

**Joint Commission on Accreditation of Healthcare Organizations  
Hospital – 2007 Medical Staff Standards**

## **Medical Staff**

### **Overview**

~~The organized medical staff has a critical role in the process of providing oversight of quality of care, treatment, and services. The organized medical staff is a self governing body that is charged with overseeing the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process. The organized medical staff must credential and privilege all licensed independent practitioners. Physician assistants (PAs) and advanced practice registered nurses (APRNs) who are not licensed independent practitioners may be privileged through the medical staff process or a process that has been developed and approved by the organization that is equivalent to the process and criteria set forth in the credentialing and privileging standards contained in this chapter. When medical staff processes are not used, there are mechanisms to assure communication with and input from the Medical Staff Executive Committee regarding those privileges.~~

~~The self governing, organized medical staff must create and maintain a set of bylaws that defines its role within the context of a hospital setting and clearly delineates its 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 organized medical staff also provides leadership in performance improvement activities within the organization. The tasks of the medical staff are numerous and require a dedicated and organized leadership to adequately perform their duties. Evaluating the competency of privileged practitioners and delineating the scope of privileges of privileged practitioners are key areas of responsibility for the organized medical staff.~~

~~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. The Joint Commission does not dictate who is eligible for medical staff membership at accredited hospitals. 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.~~

~~The Joint Commission does not determine if a practitioner is a licensed independent practitioner. State law and organization policy determine whether a practitioner can practice independently. 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."~~

~~Practitioners who are responsible for the oversight of health care delivered by all medical staff practitioners must be licensed independent practitioners. The organized medical staff develops and uses criteria to determine which licensed independent practitioners are eligible to participate in the oversight process.~~

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<sup>1</sup> 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 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 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.

---

<sup>1</sup> 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.”

## **Standards, Rationales, Elements of Performance, and Scoring**

### **Organized Medical Staff<sup>2</sup> 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<sup>3</sup>.

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
- 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

---

<sup>2</sup> 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.

<sup>3</sup> The organized medical staff role and responsibility as a component of hospital leadership is further defined in the Leadership Chapter.

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)*

### **Standard MS.1.10**

The hospital has an organized, self-governing medical staff that provides oversight of care, treatment, and services provided by practitioners with privileges, provides for a uniform quality of patient care, treatment, and services, and reports to and is accountable to the governing body.

#### **Elements of Performance for MS.1.10**

**A 1.** The organized medical staff is self governing, as referenced in the bullets defining self-governance on page MS-000.

**A 2.** There is a single, organized medical staff, unless the requirements for an exception to the single medical staff rule exist.

**A 3.** When more than one medical staff exists, the guiding principles for medical staffs are addressed by the structure of the multiple medical staffs.

**B 4.** The organized medical staff provides a mechanism to create a uniform standard of quality patient care, treatment, and services.

**A 5.** The organized medical staff is accountable to the governing body for the quality of the medical care, treatment, and services provided to patients.

**A 6.** The medical staff is organized in a manner approved by the governing body.

### **Standard MS.1.20**

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

## **Rationale for MS.1.20**

The organized medical staff and governing body must work collaboratively, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. The organized medical staff creates a written set of documents that describes the organizational structure of the medical staff and the rules for self governance. These documents are called medical staff bylaws. The medical staff bylaws create a system of rights and responsibilities between the organized medical staff and the governing body, and between the organized medical staff and its members. As required by and pursuant to the medical staff bylaws, the organized medical staff may create additional governance documents such as policies, procedures, protocols, rules, and regulations, but the requirements listed below must be retained in the medical staff bylaws.

## **Elements of Performance for MS.1.20**

**A** 1. The organized medical staff develops medical staff bylaws.

**A** 2. The medical staff bylaws are adopted and amended by the medical staff.

**A** 3. The governing body approves and complies with the medical staff bylaws.

**B** 4. The organized medical staff enforces and complies with the medical staff bylaws.

**A** 5. The medical staff bylaws, rules and regulations, and policies and the governing body bylaws do not conflict.

**A** 6. The medical staff bylaws include the following: The definition of the medical staff structure.

**A** 7. The medical staff bylaws include the following: The definition of the criteria and qualifications for appointment to the medical staff.

**B** 8. The medical staff bylaws include the following: When departments of the organized medical staff exist, the definition of the qualifications and roles and responsibilities of the department chair, including the following:

### *Qualifications*

- Certification by an appropriate specialty board or affirmatively established comparable competence 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
- The integration of the department or service into the primary functions of the organization
- The coordination and integration of interdepartmental and intradepartmental services
- The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
- The 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
- The continuous assessment and improvement of the quality of care, treatment, and services
- The maintenance of quality control programs, as appropriate
- The orientation and continuing education of all persons in the department or service
- Recommending space and other resources needed by the department or service

### **Medical Staff Executive Committee**

**A 9.** The medical staff bylaws must also include the following: A description of the medical staff executive committee's function, size, and composition, and of the methods for selecting and removing its members and the organized medical staff officers.

**B 10.** The medical staff bylaws must also include the following: That the medical staff executive committee includes physicians and may include other licensed independent practitioners.

**A 11.** The medical staff bylaws must also include the following: That the medical staff executive committee is empowered to act for the organized medical staff between meetings of the organized medical staff.

### **Corrective Actions**

**B 12.** The medical staff bylaws must also include the following: A description of indications for automatic suspension or summary suspension of a practitioner's medical staff membership or clinical privileges.

**B 13.** The medical staff bylaws must also include the following: A description of when automatic suspension or summary suspension procedures are implemented.

**B 14.** The medical staff bylaws must also include the following: A description of the mechanism to recommend medical staff membership and/or terminations, suspensions, or reduction in privileges.

### **Fair Hearing**

**B** 15. The medical staff bylaws must also include the following: A description of the mechanism for a fair hearing and appeal process.

