



Joint Commission Update 2026: Medical Staff

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Transforming to Meet the Needs of Patients & Healthcare Organizations



Our Responsibility

Joint Commission is responsible for ensuring that organizations are not only upholding the **public trust** by meeting the Conditions of Participation, but that we support honoring their spirit – the **safest, most effective, highest value and compassionate healthcare for patients**

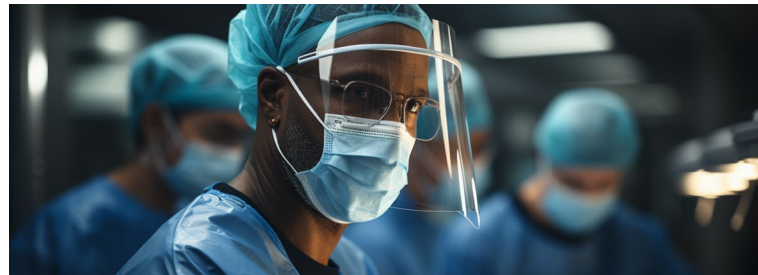
Responding to Industry Challenges

The healthcare **industry faces significant headwinds**, including cost, quality, access, and workforce challenges



Reducing Burden

Accreditation 360 is designed to **reduce complexity and burden** to place emphasis on what matters most – patient care



What Did We Hear

Sometimes the Truth Hurts: Our Requirements for Improvement

- Leaders indicated they did not know Joint Commission wanted to connect in a more collaborative way
 - "The X systems of the world can call up Joint Commission. We worry about sending an email."
 - "We never knew or thought about Joint Commission wanting a more collaborative partnership."
- Urban legends are hard:
 - "Can we just have IV fluids in our trauma bay?"
 - "What is up with the water bottles."
- Consistency is one of our number one Requirements for Improvement



Optimizing Programs & Reducing Operational Burden

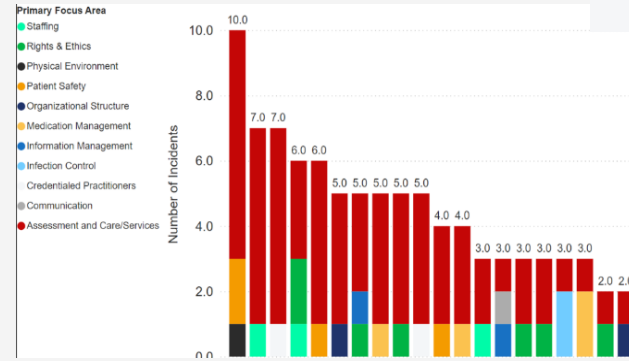
Enabling and affirming the highest standards of healthcare quality and patient safety for all

- **Announced survey process for non-deemed and deemed programs as allowed by CMS**
- **Disease specific certification review elective survey model to meet organization's needs (virtual model)**
- **Corporate summation expansion**
- **Harmonizing disease specific certification process for regional/market review**
- **Laboratory program enhancements (Medialab, system survey model)**
- **Accreditation decision management enhancements**
- **For cause data and survey process enhancements**

Broaden Resources for Performance Improvement

SAFER Placement	Standard	EP	EP Text	Observation	Cap and Cop Text
High / High	MS.01.01.01	1	The hospital provides care, treatment, services, and an environment that pose no risk of an "immediate threat to health or safety."	1) Observed in Theater Auditorium at new Hospital Site (One Renaissance Blvd, Villa Park, IL) Site Care, treatment and/or services were provided in a manner and in an environment that posed not of an "immediate threat to health or safety," also known as "immediate threat to health and safety (ITHS)" situation.	
High / High	MS.01.01.01	5	The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the manufacturer's instructions; - Use of disinfectants registered by the Environmental Protection Agency for critical devices and equipment according to the directions on the product labeling, including but not limited to: solution, chemical use, dilution, contact time, and method of application; - Use of EPA-approved liquid chemical standards for the processing of critical devices and high-level disinfectants for the processing of semi-critical devices in accordance with EPA-obtained label and device manufacturer's instructions; - Required documentation to develop engineering cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection; - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturer's instructions for automated high-level disinfection or sterilization equipment; - Criteria and process for the use of immediate-use steam sterilization; - Actions to take in the event of a reprocessing error or failure.	1) Observed in individual Theater at new Hospital Site (One Renaissance Boulevard, Park, IL) site, it was noted that the test was not performed on an endoscope during the cleaning, disinfecting and sterilization process as required by the manufacturer's instructions for use. This observation was noted by the Director of Surgical Services.	MS.01.01 Condition of participation: Infection prevention and control and antibiotic stewardship programs. (2) The hospital infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infectious agents within the hospital and between the hospital and other institutions and settings.

