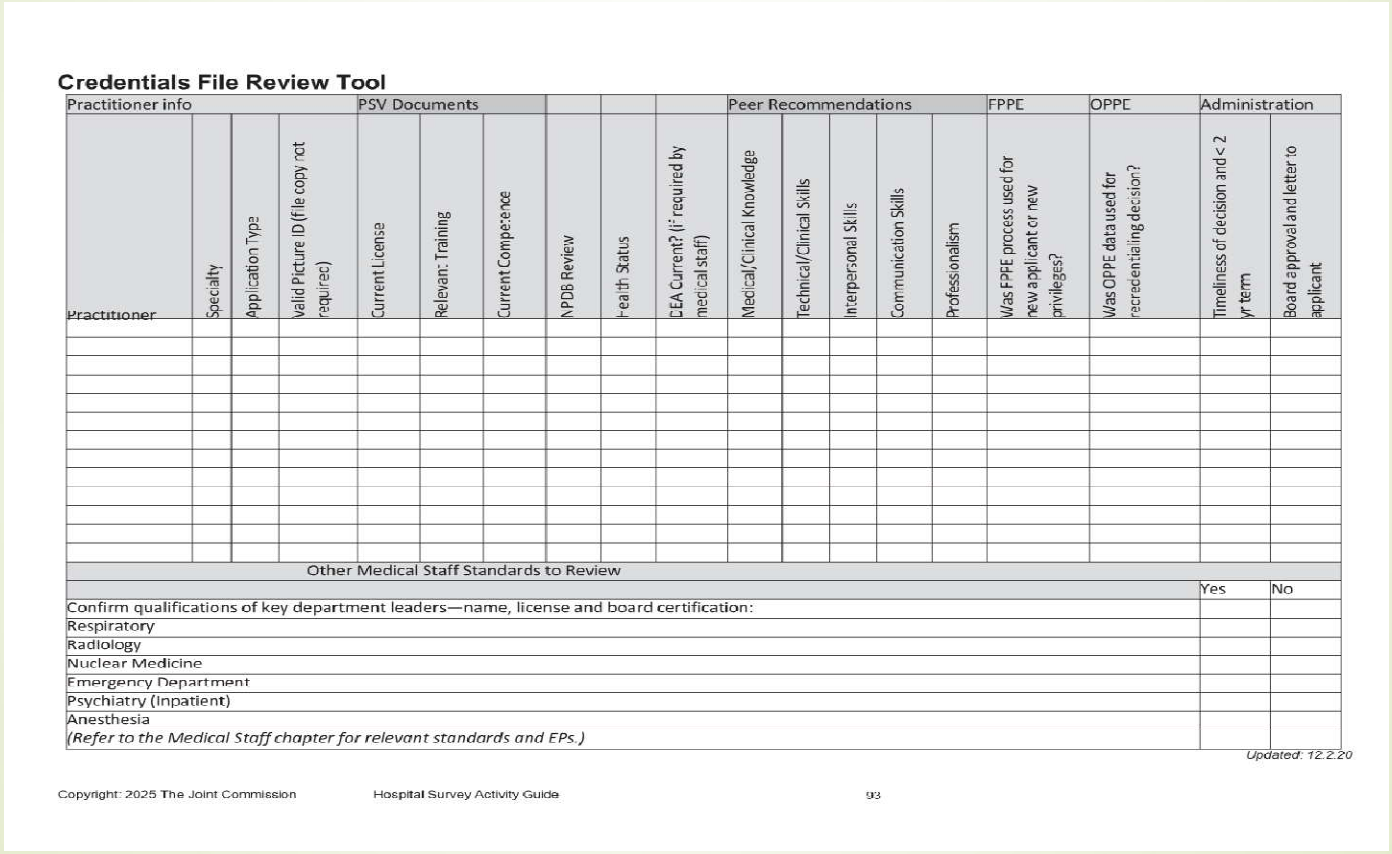


Professional Graduate Medical Education Program Standard Compliance Evaluation Guide

