The Three Cs of Medical Staff Document Review

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Practice Area: Health Law & Medical Staff and Credentialing

Medical staff bylaws and governing policies are important legal documents that too often sit on a shelf, gathering dust and accessed only before a survey by The Joint Commission (TJC) or in the midst of a medical staff crisis. These documents, however, are designed to define the purpose of the medical staff, specify the obligations and duties of its members, and provide a process for credentialing and privileging. It is therefore necessary to conduct periodic reviews to ensure compliance with applicable federal and state laws and TJC requirements. An organization also must effectively communicate their medical staff policies to all applicable staff, and apply these policies consistently throughout the organization.

A comprehensive medical staff document review consists of three Cs: Compliance, Communication, and Consistency. Applying the three Cs will help organizations create a functional set of governing documents that not only complies with applicable laws and regulations, but also provides guidance and structure to the medical staff and the organization. This article is intended to explain these three components of medical staff document review, while also highlighting specific medical staff issues that have been targeted recently by TJC.

Compliance
Medical staff bylaws and governing documents are influenced by several bodies of law including federal, state, and, if applicable, TJC standards. An organization must consider all applicable regulations when drafting and revising its medical staff governing documents. As TJC has recently revised its medical staff standards to align more closely with those required by the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (COP), this article focuses mainly on the following standards, which have reportedly been the focus of TJC surveys around the country. TJC Standard MS.01.01.01 defines those provisions that must be included in an organization's medical staff bylaws.[1]

Verbal Orders
The use and authentication of verbal orders falls in the top ten among the medical staff issues TJC focuses on during its surveys. According to The Joint Commission Resources (JCR),[2] routine and ubiquitous use is the key verbal order concept on which surveyors will focus. TJC standard MM.04.01.01, EP6 requires that hospitals minimize the use of verbal and telephone medication orders. Organizations should reserve the use of verbal orders for urgent or emergent situations only. Additionally, while practitioners may give orders verbally in the course of patient care, NPSG.02.01.01 requires practitioners who give a verbal order to verify it by asking the person receiving it to record and read back the order.

CMS also requires that all verbal orders be authenticated based on federal- and state-law requirements. Absent state law that designates a timeframe for authentication, all verbal orders must be authenticated within forty-eight hours.[3]

Organizations should include the language taken from TJC standards in their medical staff bylaws or governing documents, and should also delineate who may accept and authenticate verbal orders. Organizations also should note that the common practice of a physician authenticating an order after dictating it to a nurse, who transcribes it while in the physician's presence, is not acceptable. This practice, commonly referred to as "scribing," is considered a verbal order and thus is subject to the authentication requirements contained in each organization's verbal order policy.

Disruptive Behavior

Another hot-button issue stems from TJC's new leadership standard, which became effective January 1, 2009. LD.03.01.01 requires that hospitals have a code of conduct that defines acceptable, disruptive, and inappropriate behaviors, and that the hospital's leaders create and implement a process for managing disruptive and inappropriate behaviors. According to JCR, the code of conduct must be specific to medical staff. A hospital's general code of conduct may suffice if the hospital is able to show documentation that the code has been adopted by the medical staff; however, because the process for dealing with disruptive physicians may be handled differently, hospitals are strongly encouraged to develop a separate code of conduct for physicians. The American Medical Association recently released a model code of conduct.[4]

This standard has been in effect since January 1, 2009, so surveyors are looking not only for evidence of a medical staff adopted code of conduct, but also for evidence that the code has been implemented. Organizations should be prepared to present examples of physician files that demonstrate application of the hospital's code.

Credentialing/Privileging

The decision to credential and grant privileges to a practitioner is one of the most important decisions a hospital must make—and one that it may have to one day defend in court. TJC defines credentialing as "[t]he process of obtaining, verifying, and assessing the qualifications of a licensed independent practitioner to determine whether he or she is qualified and able to provide patient care services in or for a health care organization." Lawsuits involving negligent credentialing in which a hospital breaches its duty of care by granting privileges to an unqualified physician are becoming more common, and negligent credentialing is now a recognized tort in at least twenty-eight states. Such actions typically are not covered by malpractice insurance, and state limits on malpractice awards generally do not apply to a tort judgment. Thus, an organization must ensure that all credentialing decisions are made in compliance with its medical staff bylaws, medical staff governing documents, and applicable accreditation standards.

Once an organization has verified an applicant's credentials, it must carry out the privileging process by evaluating the applicant's current competency to perform specifically requested patient-care services. TJC and CMS require that each organization define its credentialing process and privileging process in its medical staff bylaws.[5] This process need not be the detailed, thirty-page version normally contained in a credentials manual, but rather can be a 30,000-foot view that includes references to TJC's standards that encompass three relatively new concepts, including the six areas of General Competencies, Focused Professional Practice Evaluation (FPPE), and Ongoing Professional Practice Evaluation (OPPE). These concepts should be present in the organization's credentialing and privileging policies.

General Competencies

Designed to align with the Accreditation Council for Graduate Medical Education (ACGME) competencies, TJC developed the six General Competencies to be more functional for a medical staff. TJC MS.06.01.05 requires that peer recommendations include an evaluation of these six competencies: medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. While TJC requires these six competencies be addressed in peer recommendations, form letters should not simply include yes/no checkboxes; they should include a broad scale designed to encourage comments from the person providing the reference.

Focused Professional Practice Evaluation
TJC defines FPPE as 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. [6]

TJC requires that every organization have a defined FPPE process, and the criteria for such must be approved by the organized medical staff. Such criteria may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with others involved with the care. According to JCR, the key focus during a survey is whether the hospital has a documented FPPE plan, preferably in the organization's credentialing handbook, and whether the medical staff bylaws reference the plan, as appropriate.