Preliminary Report Availability



Patient Safety Complaint Data

View Standards by Accreditation Program

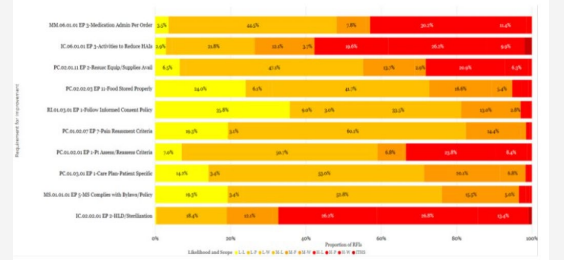
Current effective standards for all Joint Commission accreditation and certification programs are available. Click on your area of interest below.

[View the public standards.](#)

- Ambulatory Health Care
- Assisted Living Communities
- Behavioral Health Care & Human Services
- Critical Access Hospitals
- Home Care
- Hospitals
- Laboratory Services
- Nursing Care Centers
- Rural Health Clinics
- Telehealth

Public Access to Standards

Hospital Surveys Top 10 Standards Scored – Clinical Proportion of RFIs Per SAFER Placement



National Trended Clinical Data

Disease Specific Certification Dashboard

SAFER Certification Dashboard

Joint Commission Connect / SAFER® Certification Dashboard

Survey Analysis for Evaluating Risk®

Executive Summary

Top Five Most Frequently Scored Standards and Elements of Performance

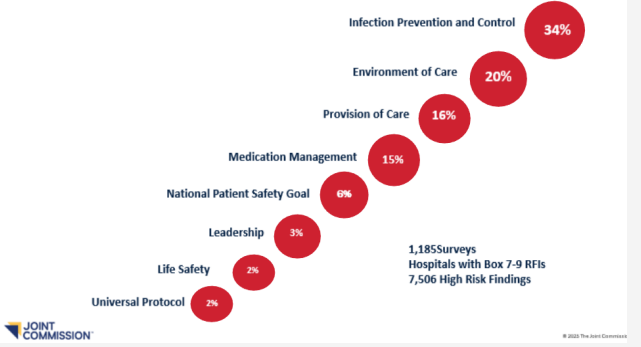
DDSF.3 EP.3 Care Based on Pt Assess Needs	100%	100%
DDSF.4 EP.2 Pt Care Plan Individualized	100%	100%
DDSF.3 EP.4 Med Record Justifies Treatment	100%	100%
DDSF.1 EP.3 Orgo Competence Assessment	100%	100%
DDSF.2 EP.5 Chel Past Guidelines Followed	100%	100%

Aggregate SAFER® Matrix

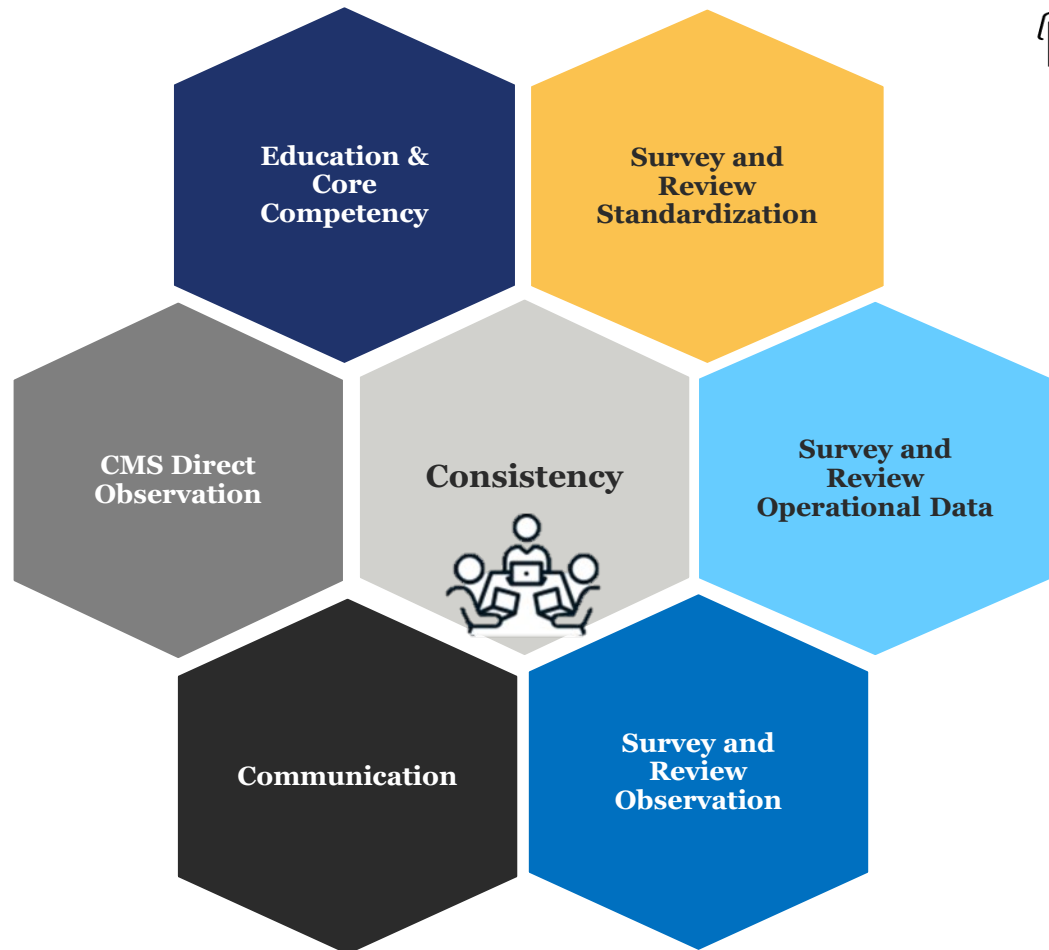
Standard	0	1	2	3	4	5	6
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0
MS.01.01.01	0	0	0	0	0	0	0