### **Credentialing, Privileging, and Appointment**

**B** 16. The medical staff bylaws must also include the following: A description of the credentialing process

**B** 17. The medical staff bylaws must also include the following: A description of the privileging process (including temporary and disaster privileging)

**B** 18. The medical staff bylaws must also include the following: A description of the process of appointment to membership of the medical staff

### **Related medical staff governance documents**

**B** 19. When administrative procedures, associated with processes described in the medical staff bylaws for corrective actions, fair hearing and appeal, credentialing, privileging, and appointment (Elements of Performance 12 – 18), are described in medical staff governance documents that supplement the bylaws (i.e., rules and regulations, and policies):

- The mechanism for the approval of the administrative procedures, which may be different from that for adoption and amendment of the medical staff bylaws, is described in the medical staff bylaws,
- Criteria to identify those administrative procedures that can be in the supplementary documents are described in the bylaws, and
- The administrative procedures are approved by both the medical staff and the governing body through the bylaws-described mechanism.

**Note:** This element of performance is not effective at this time

### **Standard MS.1.30**

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

### **Rationale for MS.1.30**

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.1.30**

**A** 1. The medical staff bylaws, rules, and regulations are not unilaterally amended.

### **Medical Staff Executive Committee**

### **Standard MS.1.40**

There is a medical staff executive committee.

## **Rationale for MS.1.40**

The organized medical staff delegates authority in accordance with law and regulation to the medical staff executive committee<sup>4</sup> 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.

## **Elements of Performance for MS.1.40**

**A 1.** The structure and function of the medical staff executive committee conforms to the medical staff bylaws.

**A 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.

**A 3.** All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.

**A 4.** The majority of voting medical staff executive committee members are fully licensed physicians actively practicing in the hospital.

**(M) C 5.** The medical staff executive committee acts on behalf of the organized medical staff between medical staff meetings.

**A 6.** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on at least the following: Medical staff membership

**B 7.** The medical staff executive committee has a mechanism to recommend medical staff membership termination.

**B 8.** 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.

**A 9.** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on at least the following: The organized medical staff's structure

---

<sup>4</sup> 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.

**B 10.** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on at least the following: The process used to review credentials and delineate privileges

**A 11.** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on at least the following: The delineation of privileges for each practitioner privileged through the medical staff process

**B 12.** The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on at least the following: The executive committee reviews and acts on reports of medical staff committees, departments, and other assigned activity groups

### **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.2.10**

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.2.10**

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.2.10**

#### **Oversight Domains**

**B 1.** Licensed independent practitioner members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.

**B 2.** ~~The organized medical staff has a mechanism to ensure that patients receive appropriate care, treatment, and services from a licensed independent practitioner who has been credentialed through the medical staff process during the entire length of stay with the organization.~~

Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

**B** 3. Licensed independent practitioners are responsible for the oversight activities of the organized medical staff.

**B** 4. The organized medical staff through its designated mechanisms provides leadership in activities related to patient safety

**B** 5. The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.

#### **Medical History and Physical Examinations**

**A** 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.

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

**A** 8. The organized medical staff requires that a practitioner who has been granted privileges by the organization to do so performs a patient's medical history and physical examination and required updates.

**A** 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 physician who is accountable for the patient's medical history and physical examination.

**A** 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.

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

#### **Standard MS.2.20**

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

#### **Rationale for MS.2.20**

Quality of care, treatment, and services is dependent upon coordination and communication of the plan of care and 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 is 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.2.20**

**B 1.** Licensed independent practitioners with appropriate privileges manage and coordinate a patient's care, treatment, and services.

**A 2.** A patient's general medical condition is managed and coordinated by a physician.

**A 3.** The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a physician or other licensed independent practitioner is required ~~and consultation is obtained as required~~.

**A 4. Consultation is obtained for the circumstances defined by the organized medical staff.**

**(M) C 5.** There is ~~communication coordination of the care, treatment, and services~~ among ~~all the~~ practitioners involved in a patient's care, treatment, and services.

### **Graduate Education Programs**

#### **Standard MS.2.30**

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.2.30**

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.2.30**

**B 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.

**A 2.** Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate educational programs are provided to the organized medical staff and hospital staff.

**A 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.

**B 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.

**B 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.

**B 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)<sup>5</sup> 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.

**B 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.

**A 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 organization.

**(M) C 9.** Medical staff demonstrates compliance with residency review committee citations.

**Note:** *Graduate medical education programs accredited by the Accreditation Counsel 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 organization should be able to demonstrate compliance with any residency review committee citations related to this standard.*

---

<sup>5</sup> The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.

## **Performance Improvement**

### **Standard MS.3.10**

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

### **Rationale for MS.3.10**

Relevant information developed from the following processes is integrated into performance improvement initiatives and consistent with hospital preservation of confidentiality and privilege of information.

### **Elements of Performance for MS.3.10**

**B** 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.

**B** 2. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Medical assessment and treatment of patients

**B** 3. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process

**B** 4. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of medications (standard PI.1.10)

**B** 5. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Use of blood and blood components (standard PI.1.10)

**B** 6. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Operative and other procedure(s) (standard PI.1.10)

**B** 7. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Appropriateness of clinical practice patterns

**B** 8. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Significant departures from established patterns of clinical practice

**B** 9. The medical staff is actively involved in the measurement, assessment, and improvement of the following: The use of developed criteria for autopsies (standard PI.1.10)

**B** 10. Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following: Sentinel event data

**B** 11. Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following: Patient safety data (standard LD.4.40)

**Standard MS.3.20**

The organized medical staff participates in organization wide the measurement, assessment, and performance improvement activities of other processes.

**Elements of Performance for MS.3.20**

**B** 1. The organized medical staff participates in the following activities: Education of patients and families

**B** 2. The organized medical staff participates in the following activities: Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient

**B** 3. The organized medical staff participates in the following activities: Accurate, timely, and legible completion of patient's medical records (standard IM.6.10)

**B** 4. The organized medical staff participates in the following activities: 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

**B** 5. The organized medical staff participates in the following activities: Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body

**Credentialing, Privileging, and Appointment**

~~The credentialing process includes a series of activities designed to collect relevant data that serve as the basis for decisions regarding appointment to membership on the medical staff, as well as privileges recommended and delineation of privileges recommended by the organized medical staff. Credentialing is the first step in the process that leads to privileging and that may lead to appointment to membership on the medical staff, if requested by the applicant.~~

~~The typical credentialing process includes processing applications, verifying credentials, evaluating applicant-specific information, and making recommendations to the governing body for appointment and privileges. The required information should include data on qualifications such as licensure and training or experience.~~