Response (if "no" score standard and EP)		Standard, EP, and Compliance Criteria
YES	**NO**	**MS.04.01.01 All EPs (1-9)**
☐	☐	MS.04.01.01 EP1 *This EP has a documentation requirement* Does the organized medical staff have a document that defines a process for supervision by a physician with appropriate clinical privileges, of each program participant while carrying out patient care responsibilities? Note: this information should reside in the Rules and Regulations or a Medical Staff approved document.
☐ If "yes" continue to next item for EP2	☐ If "no" consider also scoring EP3	MS.04.01.01 EP2 *This EP has a documentation requirement* Does the organization have documentation of written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs? Note: GME trainees have at various levels of their training specific functions and skills they may exercise either independently or with supervision. GME programs must develop criteria to determine the competence and level of independence for each trainee as they advance in the program. See EP3.
☐	☐	Does the organization provide this information to the organized medical staff and hospital staff? Note: for the resident specific roles and responsibilities to be of use, they must be available to hospital staff in the work centers. The method for making this information available is up to the organization.
☐	☐	MS.04.01.01 EP3 The descriptions from EP2 must 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.
☐	☐	MS.04.01.01 EP4 *This EP has a documentation requirement.* The 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, and what entries, if any, must be countersigned by a supervising physician.
☐	☐	MS.04.01.01 EP5 Can the organization demonstrate a mechanism for effective communication between the committee(s) responsible for professional graduate education (which may or may not reside within the organization being surveyed) and the organized medical staff and the governing body of the organization being surveyed? Note: a GME program may reside within the hospital being surveyed and usually has a professional graduate medical education committee (GMEC), or the hospital being surveyed may be an affiliated hospital with a training program residing in another hospital. Affiliated hospitals often have only a coordinator and not a full GMEC, in

The Joint Commission Survey Activity Guide

Credentials File Review Tool



Credentials File Review Tool

Practitioner info				PSV Documents						Peer Recommendations					FPPE	OPPE	Administration	
Practitioner	Specialty	Application Type	Valid Picture ID (File copy not required)	Current License	Relevant Training	Current Competence	NPDB Review	Health Status	CEA Current? (if required by medical staff)	Medical/Clinical Knowledge	Technical/Clinical Skills	Interpersonal Skills	Communication Skills	Professionalism	Was FPPE process used for new applicant or new privileges?	Was OPPE data used for recredentialing decision?	Timeliness of decision and < 2 yr term	Board approval and letter to applicant
Other Medical Staff Standards to Review																		
																	Yes	No
Confirm qualifications of key department leaders—name, license and board certification:																		
Respiratory																		
Radiology																		
Nuclear Medicine																		
Emergency Department																		
Psychiatry (Inpatient)																		
Anesthesia *(Refer to the Medical Staff chapter for relevant standards and EPs.)*																		

Updated: 12.2.20

History of Professional Practice Evaluation

- The American College of Surgeons and medicine itself owe a great deal to the life work of Ernest Amory Codman, MD, FACS, who is known more than anything else for his advocacy of the “End Result Idea.”

- The “Idea” was simply the premise that hospital staffs would follow every patient they treat long enough to determine whether the treatment was successful, then learn from any failures, and how to avoid those situations in the future.

- **In what year did Dr. Codman propose the “End Result Idea?”**

- The process has its roots dating back to the early 20th century when the American College of Surgeons began using case review as a means of defining minimum standard of care requirements for hospitals and their medical staff.

History of Professional Practice Evaluation

In 1952 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American College of Surgeons began requiring physician review at all United States hospitals.

Why Do We Perform Professional Practice Evaluation (PPE)?

Evaluation activities to assess the performance of practitioners who are granted clinical privileges and uses the results of such assessments to improve overall care.

- Accountability
- Improvement of Quality Care and Patient Outcomes
- Non-Punitive and Educational Process

Evaluation and Responsibilities

Who owns PPE?

MS.09.01.01 EP 1 states that the organized medical staff is responsible for assessing clinical practice concerns and must uniformly address reported concerns.

Elements of Professional Practice Evaluation

Ongoing Professional Practice Evaluation (OPPE)

- A continuous evaluation process assessing a provider's clinical performance over time.
- Incorporates a variety of performance metrics, including patient outcomes, peer feedback, and compliance with standards.
- Aims to ensure that competencies are maintained throughout a provider's career.

Case Review Role in OPPE/FPPE:

- Case reviews are essential during OPPE/FPPE, as they provide detailed evaluations of specific cases handled by providers who are newly privileged or under increased scrutiny.
- Establishes objective evaluations to confirm that the provider meets the necessary clinical standards to determine if privileges should continue (OPPE) or be granted as requested (Initial FPPE)

Focused Professional Practice Evaluation (FPPE)

- A targeted evaluation process used for newly granted privileges or when specific concerns arise regarding a provider's performance.
- Involves scrutiny of a provider's clinical performance for a defined period or specific cases.
- Ensures that providers meet established standards before continuing to perform specific procedures or services
- Provides a process by which a practitioner can be reviewed if deficiencies are present

Common Challenges: OPPE/FPPE

- **Lack of Standardization**: Different departments may have varying processes for OPPE and FPPE, leading to inconsistencies in evaluations and assessments across the organization.
- **Insufficient Resources:** Limited staff, time, and financial resources can hinder the implementation and maintenance of effective OPPE and FPPE processes, making it difficult to carry out evaluations thoroughly.
- **Data Collection and Management:** Gathering and analyzing performance data can be cumbersome, particularly if there are no streamlined systems in place for data management, leading to incomplete or inaccurate assessments.
- **Resistance to Change:** Staff and providers may be resistant to new practices or processes associated with OPPE and FPPE, particularly if they perceive them as adding unnecessary burden or complexity to their workload.
- **Inadequate Training**: Healthcare professionals and evaluators may not have received sufficient training on OPPE and FPPE processes, leading to confusion or misunderstanding about how to conduct evaluations effectively.