High-Risk National Data

High-Risk Requirements for Improvement (RFIs)



Journey to Excellence



EDUCATION and CORE COMPETENCY

- Onboarding: integration of content, completion of education, tracking at defined intervals, standardized content across programs, program specific content approval structure, and preceptor evaluation
- Continual Development: professional development, integration of case studies and content across programs, and tracking at defined intervals



SURVEY and REVIEW STANDARDIZATION

- Template and process standardization (Year end 2024)
- Document upload expansion (Hospital, Behavioral Health 2024)
- Survey Process Guide (SPG/SAG) (2026)
- Center for Medicare and Medicaid Services (CMS) consistency with record review and staff and patient interviews
- Utilization of surveyor and reviewer resources (e.g., CITe, templates, etc.)



SURVEY and REVIEW OPERATIONAL DATA

- Real time review data and trends
- Accredited and certified clarification data and trends
- Comparison of surveyor and reviewer requirements for improvement rate to peer group
- Level of citation trends (SAFER and level of deficiency)
- Integration of data and trends into education and core competency strategy



SURVEY and REVIEW OBSERVATION

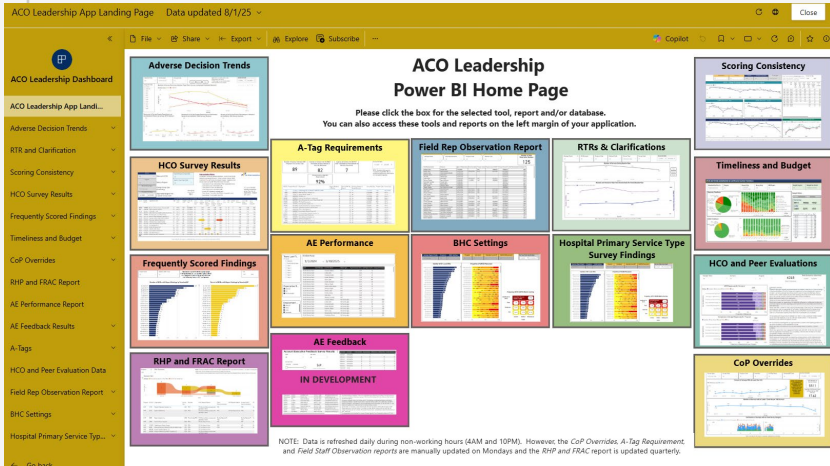
- Standardization of field director observation forms and data collection
- Structured program with incorporated cross-cadre observations within same programs
- Incorporation of CMS Direct Observation Verification (DOV) results



COMMUNICATION

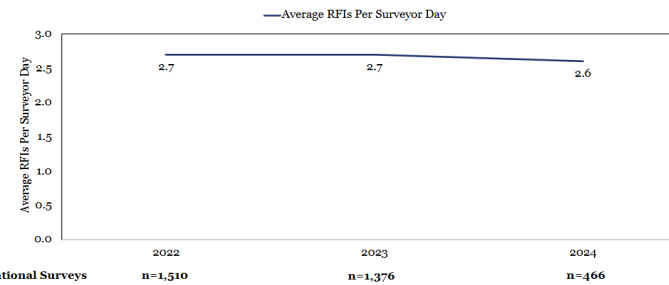
- Consistent messaging of data, trends, results and changes cascaded within the division
- Standardization of cadre and individual touchpoint calls