~~Although much of the specific information used to make decisions about privileges and appointment to membership is at the discretion of the organized medical staff, the range of information used should be explicit. The governance documents specify professional criteria for medical staff membership and clinical privileges. These criteria are designed to help establish an applicant's background, current competence, and physical and mental ability to discharge patient~~

~~care responsibilities. Moreover, they are designed to help assure the medical staff and governing body that patients will receive quality care, treatment, and services.~~

~~The organized medical staff is also responsible for planning and implementing a privileging process. At the organization's discretion, the criteria for granting initial privileges and renewing privileges may differ. The privileging process typically entails developing and approving a procedures list, processing the application, evaluating applicant specific information and making recommendations to the governing body for applicant specific delineated privileges, notifying the applicant and relevant personnel, and monitoring the use of privileges and quality of care issues. The required information should include data on the individual practitioner's performance that are collected and assessed on an ongoing basis.~~

~~Appointment refers to the process whereby an individual is selected as a member of the organized medical staff. The processes for credentialing for appointment to membership of the medical staff and delineating privileges are essentially identical. The organized medical staff defines the criteria for categories of medical staff membership. The categories and criteria include a category of membership that is responsible for the oversight of care, treatment, and services and requires the members in that category to have the requisite skills for oversight. Applicants for membership may receive appointment to membership without receiving privileges; applicants for privileges need not necessarily be members of the medical staff.~~

## **Credentialing Applications**

### **Standard MS.4.10**

~~The organized medical staff has a credentialing process that is defined in the medical staff bylaws.~~

### **Rationale for MS.4.10**

~~Credentials review is the process of obtaining, verifying, and assessing the qualifications of an applicant to provide patient care, treatment, and services in or for a health care organization. The credentials review process is the basis for making appointments to membership of the medical staff; it also provides information for granting clinical privileges to licensed independent practitioners and other practitioners credentialed and privileged through the hospital's medical staff process. The purpose of verifying credentials data is to ensure the following:~~

- ~~The individual requesting privileges is in fact the same individual that is identified in the credentialing documents~~
- ~~The applicant has attained the credentials as stated~~
- ~~The credentials are current~~
- ~~There are no challenges to any of the credentials~~

**Note:** *Acceptable documentation for credentialing criteria includes the following:*

- ~~Current licensure. The medical staff verifies and documents current licensure for all practitioners. Licensure is verified with the primary source at the time of appointment to membership and initial granting of clinical privileges, reappointment, and at renewal of clinical privileges and at the time of expiration by a letter or secure electronic communication obtained from the appropriate state licensing board or from any state~~

~~licensing board if in a federal service. Verification of current licensure through the primary source via a secure electronic communication or by telephone is acceptable, if this verification is documented. Physician assistants in federal service use criteria established by federal standards.~~

- ~~Relevant training or experience. At the time of appointment to membership and initial granting of clinical privileges, the hospital obtains verification of relevant training or experience from the primary source(s), whenever feasible. The primary source is the original source of the specific credential that can be used to verify the accuracy of a credential reported by the practitioner. Primary sources include, for example, the specialty certifying boards approved by the American Dental Association for a dentist's board certification, and letters from professional schools (for example, medical, dental and podiatric) and from residency or postdoctoral programs for completion of training. Information from credentials verification organizations (CVOs) may be used. Verification of relevant training and experience may be obtained by contacting the primary source via a secure electronic communication or telephone, if this verification is documented. Relevant training or experience is defined by the specific circumstances of the applicant, requiring that the hospital believes there is sufficient information on which to base a reasoned decision. Relevant training and experience may vary among specialties.~~
  - ~~Current competence. Current competence at the time of appointment to membership and initial granting of clinical privileges is verified in writing by peers knowledgeable about the applicant's professional performance. The hospital has obtained information directly from the primary source(s) in the form of written documentation from authoritative sources, which contain informed opinions on each applicant's scope and level of performance. Such primary source verification may be obtained through a secure electronic communication or by phone contact with the primary source. Written documentation that describes the applicant's actual clinical performance in general terms, the satisfactory discharge of his or her professional obligations as a medical staff member, and his or her ethical performance are acceptable. However, ideally the documentation also addresses at least the following two specific aspects of current competence:~~
1. ~~For applicants in fields performing operative and other procedure(s), the types of operative procedures performed as the surgeon of record; the handling of complicated deliveries; or the skill demonstrated in performing invasive procedures, including information on appropriateness and outcomes. In the case of applicants in nonsurgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician should be addressed.~~
  2. ~~The applicant's clinical judgment and technical skills.~~

~~It may not always be feasible to obtain information from the primary source. In rare or occasional instances, a primary source, such as an educational institution or a hospital, no longer exists, or the applicant's records have been lost or destroyed. Applicants may have received education, training, and experience partially or wholly in a foreign country, and for political or other reasons, information regarding their professional background is not accessible. However, when undue delay occurs in deriving information from a primary source, medical staff appointment is withheld pending receipt of this information. Under these~~

~~circumstances, the applicant may be given temporary privileges for a limited time in accordance with applicable medical staff bylaws, rules and regulations, and policies, as well as state and federal regulations. Reliable secondary sources may also be used if there has been a documented attempt to contact the primary source.~~

~~Designated equivalent sources are selected agencies that have been determined to maintain a specific item(s) of credential information that is identical to the information at the primary source. These sources may be used to verify the specific issues of credential information in lieu of using the primary source. These designated equivalent sources are the following:~~

- ~~The American Medical Association (AMA) Physician Masterfile for verification of a physician's medical school graduation and residency completion~~
- ~~The American Board of Medical Specialties (ABMS) for verification of a physician's board certification~~
- ~~The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school~~
- ~~The American Osteopathic Association (AOA) Physician Database for predoctoral education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; and Osteopathic Specialty Board Certification~~
- ~~The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license~~

~~These designated equivalent sources may be used by a hospital, a network, the network's components, or a CVO that is used by the hospital, network, or its components. Other designated equivalent sources may exist for certain applicants, such as for licensure verification of an applicant in the federal service. The physician profiles from the AMA Physician Masterfile also include other primary source reported information that is similar to primary source verified information provided by a CVO. Use of this additional information is subject to the guidelines set forth on page MS-00.~~