Common Challenges: OPPE/FPPE

- **Defining Clear Criteria**: Establishing clear, objective criteria and metrics for evaluation can be challenging, especially when attempting to measure performance across diverse clinical areas and specialties.
- **Addressing Deficiencies**: Organizations may struggle with appropriately addressing identified deficiencies in provider performance, lacking effective remediation processes or resources to help providers improve.
- **Integration with Quality Improvement**: Ensuring that OPPE and FPPE processes are effectively integrated into the organization's overall quality improvement initiatives can be difficult, especially if there are silos between departments.
- **Case Review Participation**: Encouraging active participation from peers in the review process may be challenging, especially if there are cultural barriers or concerns about confidentiality and fairness.
- **Accreditation Compliance:** Navigating the requirements for compliance with accreditation bodies (e.g., The Joint Commission) can be overwhelming, particularly for organizations that do not have established OPPE and FPPE frameworks.

Common accreditation findings: OPPE/FPPE

- **Insufficient Documentation**: Lack of thoroughly documented evidence supporting the evaluation of provider competencies, performance, and case review processes. This may include missing or incomplete files related to ongoing evaluations or focused evaluations for new privileges.

- **2. Inconsistent Implementation**: Variability in how OPPE and FPPE are applied across different departments or providers. Accreditation bodies expect standardized processes to ensure fairness and consistency in evaluations.

- 3. **Lack of Defined Criteria**: Absence of clear, measurable criteria for assessing provider performance during the OPPE and FPPE processes. Organizations must establish objective measures that align with quality care standards.

- 4.**Failure to Address Deficiencies**: Identification of performance issues without an appropriate plan or follow-up to address those deficiencies. Organizations should have mechanisms in place for remediation and tracking improvements.

- 5. **Inadequate Frequency of Evaluations**: Inconsistent timing or insufficient frequency of OPPE reviews to assess ongoing competencies, leading to concerns about the currency of provider qualifications and skills.

Common Accreditation Findings: OPPE/FPPE

- **Limited Scope of PPE**: Narrow focus during case review processes, which may overlook critical aspects of provider performance or fail to include a diverse range of input regarding a provider's practice.
- **Failure to Include Multidisciplinary Feedback**: Lack of input from a variety of stakeholders during ev aluations, such as nursing and allied health professionals, which is crucial for a comprehensive assessment of competencies.
- **Ineffective Follow-Up Mechanisms**: Weak processes in place for monitoring providers after remediation plans are implemented following identified competency issues. Continuous evaluation and follow-up are essential.
- **Poor Integration with Quality Improvement**: Difficulty demonstrating how OPPE and FPPE processes are integrated into overall quality improvement initiatives within the organization, linking evaluations directly to patient outcomes.
- **Limited Provider Involvement**: Inadequate engagement of medical staff in the development and implementation of OPPE and FPPE processes, leading to a lack of buy-in and potentially ineffective evaluations.

Documentation Examples by Practice Type

Practice Setting	Information Requested	Impact on Eligibility for Privileges
Active inpatient practice with sufficient quality data at one or more other inpatient institutions	PPE results at "Home site" plus other inpatient institutions and professional references	Independent inpatient privileges within the scope of recent practice
Active ambulatory facility-based practice (e.g., ASC, endoscope suite), but with little or no inpatient activity	PPE results at ambulatory facilities and professional references	Independent inpatient privileges within the scope of recent ambulatory practice/co-management for other requested privileges pending additional data
Active outpatient practice (e.g., physician office or clinic) but with little or no inpatient activity	Professional references	Independent inpatient privileges within the scope of ambulatory practice/co-management or dependent privileges for other requested privileges pending additional data
Active practice not primarily based in the local community, but which provides necessary clinical services (telemedicine)	PPE results from originating site that are distant site specific	Privileges within the scope of recent practice/co-management
Restricted inpatient practice at all institutions (e.g., orthopedist requesting only hand privileges or physicians reducing their workload and intensity of practice)	PPE results at all sites and other inpatient institutions and/or professional references	Independent inpatient privileges with the scope of recent practice/co-management or dependent privileges for other requested privileges pending additional data
Little or no recent clinical practice due to time off and who wish to return to practice (e.g., and OB/GYN returning to practice after taking several years to raise children)	Professional references from previous practice settings. Treated the same as new privileges FPPE, scope and time dependent on time away from practice	Co-management or dependent privileges for all privileges pending additional data
Clinically inactive practitioners who only seek to continue their affiliation as a member of the medical staff	N/A	Ineligible for privileges

General Readiness

- **Room**
  - Is the room comfortable?
  - Is water available?
  - Is there good internet access?