Data to Inform Process & Monthly/Quarterly Operations Review



Internal Operational Dashboard

Average Number of RFIs Per Surveyor Day Hospital 2023



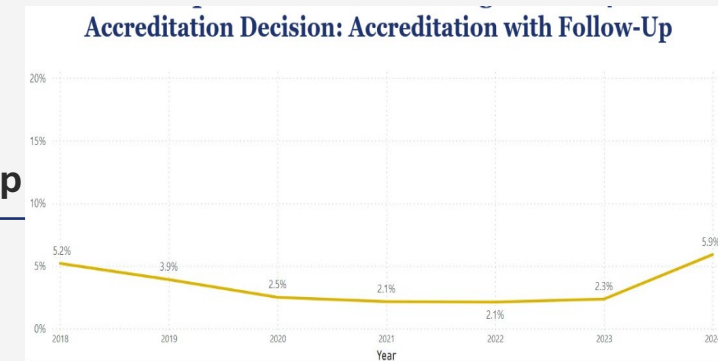
Average Number Requirements/ Surveyor Day

Ongoing Practice Performance Evaluation

FTE Status	Time in Service	Surveyor Peer Group	Program	Surveys	Average RFIs per Survey	Total RFIs	SAFER Flag	Chapter Flag	RFI Flag
FT	9	Nurse	HAP	5	0.40	2	0.60	0.78	2.17
FT	4	BHC/SW/LPC	BHC	72	4.94	356	0.61	0.65	1.91
FT	17	LSCS	AHC	7	8.14	22	0.52	0.39	1.41
FT	2	BHC/SW/LPC	BHC	43	6.44	277	0.65	0.50	1.89
FT	9	Nurse	HAP	38	2.54	71	0.50	0.47	1.52
FT	13	Nurse	HAP	5	2.60	13	0.46	0.03	1.30
FT	0	LSCS	HAP	15	8.00	120	0.53	0.30	1.29
FT	17	LSCS	HAP	30	8.20	246	0.81	0.53	1.25
FT	9	Nurse	CAH	10	2.40	24	0.57	0.51	1.24
FT	2	Nurse	HAP	39	2.82	110	0.41	0.09	1.21
FT	0	Nurse	OME	22	4.27	94	0.07	-0.10	1.17
FT	21	Nurse	OME	39	4.38	171	0.17	0.52	1.14
FT	0	BHC/SW/LPC	BHC	13	7.22	231	0.38	0.97	1.12
FT	13	Psychologist	BHC	9	5.56	50	1.12	0.57	1.06
FT	13	Pathologist/MT	LAB	57	3.56	203	0.06	0.02	1.02
FT	4	Nurse	HAP	24	3.38	81	0.17	0.21	0.99
FT	8	Nurse	OBS	5	1.40	7	0.95	0.64	0.92
FT	0	RRT	OME	17	4.47	76	0.52	0.85	0.91
FT	12	Nurse	OME	30	5.07	152	0.01	0.27	0.90
FT	8	Nurse	BHC	54	7.39	399	0.08	1.44	0.81
FT	10	LSCS	HAP	28	10.14	284	0.31	0.53	0.80
FT	3	Nurse	HAP	42	3.90	164	0.25	0.19	0.78
FT	8	Nurse	AHC	40	3.30	132	0.27	2.99	0.76
FT	19	DME	OME	46	1.96	90	1.15	0.76	0.75
FT	0	Pathologist/MT	LAB	16	4.31	69	0.04	0.33	0.74
FT	1	Nurse	HAP	27	4.04	109	0.42	0.29	0.73
FT	21	LSCS	HAP	36	10.56	380	0.28	0.57	0.70

peer group for comparison.				
Number of Surveys	Number of RFIs	Peer Group Average EP RFIs Per Survey	Number of Obs	Average Observations per Survey
4,816	65,839	13.67	82,470	17.12
Selected Surveyor (not preceptor/ee)				
Number of Surveys	Number of RFIs	Average EP RFIs Per Survey	Number of Obs	Average Observations per Survey
4,647	61,988	13.34	77,136	16.60
Total Surveyor Events				
Number of Surveys	Total Full Surveys	Total Non-Full Surveys	Total Surveys as Preceptor	Total Surveys as Preceptee
6,716	4638.00	1895	396	314

Accreditation with Follow-Up



Components of Accreditation 360



Simplified Accreditation Process

- Updated Accreditation Manual
- National Performance Goals
- Update Survey Process Guide



Outcome Driven Certification

- Perinatal Care
- Cardiovascular Procedural Care



Broadened Resources

- Survey Analysis For Evaluating STrengths (SAFEST) Program to recognize performance strengths



Continuous Engagement

- Innovative approach to continuous performance improvement

Previous State



CFR Number §482.24(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(2)	TAG: A-0454 (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	PC.02.01.03	The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
		EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietician or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.
		RC.01.01.01	The hospital maintains complete and accurate medical records for each individual patient.
		EP 7	All entries in the medical record are dated.
		EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.
		RC.01.02.01	Entries in the medical record are authenticated.
		EP 2	The hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation.
		EP 3	The author of each medical record entry is identified in the medical record.
		EP 4	Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy, law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.
		EP 5	The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.
		RC.02.03.07	Qualified staff receive and record verbal orders.
		EP 3	Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.
		EP 4	Verbal orders are authenticated within the time frame specified by law and regulation.
		EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of verbal orders includes the time the verbal order was received.