~~Verification of data from the primary source: Any hospital that bases its decisions in part on information from a CVO should have confidence in the completeness, accuracy, and timeliness of that information. To achieve this level of confidence in the information, the hospital should evaluate the agency providing the information initially and then periodically as appropriate. The principles that guide such an evaluation include the following:~~

- ~~The agency makes known to the user what data and information it can provide.~~
- ~~The agency provides documentation to the user describing how its data collection, information and development, and verification process(es) are performed.~~
- ~~The user is provided with sufficient, clear information on database functions. This information includes any limitations on information available from the agency (for example, practitioners not included in the database); the time frame for agency responses to requests for information; and a summary overview of quality control processes relating to data integrity, security, transmission accuracy, and technical specifications.~~

- ~~The user and agency agree on the format for transmission of an individual's credentials information from the agency.~~
- ~~The user can easily discern which information, transmitted by the agency, is from a primary source and which is not.~~
- ~~When the agency transmits information that can become out of date, it provides the date on which the information was last updated from the primary source.~~
- ~~The agency certifies that the information transmitted to the user accurately presents the information obtained by it.~~
- ~~The user can discern whether the information transmitted by the agency from a primary source is all the primary source information in the agency's possession pertinent to a given item and, if not, where additional information can be obtained.~~
- ~~When necessary, the user can engage the agency's quality control processes to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.~~
- ~~The user has a formal arrangement with the CVO for communication of any changes in credentialing information.~~

~~There may be circumstances when it is impossible to obtain data from the primary source. In these circumstances the hospital may rely on a secondary source if the secondary source obtained the information from the primary source and the hospital believes the information to be credible and accurate.~~

~~A primary source of verified information may designate to an agency the role of communicating credentials information. The delegated agency then becomes acceptable to be used as a primary source.~~

#### **~~Elements of Performance for MS.4.10~~**

~~B-1. There are credentialing processes (see standard MS.1.20) that are designed to ensure that patients receive care, treatment, and services from qualified providers.~~

~~B-2. The credentialing process follows the steps outlined in the medical staff bylaws or other documents as previously approved by the governing body.~~

~~A-3. The credentialing process includes a mechanism to ensure that the individual requesting approval is the same individual identified in the credentialing documents.~~

~~A-4. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible or from a CVO (see note in standard MS.4.10, page MS-00) the following information:~~

- ~~The applicant's current licensure, at time of granting and renewal of privileges and at the time of expiration~~
- ~~The applicant's specific relevant training~~
- ~~The applicant's current competence~~

## **Initial Granting, Renewal, and Revision of Privileges**

### **Standard MS.4.20**

~~There is a process for granting, renewing, or revising setting specific clinical privileges.~~

### **Rationale for MS.4.20**

~~Essential information needs to be gathered in the process of granting, renewing, or revising clinical privileges. The information will dictate the type(s) of care, treatment, and services or procedures that a practitioner will be authorized to perform. Privileges are setting specific because they require consideration of setting characteristics, such as adequate facilities, equipment, number, and type of qualified support personnel and resources. Setting specific decisions mean that privileges granted to an applicant are based not only on the applicant's qualifications, but also on consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting. All licensed independent practitioners are privileged through the medical staff process.~~

~~**Note 1:** Ability to perform privileges requested. 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 their ability to practice should be confirmed. Initial applicants may have his or her health status confirmed by the director of a training program, the chief of services or chief of staff at another hospital at which the applicant holds privileges, or a currently licensed physician 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.~~

~~**Note 2:** The Americans with Disabilities Act (ADA) bars certain discrimination based on physical or mental impairment. Toward preventing such discrimination, the act prohibits or mandates various activities.~~

~~Hospitals need to determine the applicability of the ADA to their medical staff. If applicable, the hospital should examine its privileging or credentialing procedures as to how and when it ascertains and confirms an applicant's ability to perform the privileges requested.~~

~~The Joint Commission cannot provide legal advice to hospitals. However, the Joint Commission has and will absolutely construe standard MS.4.20 in such a manner as not to be inconsistent with hospital efforts to comply with the ADA.~~

### **Elements of Performance for MS.4.20**

~~A1. There is a mechanism for granting and renewing clinical privileges.~~

~~A2. There is a mechanism for revising clinical privileges.~~

~~B3. Criteria are developed that determine an applicant's ability to provide patient care, treatment, and services within the scope of privileges requested.~~

- ~~• The criteria include evidence of current competence.~~
- ~~• The criteria include peer recommendations when required.~~

~~A4. Setting specific privileges are granted, renewed, or revised and do not exceed a period of two years.~~

~~A5. The governing body or delegated committee has final authority for granting, renewing, revising, or denying privileges.~~

~~B6. Before granting privileges, the organized medical staff 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 are compared to aggregate data, when available~~
- ~~• Performance Measurement Data including morbidity and mortality data, when available~~

~~(M) C 7. Each reappraisal includes information concerning professional performance, including clinical and technical skills and information from organization performance improvement activities, when such data are available.~~

~~(M) C 8. When department chairpersons exist, the chairperson participates in the evaluation of practitioners practicing within the department.~~

~~A9. The process for privileges includes the following: A clearly defined mechanism for the processing of applications for initial, renewal, or revisions of clinical privileges.~~

~~A10. The process for privileges includes the following: An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.~~

~~A11. The process for privileges includes the following: If the organization uses a provisional period of initial appointment to membership, a description is included.~~

~~(M) C 12. The process for privileges includes the following: Completed applications for privileges are acted on within the time period specified in the bylaws.~~

~~(M) C 13. The process for privileges includes the following: Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.~~

~~(M) C 14. The process for privileges includes the following: Decisions on membership and granting of privileges must consider criteria that are directly related to the quality of health care, treatment, and services. 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.~~

~~A 15. The process for privileges includes the following: The hospital queries the National Practitioner Data Bank (NPDB) at the time of initial medical staff appointments to membership and initial granting of clinical privileges, and at the time of expanding privileges or requesting to add new privileges, as well as at least every two years thereafter for information on physicians, dentists, and other health care practitioners granted clinical privileges.~~

### 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<sup>6</sup>.

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.<sup>7</sup> The areas of general competencies include the following:

- Patient Care

---

<sup>6</sup>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, restricting, and revoking privileges rests with the governing body. The range of information collected to make such decisions is clearly defined in governance documents.