Ongoing Practice Performance Evaluation
While FPPE addresses evaluation of new practitioners and newly sought privileges, OPPE focuses on maintaining privileges once they have been granted.[7]

Unlike the traditional two-year cyclical credentialing process, OPPE involves continuous monitoring, the goal of which is to identify performance problems early and to resolve them before reappointment occurs. Under this standard, an organization must factor OPPE into its 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."

According to JCR, ongoing means that the OPPEs must be published less than twelve months apart, and JCR recommends conducting OPPE every six months to start, with a monthly process being ideal. The OPPE can be published as a "physician report card," and the type of information to be used in OPPE may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel. Suggestions for OPPE include universal indicators such as history and physicals (H&P) quality, medical records completion, use of clinical practice guidelines, and peer review trends. Whatever an organization decides to use as OPPE indicators, JCR recommends that it be practical data that the organization has the ability to measure.

When surveying an organization for its compliance with the OPPE standard, TJC will look first to ensure that the OPPE used by the organization has been defined by the medical staff, with clinical indicators chosen by applicable departments. Thus, organizations should include their OPPE plans in either the medical staff bylaws or governing documents. Finally, organizations that credential mid-level providers through the medical staff process must include mid-levels in the FPPE and OPPE processes. Midlevel providers governed by an organization's human resources department (rather than its medical staff) are not subject to the FPPE/OPPE standards, but the credentialing and privileging process for certain mid-level providers must be equivalent to the medical staff process.[8]

Low-Volume/No-Volume Practitioners
Managing low-volume practitioners poses new challenges to an organization's credentialing and privileging process, and medical staff governing documents should address low-volume practitioners, if applicable. Fewer physicians practice in the hospital because of recent trends including office-only, primarycare physicians; retired or part-time practitioners; or specialists who mainly work in surgery centers. While TJC's increased focus on FPPE and OPPE forces hospitals to address how to credential and privilege low-volume practitioners, even those hospitals who decide to forgo TJC accreditation are subject to the Medicare COP, which require hospitals to assess current clinical competency.[9]

TJC Standard MS.07.01.03, EP 2 allows hospitals to use peer recommendations when there is insufficient peer review data available to asses a practitioner's current competence. Medical staff credentialing policies should define this process and require that such peer recommendations come from peers who practice in the same specialty and who can attest to "current" clinical competence. Medical staff governing documents also should define what is "current," but in no case should this definition extend beyond the two-year reappointment period.

Communication
Although effectively drafted governing documents serve as a roadmap for the organization's medical staff, the most deftly crafted medical staff documents will be rendered ineffective if the organization does not appropriately communicate the provisions contained within these documents. JCR recently ranked communication as the number one medical staff issue identified in surveys throughout the country. This includes communication between providers as well as communication between providers and staff.

When surveying an organization, TJC will look first to the medical staff bylaws and governing documents to determine whether they include applicable provisions. They also may ask to see meeting minutes from various medical staff committees to determine whether there is evidence that the medical staff has created and adopted the applicable polices as required by the standards. Lastly, surveyors will talk with organizational staff to determine whether the applicable medical staff policies have been communicated appropriately throughout the organization.

For example, TJC Standard MS.03.01.01, EP 2 provides that "[p]ractitioners practice only within the scope of privileges as determined through mechanisms defined by the organized medical staff." Although a well-drafted set of governing documents outlines the process for granting privileges to a provider, and the meeting minutes from a medical staff committee reflect approval and adoption of the credentialing policy, organizations often fail the third test—ensuring that applicable provisions have been communicated to the appropriate nursing or other staff. In fact, JCR recently reported that at least 50% of the time, the scheduling nurses (or other applicable personnel) are unable to articulate to the surveyors the method for determining whether the physician actually has the privileges to perform the requested procedure, potentially resulting in the organization allowing a physician to perform a procedure for which he was never privileged.

Consistency
In conjunction with compliance and communication, an organization also must consistently apply its medical staff documents. Although this includes all applicable medical staff polices, organizations should pay particular attention to disruptive behavior codes of conduct, credentialing and privileging, and peer review policies. If an organization's credentialing policy defines "current competence" as being within a two-year period, the organization should not accept peer recommendations outside the two-year limitation for some applicants. Similarly, as discussed above, an organization's failure to follow its own credentialing policies for some of its medical staff could result in the hospital having to defend a negligent credentialing lawsuit. Thus, it is important for the drafter to work closely with the organization to ensure that the proposed provisions can be effectively enforced throughout the medical staff.

Conclusion
The three Cs of medical staff review include Compliance with the applicable laws and regulations, Communication of the provisions not only to the entire medical staff but also to the applicable organizational staff, and Consistency in an organization's application of these provisions. When undertaking a medical staff document review, drafters should consider these three components to assist the organization in creating a more useful and compliant set of documents. An effective set of medical staff documents and a specific focus on the issues currently targeted by TJC will help ensure a successful and strong medical staff program.

[1] While TJC recently revised its standards to require that all substantive provisions of medical staff governing documents be included in the medical staff bylaws, it has delayed implementation until further notice, and any changes that eventually are approved likely will not be effective until 2011.

[2] The JCR is an affiliate of TJC and is the official publisher and educator of TJC.

[3] 42 C.F.R. § 482.24.

[4] Available at http://www.ama-assn.org.

[5] 42 C.F.R. § 482.22(6); TJC Standard MS.06.01.03.

[6] *See* TJC Standard MS.08.01.01.

[7] *See* TJC Standard MS.08.01.03.

[8] *See* TJC Standard HR.01.02.05, EP 10, 11.

[9] 42 C.F.R. § 482.22.