Current State



§482.24(c)(2)	TAG: A-0454 (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	RC.11.02.01	Entries in the medical record are authenticated.
		EP 1	All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care and who is authorized to write orders, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations.

Manual Redesign

Accreditation Participation Requirements (APR)

Emergency Management (EM)

Human Resources (HR)

Infection Prevention and Control (IC)

Information Management (IM)

Leadership (LD)

Medication Management (MM)

Medical Staff (MS)

National Performance Goals (NPG)

Nursing (NR)

Provision of Care, Treatment, and Services (PC)

Physical Environment (PE)

Performance Improvement (PI)

Record of Care, Treatment, and Services (RC)

Rights and Responsibilities of the Individual (RI)

Transplant Safety (TS)

Survey Process Guide

Survey Process Guide (SPG) – Overview

- Replaces Survey Activity Guide (SAG)
- Better reflects State Operations Manual (SOM) related to survey process for the CoPs
- Same version shared between surveyors and accredited organizations

UPDATED DECEMBER 1, 2026



Hospital Accreditation

Survey Process Guide

Survey Process Guide (SPG) – Overview

- Organized into sections based on the CMS CoP structure
- Contains separate section for evaluating NPG Chapter
- Includes updated Compliance Evaluation Tools



Hospital Accreditation

Survey Process Guide

Survey Process Remains the Same

Surveyors will continue to conduct activities for evaluating compliance with the standards and Elements of Performance such as:

- Individual tracers
- Medical record reviews
- Interview staff & patients
- Observation of care provided



Hospital Accreditation

Survey Process Guide

A360 Medical Staff Chapter Outline

Program HAP Chapter MS



▼ I. Medical Staff Bylaws

..... A. Self-Governance and Accountability (MS.14.01.01)

..... B. Adopting or Amending Bylaws (MS.14.02.01)

..... C. Unified and Integrated Medical Staff (MS.14.03.01)

..... II. Medical Staff Executive Committee (MS.15.01.01)

▼ III. Medical Staff Roles

..... A. Oversight of Care, Treatment, and Services (MS.16.01.01, MS.16.01.03)

..... B. Graduate Education Programs (MS.16.02.01)

..... C. Performance Improvement (MS.16.03.01)

▼ IV. Credentialing and Privileging

..... A. Credentialing (MS.17.01.01, MS.17.01.03)

..... B. Privileging (MS.17.02.01, MS.17.02.03)

..... C. Expedited Approval (MS.17.03.01)

..... D. Temporary Privileges (MS.17.04.01)

▼ V. Evaluation of Practitioners

..... A. Recommendations for Appointment (MS.18.01.01)

..... B. Performance Monitoring (MS.18.02.01, MS.18.02.03)

..... C. Acting on Reported Concerns (MS.18.03.01)

..... D. Fair Hearing and Appeal Process (MS.18.04.01)

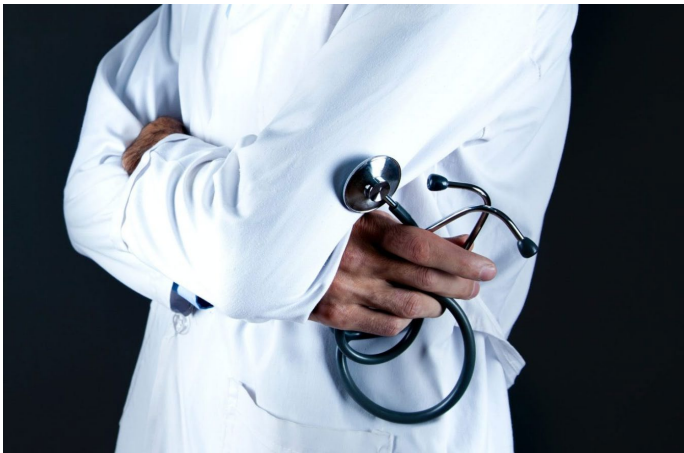
..... E. Licensed Practitioner Health (MS.18.05.01)

..... VI. Continuing Education for Practitioners (MS.19.01.01)

..... VII. Care, Treatment, and Services via Telehealth (MS.20.01.01, MS.20.01.03)

National Trends: Improving Quality and Safety

Medical Staff National Trends



MS Complies with Bylaws/Policy (MS.01.01.01 EP 5)

OPPE- Process Developed (MS.08.01.03 EP 1)

OPPE- Data Collection (MS.08.01.03 EP 2)

OPPE- Data Used (MS.08.01.03 EP 3)

Scope of Privileges (MS.03.01.01 EP 2)

FPPE: Us Eval criteria (MS.08.01.01 EP 4)