<sup>7</sup> 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.

- 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 expand to 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 practitioners 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 revised process outlined in these revised 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.

### **Determination of Organizational Resource Availability**

#### **Standard MS.4.00**

Prior to granting of 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.4.00**

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.4.00**

B 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.

**B 2. The organization consistently determines the resources needed for each requested privilege.**

**Credentialing**

**Introduction**

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 residency or postdoctoral programs for completion of training. Information from credentials verification organizations (CVOs) may also be used. When it is not possible to obtain information from the primary source, reliable secondary sources<sup>8</sup> may be used if there has been a documented attempt to contact the primary source.

Designated equivalent sources include but are not limited to the following:

- The American Medical Association (AMA) Physician Masterfile for verification of a physician's United States and Puerto Rican medical school graduation and residency completion
- The American Board of Medical Specialties (ABMS) for verification of a physician's board certification
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license

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"

---

<sup>8</sup> A reliable secondary source can be another hospital that has documented primary source verification of the applicant's credentials.

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<sup>9</sup> 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.

### **Standard MS.4.10**

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

---

<sup>9</sup> The Joint Commission considers diversity to include race, culture, gender, religion, ethnic background, sexual preference, language, mental capacity and physical disability.

### **Rationale for MS.4.10**

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.4.10**

A 1. The hospital credentials applicants using a clearly defined process.

A 2. The credentialing process is based on recommendations by the organized medical staff

A 3. The credentialing process is approved by the governing body.

A 4. The credentialing process is outlined in the medical staff bylaws (*see also Standard MS.1.20*)

A 5. The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing any of the following:

- A current picture hospital ID card
- A valid picture ID issued by a state or federal agency (e.g., drivers license or passport)

A 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 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

## **Privileging**

### **Introduction**

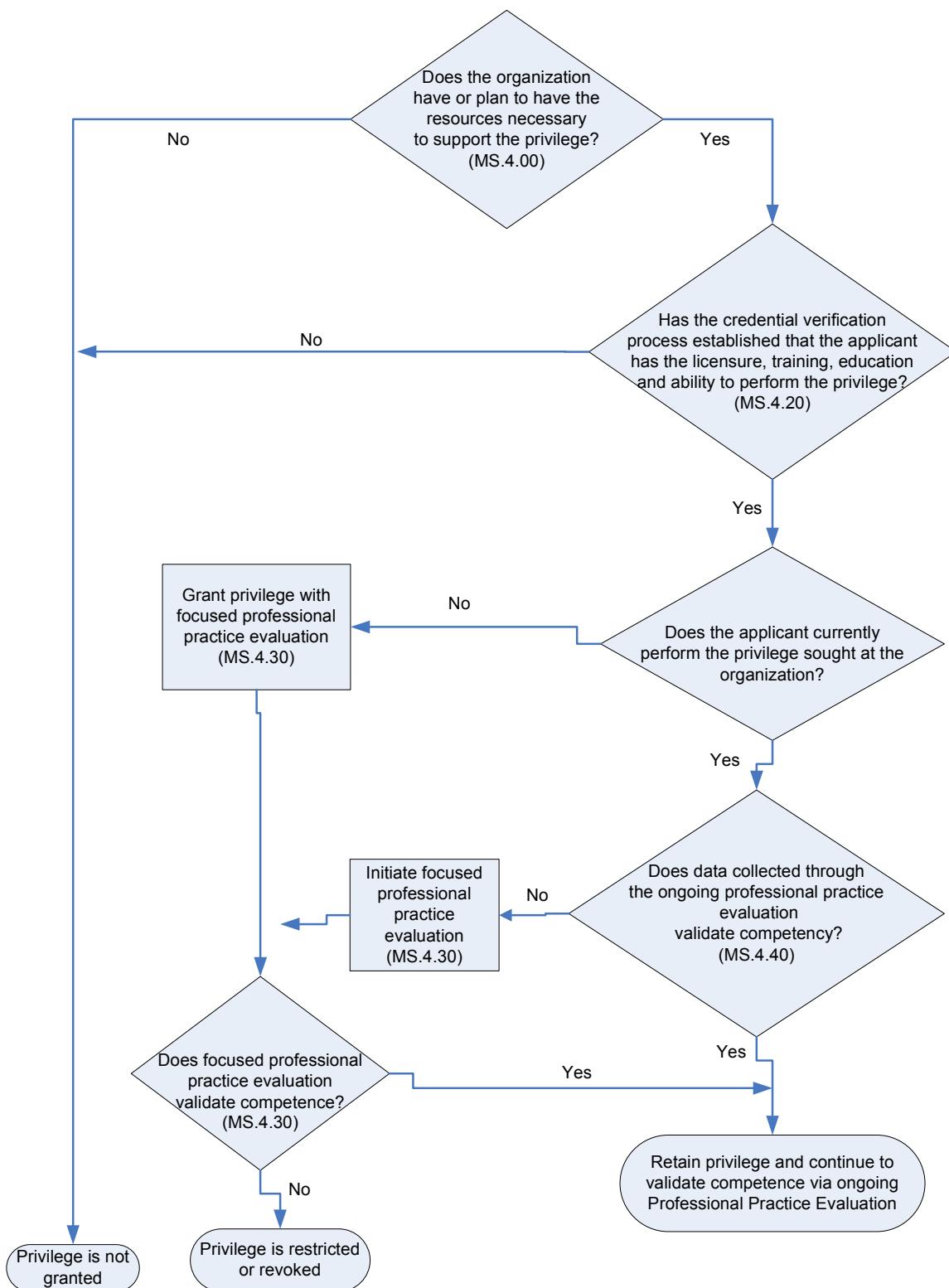
The organized medical staff is responsible for planning and implementing a privileging process. This process typically entails the following:

- 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 an practitioner with a record of competent professional performance at the organization (for example, a practitioner seeking additional privilege(s)) should include information from the practitioner's professional practice evaluation data that 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.

## Process for Privileging and Re-privileging



### **Standard MS.4.15**

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

#### **Elements of Performance for MS.4.15**

**B 1.** 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 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<sup>10</sup>.
- 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 organization.