- **Who will attend?**
  - **Appropriate Personnel**
    - MSPs responsible for all aspects of record keeping
    - Education Representative if that is where ACLS, etc. records are house
    - HR Representative if that is where required vaccinations, etc. are held
    - Medical Staff Leadership and medical staff who can speak to OPPE
    - PLAN B: Who will cover for each individual if they are unable to attend?

Practice!
Practice!
Practice!

- **Regularly perform file audits using a file audit tool that includes the commonly reviewed elements of the provider file.**
  - "Clean Files" List
  - Not necessary to "scrub" all files when surveyor is on site.
  - Useful if surveyors ask for an individual in a specialty instead of a specific name.

“They’re Here!”

- **Tracers**
  - **Scribe Conferences**
    - Ideally, a member of MSO staff meets with each scribe at lunch and at end of day to obtain LIP names
    - Pull these files and review with audit tool
    - If items are missing, obtain them if possible
    - If items unable to be obtained, BE HONEST! It is better to have a finding for a missing item than a finding for falsification.
  - **If intermittent conferences are not possible, then ask to meet with the surveyor the afternoon before your session**

Take Aways Post Survey

- A finding can be your friend!
  - For example, if you have been asking for resources to more fully implement OPPE, a finding should lead to those resources being available.
- In the case of a serious finding (lack of license or multiple providers practicing without appropriate privileges), leadership will become involved.
- Work the problem to resolve the issue and be in compliance.
- Then, do a deeper dive into the issue, obtain resources as noted above, and correct the root cause so it doesn't happen again.

KEEP CALM & DON'T FEAR THE FINDING!

Thank You!

PDFs of Medical Staff Session and Review Guides

Medical Staff Credentialing and Privileging

Organization Participants
Suggested participants include the President of the medical staff; Medical Director and Medical Staff Coordinator, if applicable; and medical staff credentials committee representatives.

Logistical Needs
The suggested duration of this session is approximately 60 minutes. The surveyor requests specific credential files of physicians and other licensed practitioners who are identified from traces, from OR log, from the ICU and special procedures unit logs, etc. The type of files a surveyor requests are from high-risk specialties, non-physician specialties, non-physician licensed practitioners, moonlighters, hospitalists, practice outside the usual scope of specialty, and low volume specialties. When a Nursing Care Center is integrated with the hospital, the surveyor reviews credential files of the Medical Director of the NCC and other physicians and licensed practitioners.

The surveyor also requests the Medical Staff Bylaws, Rules, and Regulations, Medical Executive Committee minutes, peer review and focused monitoring records for the session.

Objectives
The surveyor will:
- Learn about the process used to collect data relevant to appointment decisions, the process for granting and delineating privileges, and the structures that guide consistency of implementation (e.g., bylaw requirements)
- Evaluate the credentialing and privileging process for the medical staff and other physicians and licensed practitioners who are privileged through the medical staff process

Overview
During this session, the surveyor discusses with organization participants:
- How your organization collects data used in making decisions on appointment, granting and delineating privileges
- Consistent implementation of the credentialing and privileging process for the medical staff and other licensed practitioners who are privileged through the medical staff process
- Processes for granting privileges and the delineation of privileges
- Whether physicians and other licensed practitioners practice within the limited scope of delineated privileges
- The link between peer review and focused monitoring to the credentialing and privileging process
- Potential concerns in the credentialing, privileging, and appointment process
- Education on antibiotic resistance and antibiotic stewardship (Note: surveyors will not review medical staff records related to antibiotic stewardship)

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Medical Staff-Related Standards Compliance Evaluation Guides

The material presented in this section is representative of what surveyors use when they are evaluating compliance with the Medical Staff-related standards in the Hospital accreditation program. Organizations may find these tools useful to continuous compliance and survey readiness efforts.

1. Medical Staff Bylaws Review Guide
2. Medical Staff and Related Standards Compliance Evaluation Guide
3. Professional Graduate Medical Education Program Standard Compliance Evaluation Guide
4. Credentials File Review Tool

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Please reach out with additional questions:

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