Criteria for Privileging (MS.06.01.05 EP 2)

Credentials Verification (MS.06.01.03 EP 6)

FPPE: Initial Privileges (MS.08.01.01 EP 1)

NPDB Query (MS.06.01.05 EP 7)

National Trends

SAFER Matrix Scoring

Likelihood to Harm		Immediate Threat to Health or Safety -			Total
		Limited	Pattern	Widespread	
High		2.7%	1.4%	2.2%	6.3%
Moderate		43.7%	17.3%	11.8%	72.8%
Low		15.8%	3.3%	1.8%	20.9%
		62.2%	22.0%	15.8%	

Total For Time Period and Program

Surveys	Average RFIs Per Survey	Number of RFIs
2,076	31.57	65,544

Statistics for Selected Standards

Surveys	Average RFIs Per Survey	Number of RFIs
973	1.68	1,638

MS.01.01.01 EP 5

MS Complies Bylaws/Policy

- **Incomplete or Missing Required Elements in History and Physical (H&P) Documentation:** A significant number of observations highlight that patient history and physical examinations frequently lack mandated elements such as review of systems, family/social/medical history, medication lists, allergies, vital signs, and comprehensive physical exams (including cardiac and pulmonary assessments). These deficiencies are noted across various units and specialties, often in violation of medical staff bylaws, rules, and organizational policies. The absence of these elements can impact patient safety, care continuity, and regulatory compliance. **MS.14.01.01 EP 3**
- **Timeliness, Authentication, and Co-Signature of Medical Records:** Many records reveal delays in completing, authenticating, or co-signing critical documents such as H&Ps, discharge summaries, operative reports, and consult notes. Common issues include late or absent physician co-signatures for records completed by residents, advanced practice providers, or physician assistants, and discharge summaries not completed within required timeframes. These lapses contravene medical staff rules and can lead to delinquent records, impacting both compliance and patient care. **RC.11.01.01 EP 4**
- **Credentialing, Privileging, and Policy Adherence:** Numerous findings pertain to failures in credentialing and privileging processes, such as missing peer references, expired certifications, lack of proper privileging for specific procedures, and non-adherence to bylaws regarding committee participation and policy review. These issues extend to improper delegation of duties, lack of required supervision, and outdated or unreviewed bylaws and policies, all of which pose risks to organizational governance and regulatory standing. **MS.17.01.03 EP 4**

OPPE – Process Developed

- **Lack of Clearly Defined or Implemented OPPE Processes:** Many observations highlight that healthcare organizations either do not have a clearly defined process for Ongoing Professional Practice Evaluation (OPPE) or have not implemented the process as required. This includes missing documentation, undefined frequency or indicators, and lack of privilege-specific measures.
- **Non-Compliance with Policy or Bylaws:** Numerous entries note that organizations are not following their own policies or bylaws regarding OPPE. Examples include OPPE being performed less frequently than required (e.g., only at reappointment every two years instead of semi-annually), incomplete reviews, or missing data for specific timeframes or provider categories.
- **Incomplete or Missing OPPE Data for Providers:** There are repeated findings of incomplete or missing OPPE data for various provider types, including allied health professionals, telemedicine providers, and low/no volume practitioners. This includes files lacking any OPPE documentation, missing quality indicators, or OPPE not being reviewed by appropriate medical staff.

OPPE – Data Collected

- **Lack of Specialty/Privilege-Specific Data:** Many observations highlight that OPPE data collected is generic and not tailored to specific specialties or privileges. For example, data such as records completion, length of stay, and readmission rates are commonly used across all providers, with no discipline-specific performance quality data identified for specialties like anesthesia, psychiatry, radiology, and others.
- **Absence of Departmental Approval or Defined Metrics:** Numerous entries note that the type of data to be collected for OPPE has not been determined by individual departments nor approved by the organized medical staff. This includes a lack of evidence that departments have selected or approved relevant quality metrics, and policies or bylaws are not being followed regarding specialty-specific data collection.
- **Reliance on Subjective or Incomplete Assessments:** Several observations indicate that OPPE processes often rely on subjective assessments by department chiefs or supervisors, rather than objective, measurable data. In some cases, only subjective judgments or checklists are used, and there is no evidence of objective data collection or meaningful quality indicators being tracked.

OPPE – Data Used

- **Lack of OPPE Data Collection and Utilization:** Numerous observations highlight that ongoing professional practice evaluation (OPPE) data was either not collected, not available, or not utilized in the credentialing and privileging process. For example, in several cases, there was no OPPE data available at the time of reappointment for various providers, including physicians, advanced practice nurses, and telemedicine practitioners.
- **Non-Compliance with Organizational Policies and Bylaws:** Many findings indicate that the OPPE process did not adhere to established organizational policies or medical staff bylaws. This includes missing required reviews, incomplete documentation, or failure to obtain alternative data for low/no volume providers as mandated by policy.
- **Insufficient Specialty-Specific or Individualized Evaluation:** Observations frequently note that OPPE metrics were not specialty-specific or individualized, with data often limited to event-related performance or aggregate group metrics. This lack of tailored evaluation prevented meaningful assessment of practitioner competence and did not meet the intent of ongoing performance monitoring.