**B 2.** Each of the criteria used are consistently evaluated for all practitioners holding that privilege.

**A 3.** The process for granting privilege(s) includes the following: The hospital has a clearly defined procedure approved by the organized medical staff for the processing of applications for the granting, renewal, or revision of clinical privileges.

**A 4.** The process for granting privilege(s) includes the following: An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.

***Note: Ability to perform privileges requested.*** 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 their ability to practice should be confirmed. Initial applicants may have his or her health status confirmed by the director of a training program, the chief of services or chief of staff at another hospital at which the applicant holds privileges, or a currently licensed physician approved by the organized medical staff.

*In instances where there is doubt about an applicant's ability to perform privileges requested, an*

---

<sup>10</sup> 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.

evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.

A 5. 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.

A 6. Peer recommendation includes written information regarding the practitioner's current:

- Medical/Clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

B 7. 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

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.

A 8. 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.

(M) C 9. Completed applications for privileges are acted on within the time period specified in the medical staff bylaws.

(M) C 10. Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made.

### Analysis and use of information received

#### Standard MS.4.20

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.4.20**

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

B 2. The organization, 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.

(M) C 3. The organization completes the credentialing and privileging decision process in a timely manner.

A 4. The organization's privilege granting /denial criteria are consistently applied for each requesting practitioner.

(M) C 5. Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.

(M) C 6. 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.

A 7. The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. (See Standard MS.1.20)

A 8. Privileges are granted for a period not to exceed two years.

**Privilege Decision Notification**

**Standard MS.4.25**

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.4.25**

A 1. Requesting practitioners are notified regarding the granting decision.

A 2. In the case of privilege denial, the applicant is informed of the reason for denial.

B 3. The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and/or external persons or entities, as defined by the organization and applicable law.

**B 4. The organization 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 as described in MS.4.50.**

## **Focused Professional Practice Evaluation**

### **Introduction**

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.4.30**

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

### **Rationale for MS.4.30**

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 (e.g., 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.4.30**

**B 1. A period of focused professional practice evaluation is implemented for all initially requested privileges. (Effective January 1, 2008)**

**A 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.**

**A 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

**B 4. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.**

**A 5. The triggers<sup>11</sup> that indicate the need for performance monitoring are clearly defined.**

**B 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.<sup>12</sup>**

**A 7. Criteria are developed that determine the type of monitoring to be conducted.**

**A 8. The measures employed to resolve performance issues are clearly defined.**

**B 9. The measures employed to resolve performance issues are consistently implemented**

## **Expedited Credentialing and Privileging Process**

### **Standard MS.4.35**

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

### **Elements of Performance for MS.4.35**

**B 1. The organized medical staff develops criteria for an expedited process for granting privileges.<sup>13</sup>**

---

<sup>11</sup> Triggers can be single incidents or evidence of a clinical practice trend

<sup>12</sup> Other existing privileges in good standing should not be affected by this decision

<sup>13</sup> 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.

**C 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

**(M) C 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

**(M) C 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 organization

**(M) C 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

Or

**(M) C 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

**(M) C 7.** The organized medical staff uses the criteria developed for the expedited process when recommending privileges.

### **Ongoing Professional Practice Evaluation (Maintaining Privileges)**

#### **Introduction**

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)<sup>14</sup> performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures;

---

<sup>14</sup> **Operative and other clinical procedures** Includes 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.

- 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, 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: Privileged practitioners have access to the medical staff fair hearing and appeal process should the intervention result in corrective action. (See Standard MS.4.50)

#### **Standard MS.4.40**

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.4.40**

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

A 1. There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice

B 2. The type of data to be collected is determined by individual departments and approved by the organized medical staff.

B 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.4.45**

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

**Rationale for 4.45**

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.4.45**

A 1. The organization, 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 Standard RI.1.120 regarding complaints received from patients and families)

B 2. Reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed, as defined by the organization and applicable law.

**Renewal or Reappraisal Process for Privileging**

**Standard MS.4.40**

At the time of renewal of privileges, the organized medical staff evaluates individuals for their continued ability to provide quality care, treatment, and services for the privileges requested as defined in the medical staff bylaws.

**Rationale for MS.4.40**

The process for renewal of privileges involves the same steps as those outlined under standard MS.4.20 for granting initial privileges and additionally requires the medical staff to evaluate a practitioner's ability to perform the privileges requested based upon his or her performance during the period of time he or she has been practicing at the organization. An organization reviews the performance of each practitioner for every setting, under the control of the hospital, where the individual practices. Current competence is determined by the results of performance improvement activities and peer recommendations.

Evidence of current ability to perform privileges requested is required of all applicants for renewal of clinical privileges. The process should emphasize the organization's performance improvement philosophy. The process should identify quality of care, treatment, and services issues for groups of individuals as well as individual practitioners (see also the "Improving Organization Performance" chapter in this manual.)

In evaluating the ability to perform requested privileges and when renewing or revising privileges, criteria could include procedures performed and their outcomes and could be based on

~~pertinent results of review of operative procedures and other procedure(s),<sup>15</sup> medication usage, blood usage, medical records, and other performance improvement activities, as appropriate. Additional criteria may be based on mortality rates, utilization management, meeting and committee attendance, and risk management data. Relevant information developed from these activities is integrated into performance improvement initiatives consistent with any of the organization's policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law. The hospital may wish to add other reasonable criteria, such as patient care, treatment, and service needs for additional staff members with the applicant's skill and training.~~

~~In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by someone other than the applicant's chairperson or chief of service may be necessary to resolve the issue. The executive committee of the organized medical staff is responsible for requesting such an evaluation.~~

~~One indicator of the effectiveness of the reappraisal process may be objective documentation in an individual's file that, within the past few years, an individual's privileges were increased, reduced, or terminated because of the following:~~

- ~~• Assessments of his or her documented performance~~
- ~~• Nonuse of privileges for a procedures or treatments~~
- ~~• Emergence of new technologies~~

#### **~~Elements of Performance for MS.4.40~~**

~~A.1. In addition to meeting the requirements of standard MS.4.20, upon renewal or revision of privileges an individual must also meet the following additional requirements: Each renewal or revision of privileges is based on a reappraisal<sup>16</sup>~~

~~A.2. In addition to meeting the requirements of standard MS.4.20, upon renewal or revision of privileges an individual must also meet the following additional requirements: There are criteria that pertain to evidence of current competence and ability to perform the privileges requested~~

~~B.3. In addition to meeting the requirements of standard MS.4.20, upon renewal or revision of privileges an individual must also meet the following additional requirements: Upon renewing or revising privileges, the organized medical staff 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~~
- ~~• Involvement in a professional liability action, as defined in the medical staff bylaws, including final judgments and settlements involving a practitioner~~

---

<sup>15</sup> **Operative and other procedures** Includes operative, other invasive, and noninvasive procedures such as radiotherapy, hyperbaric treatment, CAT scan, and MRI that place the patient at risk. The focus is on procedures and is not meant to include medications that place the patient at risk.

<sup>16</sup> Renewal of privileges may not exceed a period of two years.

- Documentation as to applicant's health status
- Relevant practitioner specific data are compared to aggregate data if such data are available for that practitioner
- Morbidity and mortality data if such data are available for that practitioner
- Peer recommendations

~~(M) C 4. In addition to meeting the requirements of standard MS.4.20, upon renewal or revision of privileges an individual must also meet the following additional requirements: Each reappraisal includes information concerning professional performance, including clinical and technical skills and information from organization performance improvement activities, when such data are available.~~

~~A 5. In addition to meeting the requirements of standard MS.4.20, upon renewal or revision of privileges an individual must also meet the following additional requirements: Practitioners do not practice outside the scope of their privileges.~~

## Fair Hearing and Appeal Process for Adverse Privileging Decisions

### Standard MS.4.50

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.4.50

Mechanisms for fair hearing and appeals 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 NPDB, allow practitioners an opportunity to defend themselves.

### Elements of Performance for MS.4.50

**B** 1. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Is designed to provide a fair process that may differ for members and non-members of the medical staff

**B** 2. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Has a mechanism to schedule a hearing of such requests

**B** 3. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Has identified the procedures for the hearing to follow

**B** 4. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: Identifies the composition of the hearing committee as a committee that includes impartial peers

**B** 5. The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics: With the governing body provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws

### **Appointment to Membership on the Medical Staff**

#### **Standard MS.4.60**

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.4.60**

**A** 1. The organized medical staff develops criteria for medical staff membership.

**(M) C** 2. The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services.

**(M) C** 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.

**(M) C** 4. ~~The members of the organized medical staff who are responsible for the oversight of quality of care, treatment, and services are licensed independent practitioners.~~

**(M) C** 4. Membership is recommended by the medical staff and granted by the governing body.

### **Peer Recommendation**

#### **Standard MS.4.70**

~~Recommendations from peers in the same professional discipline as the applicant are used as part of the basis for the initial granting of privileges. Peer recommendations are used to recommend individuals for the renewal of clinical privileges when insufficient practitioner-specific data are available. 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.4.70**

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.4.70**

**(M) C 1.** Recommendations from peers are obtained and evaluated for all new applicants for privileges.

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

**(M) C 3.** Peer recommendations include the following information:

- Relevant training and experience
- Current competence
- Any effects of health status on privileges being requested

**(M) C 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.

### **Licensed Independent Practitioner Health**

#### **Standard MS.4.80**

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.4.80**

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.

**Note:** ~~The Americans with Disabilities Act (ADA) bars certain discrimination based on physical or mental impairment. Toward preventing such discrimination, the act prohibits or mandates various activities.~~

~~Hospitals need to determine the applicability of the ADA to their medical staff. If applicable, the hospital should examine its privileging or credentialing procedures as to how and when it ascertains and confirms the ability of an applicant to perform the privileges requested.~~

~~The Joint Commission cannot provide legal advice to hospitals. However, the Joint Commission has and will absolutely construe standard MS.4.80 in such a manner as not to be inconsistent with hospital efforts to comply with the ADA.~~

### **Elements of Performance for MS.4.80**

**B** 1. Process design addresses the following issues: Education of licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria)

**A** 2. Process design addresses the following issues: Self referral by a licensed independent practitioner

**A** 3. Process design addresses the following issues: Referral by others and maintaining informant confidentiality

**A** 4. Process design addresses the following issues: Referral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern

**A** 5. Process design addresses the following issues: 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

**A** 6. Process design addresses the following issues: Evaluation of the credibility of a complaint, allegation, or concern

**A** 7. Process design addresses the following issues: Monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required

**A 8.** Process design addresses the following issues: Reporting to the organized medical staff leadership instances in which an licensed independent practitioner is providing unsafe treatment

**A 9.** Process design addresses the following issues: Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

### **Focused Review of Practitioner's Performance**

#### **Standard MS.4.90**

~~There is a process that defines circumstances requiring a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers.~~

#### **Rationale for MS.4.90**

~~The purpose of this standard is to require an organization to identify a minimum set of circumstances that will require further intensive review to determine whether a practitioner's performance may require further action to improve that practitioner's performance. This process allows an organization to define its own circumstances for review of a practitioner's performance and also to define when external reviewers are necessary. Additionally, the goal of this process is not necessarily disciplinary but primarily to improve a practitioner's performance.~~

~~The practitioner's peers conduct the focused review of a practitioner's performance. Members of the organized medical staff are involved in activities to measure, assess, and improve performance on an organizationwide basis, including a focused practitioner review process. The focused review process involves monitoring, analyzing, and understanding those special circumstances of practitioner performance, as defined by the organized medical staff, which requires further evaluation. When the findings of the assessment process are relevant to an individual's performance, the organized medical staff is responsible for determining their use in ongoing evaluations of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges identified in this chapter.~~

~~Relevant information developed from the following processes is integrated into performance improvement initiatives and consistent with organization preservation of confidentiality and privilege of information.~~

#### **Elements of Performance for MS.4.90**

~~A 1. The focused review process includes the following: Definition of the special circumstances requiring focused review~~

~~A 2. The focused review process includes the following: Method for selecting focused review panels for specific circumstances~~

~~A.3. The focused review process includes the following: Time frames in which focused review activities are reasonably adhered to~~