Scope of Privileges

- **Lack of Credentialing and Privileging for Contracted or Mobile Providers:** Numerous observations highlight that contracted radiologists, teleradiologists, psychologists, and other specialists were providing services without being formally credentialed or privileged by the health care organization. This includes both initial credentialing failures and lapses in re-credentialing, often confirmed by leadership or credentialing staff.
- **Practitioners Operating Outside Approved Scope of Privileges:** Several entries describe situations where physicians, nurse practitioners, or physician assistants performed procedures or provided services (such as sedation, joint injections, or psychiatric evaluations) without having the specific privileges granted for those activities. In some cases, privileges were requested but not granted; in others, practitioners performed services not included in their approved scope.
- **Incomplete or Missing Documentation of Privileges:** There are repeated findings of missing or incomplete documentation regarding the delineation of privileges in credential files. This includes absent privilege forms, lack of evidence for specific privileges (e.g., moderate sedation, ECT, or hyperbaric medicine), and gaps in credentialing history, sometimes attributed to organizational changes or misunderstandings about contractual arrangements.

If Telemedicine: MS.20.01.01 EP3

FPPE – Us Eval Criteria

- **Lack of Implementation or Documentation of FPPE:** Many observations highlight that the Focused Professional Practice Evaluation (FPPE) process was either not implemented or not documented for newly credentialed providers. Examples include files where no evidence of FPPE was found at initial appointment, or where the process was started but never completed.
- **Inconsistent or Incomplete FPPE Processes:** Several entries note inconsistencies in how FPPE is conducted, such as incomplete evaluations, missing documentation, or deviations from established policies and bylaws. This includes cases where FPPE forms were missing signatures, lacked provider-specific data, or did not reflect the actual privileges being granted.
- **Policy Non-Compliance and Delays:** Observations frequently mention non-compliance with organizational policies or medical staff bylaws regarding FPPE. This includes delays in completing FPPE within required timeframes, failure to follow review procedures, and instances where OPPE (Ongoing Professional Practice Evaluation) was used in place of FPPE.

Criteria for Privileging

- **Credentialing and Privileging Without Required Documentation or Verification:** Numerous observations highlight that privileges were granted to practitioners without complete credentialing applications, missing required documents, or absent primary source verification of licensure and DEA registration. For example, in several cases, privileges were granted before peer references, health attestations, or application forms were completed.
- **Lack of Defined or Applied Criteria for Privileging:** Multiple entries note the absence of clearly defined or consistently applied criteria for granting specific privileges. This includes missing evidence of required training, experience, or competency for specialized procedures (such as sedation, radiology, or surgical privileges), and situations where privileges were granted outside of established processes or without committee review.
- **Contracted Providers Not Credentialed or Privileged:** Several observations report that contracted providers, such as radiologists or cardiologists, were delivering services without being credentialed or privileged by the hospital. This includes instances where entire groups of contracted providers were not processed through the hospital's credentialing system, as confirmed by various hospital leaders.

Credentials Verification

- **Delayed or Missing Primary Source Verification (PSV) of Licensure:** Numerous observations highlight that PSV of medical staff licensure was either not completed on time, was missing at the time of credentialing, or was conducted after license expiration or privilege renewal. For example, in several cases, PSV was performed weeks or even months after the required date, and in some instances, verification was only completed during or after the survey.
- **Verification Issues with DEA and Other Credentials:** Several entries note that documentation or verification of DEA licenses was not current or missing at the time of review. There are also instances where other required credentials, such as PALS certification or malpractice insurance, were not verified or had expired at the time of review.

FPPE: Initial Privileges

- **Lack of Evidence or Documentation of FPPE Implementation:** Many observations highlight that there was no evidence or documentation that a Focused Professional Practice Evaluation (FPPE) was implemented for newly privileged providers. This includes cases where files lacked documentation, processes were not initiated, or leadership confirmed the absence of FPPE.
- **FPPE Process Not Specific to Privileges Granted:** Several entries note that even when an FPPE process existed, it was generic and did not include an initial performance evaluation of the specific privileges granted. This includes missing criteria for type, frequency, or discipline-specific evaluations.

NPDB Query

- **Lack of Timely NPDB Queries:**

A significant number of observations highlight that hospitals were **unable to provide evidence that the National Practitioner Data Bank (NPDB) had been queried at the time of appointment, reappointment, or renewal of privileges**. This issue was noted across various roles, including physicians, nurse practitioners, and telehealth providers. In several cases, the NPDB query was either missing entirely or completed only after privileges had already been granted.