~~A.4. The focused review process includes the following: Circumstances under which external peer review is required~~

~~A.5. The focused review process includes the following: Provision of participation in the review process by the individual whose performance is being reviewed~~

~~(M) C.6. The focused review process includes the following: The focused review is conducted in accordance with circumstances requiring a focused review, as defined by the organization~~

~~(M) C.7. The organized medical staff is involved in the following: Evaluation of individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities~~

~~(M) C.8. The organized medical staff is involved in the following: Communication to the appropriate parties of the findings, conclusions, recommendations, and actions taken to improve practitioner performance~~

~~(M) C.9. The organized medical staff is involved in the following: Implementation of changes to improve performance~~

## Temporary Privileges

### Standard MS.4.100

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

### Rationale for MS.4.100

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 are acceptable include the following:

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

~~Temporary privileges for the fulfillment of important patient care, treatment, and service needs are time limited as determined in the medical staff bylaws or other documents. Temporary privileges for new applicants are not to exceed 120 days.~~

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.4.100**

##### **Temporary privileges granted for an important patient care need:**

**(M) C 1.** Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws.

**A 2.** When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.

##### **Temporary privileges for new applicants:**

**A 3.** Temporary privileges for new applicants may be granted while awaiting review and approval by the organized medical staff upon verification of the following:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the privileges requested
- Other criteria required by the organized medical staff bylaws
- A query and evaluation of the 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

**A 4.** All temporary privileges are granted by the CEO or authorized designee.

**A 5.** All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.

**A 6.** Temporary privileges for new applicants are granted for no more than 120 days.

#### **Disaster Privileges**

#### **Standard MS.4.110**

The organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners.

#### **Rationale for MS.4.110**

When the disaster plan has been implemented (see Standard EC.4.10 for a description of emergency management planning requirements) and the immediate needs of the patients cannot

be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (see Elements of Performance 5-8). The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment, and services in the event of a disaster (refer to the Glossary for definitions of disaster and emergency) due to the length of time it would take to complete the process. A similar modified process for the assignment of disaster responsibilities for volunteers that are not independent practitioners exists at Standard HR.1.25.

While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained:

1. Verification of licensure
2. Oversight of the care, treatment, and services provided

This option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer practitioners.

There are a number of state and federal systems engaged in pre-event credentialing that may facilitate the implementation of disaster privileging of volunteers at the time of a disaster. Examples of such systems include the Medical Reserve Corps (MRC<sup>17</sup>) and the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP<sup>18</sup>). It is expected that additional programs will emerge and evolve.

#### **Elements of Performance for MS.4.110**

**A 1.** Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

**A 2.** As described in the bylaws, the individual(s) responsible for granting disaster privileges is identified.

---

<sup>17</sup> **MRC** – Medical Reserve Corps units comprise of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism. The MRC Program was formed in 2002, in cooperation with the White House’s USA Freedom Corps, as one of the charter programs of Citizen Corps. Pre-identifying, training and organizing medical and public health professionals to strengthen their communities through volunteerism is at the core of the MRC concept. MRC volunteers offer their expertise throughout the year by supporting local public health initiatives, such as immunization and prevention activities. When an emergency community need occurs, MRC volunteers can work in coordination with existing local emergency response programs.

<sup>18</sup> **ESAR-VHP** – The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and credentialing of healthcare professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs.

**B** 3. The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.

**A** 4. The organization has a mechanism to readily identify volunteer practitioners who have been granted disaster privileges.

**A** 5. ~~While disaster privileges are granted on a case-by-case basis, In order for~~ volunteers ~~to be~~ considered eligible to act as licensed independent practitioners, ~~the organization obtains for each~~ ~~volunteer practitioner in the organization must~~ at a minimum, ~~present~~ a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture hospital ID card that clearly identifies professional designation
- A current license to practice
- Primary source verification of the license
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
- Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster

**A** 6. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

*Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.*

**B** 7. The medical staff oversees the professional practice of volunteer licensed independent practitioners.

**A** 8. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

## **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<sup>19</sup> link. 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.3.50.

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.4.100) for this clinical situation.

These standards introduce the concept 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 credentialing and 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 involves 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

### **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 the “Management of the Environment of Care” chapter standards EC.6.10 and EC.6.20 for additional standards related to maintaining telemedical equipment.

#### *For Originating Sites Only*

##### **Standard MS.4.120**

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.

---

<sup>19</sup> **Telemedicine** The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. **Source:** American Telemedicine Association.

## **Rationale for MS.4.120**

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

## **Elements of Performance for MS.4.120**

**A 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:

a. The originating site fully privileges and credential the practitioner according to standards MS.4.10 through MS.4.110

b. The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission-accredited organization

Or

c. The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization<sup>20</sup>.

2. The practitioner is privileged at the distant site for those services to be provided at the originating site.

3. 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<sup>21</sup> 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.

*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.*

## *For Originating and Distant Sites*

### **Standard MS.4.130**

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.4.130**

---

<sup>20</sup> In the case of an accredited ambulatory care organizations the organization must verify that the distant site made its decision using the process described in MS.4.10 through MS.4.20 (excluding EP 2 from MS.4.10 and EPs 11 and 12 from MS.4.20) This is equivalent to meeting HR.4.10 through HR.4.34 in the Comprehensive Accreditation Manual for Ambulatory Care

<sup>21</sup> A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. See the "Sentinel Events" chapter in this manual for additional information.

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 or renewal or revision of clinical privileges.

**Elements of Performance for MS.4.130**

**B** 1. The medical staff recommends which clinical services are appropriately delivered by licensed independent practitioners through this medium.

**B** 2. The clinical services offered are consistent with commonly accepted quality standards.

**Continuing Education**

**Standard MS.5.10**

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

**Rationale for MS.5.10**

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

**Elements of Performance for MS.5.10**

*Hospital-Based Education:*

**A** 1. Hospital-sponsored educational activities are offered prioritized by the organized medical staff.

**A** 2. These activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.

**A** 3. The organized medical staff helps prioritize hospital-sponsored continuing education.

**B** 4. Education is based on the findings of performance improvement activities.

*Individual-Based Education:*

**(M) C** 5. Each individual's participation in continuing education is documented.

**(M) C** 6. Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.