- **Documentation and Process Gaps:**

Many observations point to **incomplete or missing documentation in credentialing files**. This includes files lacking evidence of NPDB queries, queries performed outside the required timeframe, or documentation not aligning with medical staff bylaws and policies. Some organizations relied on continuous query processes but failed to demonstrate that results were considered during reappointment.

Practitioner Performance Monitoring

History

- Adopted the Accreditation Council for Graduate Medical Education (ACGME) six areas of “General Competencies” (2007)
 - Patient Care
 - Medical/Clinical Knowledge
 - Practice-Based Learning and Improvement
 - Interpersonal and Communication Skills
 - Professionalism
 - Systems-Based Practice
- Defined and clarified “Peer Recommendations” (2007)
- Introduced Ongoing Professional Practice Evaluation (OPPE) (2007) – new concept of “real time” objective monitoring
- Introduced Focused Professional Practice Evaluation (FPPE) (2007) - replaced “peer review”

Focused Professional Practice Evaluation

FPPE



Became effective January 2008



The goal of FPPE is for the hospital and medical staff to get a comfort level with the practitioner's performance of new privileges within the context of the hospital's policies and procedures, staffing, available equipment, the physical facility and financial support.



All applicants for new privileges must have a period of focused review. There is no exemption for board certification, documented experience, or reputation.



It is acceptable to group activities where the knowledge, and skills are so similar that if the practitioner performed a mix of the activities they could be deemed competent in the entire group.

FPPE Requirements

- The process must be defined
- The process must be consistently implemented as defined
- All new privileges (new applicants and new privileges for existing applicants) must be reviewed in accordance with the defined process
- There are no exceptions for any applicant or privilege
- Qualitative data is required, quantitative data may be necessary as well

Data Types

Quantitative

- Length of stay trends
- Post-procedure infection rates
- Periodic Chart Review
 - Dating/timing/signing entries
 - T.O./V.O. authenticated within defined time frame
- Number of H & P / updates completed within 24 hours after inpatient admission/registration
- Compliance with medical staff rules, regulations, policies, etc.

Qualitative

Description of procedures performed

Periodic Chart Review

appropriateness of tests ordered / procedures performed

Types of patient complaints

Peer recommendations

Discussion with other individuals involved in the care of patient(s), IE: consultants, surgical assistants, nursing, administration, etc.

FPPE for Residency/Fellowship Programs

- Residents and Fellows are not fully credentialed for independent practice
 - Must have FPPE upon granting of initial LIP privileges
 - A less intensive program may be established if provider is known to the organization

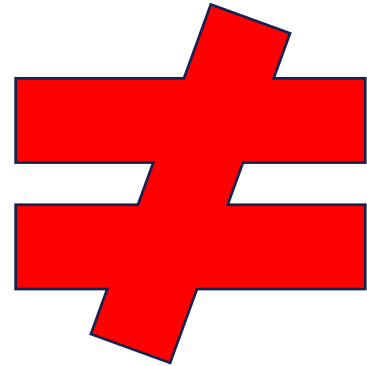


Ongoing Professional Practice Evaluation

OPPE

- OPPE has been in effect since January 1, 2007.
- Overarching goal is that organizations maintain a comfort level with
 - the performance of practitioners on an ongoing basis, identify performance issue on an ongoing basis,
 - take steps to improve performance when issues are identified
 - collection of data will result in a more evidence based re-privileging process at the two year renewal point.

OPPE



Peer Review

OPPE Requirements

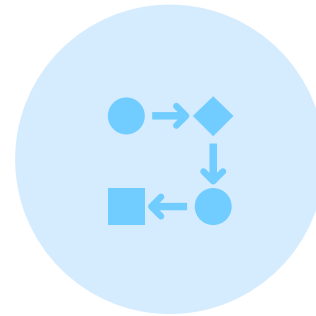
The process must be clearly defined:

- Responsibility for data review:
 - Department chair, department as a whole, etc as defined by the organization
 - Credentialing committee
 - Medical Executive Committee
 - Special committee of the organized medical staff
- Frequency of data review
- The process to use the data for decision-making
- The decision process resulting from the review

OPPE Outcomes



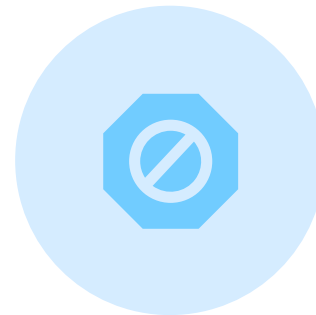
Determining that the practitioner is performing within desired expectations, no further action is warranted



Determining that a performance issues exists and requires a focused evaluation



Revoking the privilege because it is no longer required



Suspending the privilege, which suspends the data collection, and notifying the practitioner that if they wish to reactivate it they must request a reactivation



Thank You